

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

PRINTED: 03/20/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505515	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/06/2014
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NAME OF PROVIDER OR SUPPLIER OLYMPIA MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 1811 EAST 22ND AVENUE OLYMPIA, WA 98501
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F 000 INITIAL COMMENTS

This report is the result of an unannounced Abbreviated Survey conducted at Olympia Manor on March 4, 5, and 6, 2014. A sample of 18 current residents was selected from a census of 24.

The following complaints were investigated.

2961613
2961412

The survey was conducted by:

Susan Henderson, R.N., B.S.N., Investigator
Catherine Litsiba, R.N., B.S.N., Investigator

The Complaint Investigators were from:

Department of Social & Health Services
Aging & Long-Term Support Administration
Division of Residential Care Services,
District 3, Unit C
P.O. Box 45819
Olympia, Washington 98504-5819
Telephone: 360.664.8420
Fax: 360.664.8451

[Signature] 3-20-14
Residential Care Services 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.

4-2-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE NHA	(X6) DATE 4-2-14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution's policies and procedures provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000	F176		
F 176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to determine that self-administration of a medication was a safe practice for 1 of 1 current residents (#1) reviewed. This failed practice placed the resident at risk for unsafe administration of medication when Resident #1 self-administered nebulizing breathing treatments without physician orders for self-administration.</p> <p>Findings include:</p> <p>Resident #1's first admission to the facility was initially admitted to the facility on [REDACTED] 12 and had a history of multiple medical conditions with hospitalizations and re-admissions to the facility. Resident #1's most recent admission on [REDACTED] 14 from hospitalization for treatment of [REDACTED]</p> <p>[REDACTED] Resident #1 was cognitively intact with no memory problems.</p>	F 176	<p>How the nursing home will correct the deficiency as relates to the resident:</p> <p>Resident #1 was assessed for self-administration of medications. MD has been notified, order has been obtained, and care plan updated.</p> <p>How the nursing home will act to protect residents in similar situations</p> <p>A full house audit was completed to ensure that all resident that self-administer medications have appropriate orders, assessments, care plans, and notifications in place per facility policy as it relates to the regulatory guidelines.</p>	4-2-14	

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F 176	<p>Continued From page 2</p> <p>On 3/4/14, Resident #1 was observed sitting upright in his bed with a breathing treatment machine and ampules of medication to his right on a bedside table. The breathing treatment machine was operating and delivering medication via a mist to the resident's [redacted] site.</p> <p>Resident #1 turned off the breathing treatment machine. He stated he administered the breathing treatment medication to himself when he needed it, the nurses give him several ampules of medication to keep at his bedside during the course of the day.</p> <p>On 3/5/14, the Minimum Data Set Coordinator (MDS) stated Resident #1 preferred to give himself his breathing treatments. He was not aware there were no physician orders for Resident #1 to self administer medications. He was not aware that an assessment was not completed and was without a care plan to indicate the resident was safe to self administer medications.</p> <p>LN B stated Resident #1 had been giving himself the nebulizer breathing treatments for as long as she was employed there.</p> <p>The Director of Nursing (DNS) stated she was not aware that Resident #1 was administering medications to himself without a physician order or any assessment of his ability to do so.</p> <p>On 3/7/14, the physician stated she was not notified or consulted regarding Resident #1 administering his own breathing treatments or his desire to self administer this medication.</p>	F 176	<p>Measures the nursing home will take or the systems it will alter to ensure that the problem does not occur:</p> <p>Licensed nurses have been educated on the facility process of assessing residents for self-med administration, assessments, MD notifications, and obtaining MD orders.</p> <p>How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <p>An audit will be performed weekly by the Director of Nursing and/or designee to ensure that the Self-Administration of medication process is followed. 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.</p> <p>The title of person responsible to ensure correction</p> <p>Director of Nursing</p>		

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F 176	Continued From page 3	F 176			
F 312 SS=E	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to ensure residents who needed assistance with activities of daily living received showers/baths according to their plan of care for 11 of 11 residents (#s #1, 3, 4, 7, 9, 11, 13, 14, 15, 17 & 18) reviewed for provision of showers/baths. Failure to provide weekly showers/baths to dependent residents potentially placed residents at risk for poor personal hygiene, dignity issues, skin discomfort and potential skin breakdown when the only facility shower/bathing room was non-operational for 7 weeks.</p> <p>Findings include:</p> <p>On 3/4/14, the facility halls and residents including their rooms were malodorous with stale body odors. The only bathing room for the residents had been non-operational since 1/14/14 to present.</p> <p>The Administrator (ADM) and Director of Nursing</p>	F 312	F312	4-2-14	
			<p>How the nursing home will correct the deficiency as relates to the resident:</p> <p>Resident #1, 3,4,7,9,11,13,14,15,17, and 18 were assessed for activities of daily living regarding personal hygiene. All identified issues were resolved and residents are receiving personal hygiene per preference and care plans were updated. Shower repair has been completed</p> <p>How the nursing home will act to protect residents in similar situations</p> <p>An audit was completed on 03/18/14 by the Director of Nursing of resident's activity of daily living in regards of personal hygiene. Preferences verified and care plans have been updated as needed. Any identified issues were addressed.</p>		

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F 312	<p>Continued From page 4</p> <p>Services (DNS) stated (3/4/14) construction had started 1/14/14 and was expected to be completed later in the day.</p> <p><Resident #1></p> <p>Resident #1's most recent admission [REDACTED] 14 from hospitalization for a [REDACTED]</p> <p>On 3/4/14, Resident #1 was observed sitting upright in his bed with soiled linen articles on the floor. His nails were long with a dark brown material underneath them, his hair uncombed, and his feet dangling off the edge of the bed. The resident had a foul odor coming from him.</p> <p>Resident #1 stated he recently returned to the facility after a 10 day hospitalization for pneumonia. He stated prior to his hospitalization, the facility shower/tub had not been working due to construction. He stated he was given a pack of wipes (Aloe wipes, similar to a baby wipe) to cleanse himself. He stated occasionally he was offered a bed bath by staff but mostly he had to clean himself, he preferred a tub bath to showers. He stated he had not had his hair washed since January while residing in the facility. "What are any of us going to do? Move out of here—I don't think so, most of us have no where to go." He then stated, "Be honest, do I smell?"</p> <p>On 3/6/14, Resident #1 stated he preferred a tub bath and was hoping to take one in the evening. The tub had not been operational for seven weeks.</p>	F 312	<p>Measures the nursing home will take or the systems it will alter to ensure that the problem does not occur:</p> <p>Staff education has been completed with licensed staff of the facility process in regards to following care plans of residents personal preference of bathing and residents receive the assistance they need as it relates to the regulatory guidelines.</p> <p>How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <p>An audit will be performed weekly by the Director of Nursing and/or designee of residents activity of daily living regarding personal hygiene. 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.</p> <p>The title of person responsible to ensure correction</p> <p>Director of Nursing</p>		

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F 312	<p>Continued From page 5</p> <p>The February and March Medication Administration Records (MARS) documented Nizoral was not administered the entire of month of February with two documentations as, "No Nizoral-no shower." The March MAR was devoid of any documentation indicating it was offered/attempted. There was no evidence the physician was consulted to consider alternate treatments.</p> <p><Resident #2> Resident #2 was admitted to the facility on [REDACTED] 12 with diagnoses to include current changes in [REDACTED] and [REDACTED]</p> <p>On 3/4/14, Resident #2 was observed in her wheelchair in the dining room. Her clothes were soiled with white crusted material, her glasses smudged with white material, her eyes were matted and her hair was not combed. Her finger nail polish was chipped and her nails were jagged. There was a foul odor coming from her.</p> <p>Resident #2 stated it had been a really long time since she had been showered and she "really misses it." She indicated she had occasionally gotten a bed bath, with warm water and wash rags but was unsure of the last time she received one.</p> <p><Resident #3> Resident #3 was admitted to the facility on [REDACTED] 12 with diagnoses to include diabetes and a scalp condition. Resident #3 required extensive staff assistance for activities of daily living.</p> <p>On 3/4/14, Resident#3 was observed in her room</p>	F 312			

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F 312	<p>Continued From page 6</p> <p>wearing a blue flowered dress that was soiled with dried food material, white and brown substances. Her hair was standing up and uncombed. The bottom of her left foot had white material approximately 1/4 inch thick on the bottom surface and elongated toenails. There was a foul odor emanating from her.</p> <p>Resident #3 stated the shower had been broken for months, "None of us have had any shower or bath for so long, they keep telling us it will be done soon butdo you know what it's like not to have your hair not washed for more than a month? The itching is horrifying!" She continued, "We're supposed to have bed baths but instead they give you these wipes and you have to do it yourself. Occasionally they bring in a bucket of soap and water and they wipe your arm pits, a little in the front, but never in the back." She stated she should stop complaining because she did not want to get in trouble.</p> <p>According to the physician monthly March 2014 orders documented Resident #3 was to receive a medicated shampoo twice weekly on Tuesdays and Fridays for a scalp condition.</p> <p>On 3/4/14 the TAR records were reviewed. Resident #3 had not received the medicated shampoo since the end of January 2014, with no evidence the physician was consulted to consider an alternative treatment.</p> <p><Resident #4> Resident #4 was admitted to the facility on [REDACTED] '11 with diagnoses to include skin conditions.</p>	F 312			

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F 312	<p>Continued From page 7</p> <p>On 3/4/14, Resident#4 was observed in her room, the skin on her face and hands was dry and flaking. She stated it had been "So long" since she received a shower. She stated she had been washing herself the best she could at the sink or would use wipes. She said, "I've been smelling my ampits every day to see if I smell. I try not to get close to any other the other people because I don't want to smell them. In fact I've been trying to stay in my room as much as possible."</p> <p>Resident #4 stated since the lack of showering she had been noticing itching under her breast that burned at times.</p> <p>On 3/5/14, the February and March Shower Aide flows sheets were reviewed. Resident #4 was to have weekly showers, hair shampoo and nail care. It was documented the resident had her hair washed once on 2/27/14 in the 5 week time span.</p> <p><Resident #5> Resident #5 was admitted to the facility on [redacted] 14 with [redacted] and was dependent on staff for activities of daily living. The facility identified he was able to answer simple yes/no questions.</p> <p>On 3/4/14, Resident#5 was observed in his room, lying in his bed. His bed linens were soiled with a yellowish brown material. There was a container of wipes at the bedside. The skin on his face was flushed and he had a white beard with dry and flaking white material in it. His fingernails were elongated with brown material underneath several of them. There was a foul odor emanating from him.</p>	F 312		

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F 312	<p>Continued From page 8</p> <p>Resident #5 was asked several yes/no questions. He stated he had not received a shower recently (timeframe not able to identify) and was unhappy about it.</p> <p><Resident #6></p> <p>Resident #6 was admitted to the facility [REDACTED] 13 with diagnoses to include pneumonia, diabetes and recent "shearing wounds on coccyx area." Resident #6 was able to make his basic needs known. He relied on staff to meet his daily needs.</p> <p>On 3/4/14, Resident #6 was observed in his room working in an activity book. His hair was oily appearing, uncombed and matted in places. He appeared to not have been shaved for days, and his face was oily with a accumulated dead skin by his nostrils. His glasses were smudged. There was a foul odor emanating from him. He stated he had not been showered for a lengthy amount of time.</p> <p>On 3/5/14, NA B was interviewed, stating she had just finished a shower for Resident #6, because he "needed it badly." NA B said Resident #6 had an incontinent episode and "was crusted with stuff" in his private area. NA B stated Resident #6 had open sores on his bottom that started as reddened skin at the top of his coccyx, she told Licensed Nurse (LN) A who gave her some cream to put on it.</p> <p>On 3/5/14, the February and March Shower Aide flows sheets were reviewed. Resident #6 was to have weekly showers, hair shampoo and nail care. It was documented the resident had one bed bath on 2/11/14 but his hair was washed once in a 6 week time span.</p>	F 312			

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F 312	<p>Continued From page 9</p> <p><Resident #7> Resident #7 was admitted to the facility on [redacted] 14 with diagnoses to include diabetes and skin infections. Resident #7 required set up assistance from staff with bathing and hygienic tasks.</p> <p>On 3/4/14, Licensed Nurse (LN) A stated since the construction began on the shower/bathing room in mid January, she noticed Resident # 4, 7 and 10 had an increase in yeast skin issues and discomfort.</p> <p>On 3/5/14, Resident #5 stated she had been giving herself sponge baths during the construction of the shower/bathing room. She stated she did have yeast skin issues under both her breasts, that she did not have staff assistance.</p> <p>LN B was interviewed regarding LN A's statements of observing an increase in skin issues with no available showering/bathing room. LN B stated, "I don't know if I could say it's from people not getting showers for weeks, I personally think the ARNP just overwrites (prescribes) orders for stuff like that."</p> <p>The shower was repaired on 3/4/14. On 3/6/14, Resident #7 stated she had received a shower the evening prior. She said "It felt amazing!" and she until the shower did not realize how much burning and itching she had in her private area. "The longer I went without a shower the worse it got."</p> <p>On 3/5/14, the February and March Shower Aide flows sheets were reviewed. Resident #7 was to have weekly showers, hair shampoo and nail</p>	F 312			

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F 312	<p>Continued From page 10</p> <p>care. It was documented the resident had not had staff assistance to wash her hair since 2/18/14, and last given herself a bed bath on 2/25/14.</p> <p><Resident #8> Resident #8 was admitted to the facility on [redacted] 14 with diagnoses to include [redacted] with [redacted] and required extensive assistant from staff with activities of daily living.</p> <p>On 3/4/14 Resident #8 was observed sitting in his wheelchair in his room. His glasses were smudged on both lenses, his skin was dry and flaking on his arms, face and lower shins. He was not shaved and his hair was uncombed with white debris in it. His teeth and corners of his mouth had a sticky white-gray film on them. His hair was uncombed, sticking up at the back of his head in places. There was a foul odor emanating from him. His cognitive abilities made him inconsistent with answers, but when asked if he had had a shower or bath he responded "Can you give me one?"</p> <p>On 3/5/14, the February and March Shower Aide flows sheets were reviewed. Resident #8 was to have weekly showers, hair shampoo and nail care. It was documented the resident had not received any the entire month of February or yet for the month of March.</p> <p><Resident #9> Resident #9 was admitted to the facility on [redacted] 13 with diagnoses of [redacted] and required extensive assistant from staff with activities of daily living.</p>	F 312			

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NAME OF PROVIDER OR SUPPLIER OLYMPIA MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1811 EAST 22ND AVENUE OLYMPIA, WA 98501		
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F 312	<p>Continued From page 11</p> <p>On 3/4/14 Resident #9 was observed laying her bed. She did not respond when spoken to, as she appeared to be sleeping. She had a crusted white matter on her face and in the corners of her eyes. Next to her bed was the bath wipes observed in other resident rooms. There was a foul odor emanating from her.</p> <p>On 3/5/14, Resident #9 was observed sitting in her wheelchair in the same clothes as the day prior with dried food particles on the front. Her hair was uncombed, sticking up at the back of her head in places as if she had been lying down. There was the foul odor emanating from her as the day previous.</p> <p>The shower was repaired on 3/4/14. On 3/6/14, Resident #9 was interviewed stating she had received a shower the evening prior. She stated, "it had been so long" since she had a shower. Resident #9 stated she was given the wipes to clean herself when the shower was not operating, and staff would help her to get a "spit bath" but she mostly had to clean herself. She stated her normal routine was to really make sure her bottom was cleaned well at least weekly, but it hadn't been washed for "weeks." She stated she began to itch there and "in the front too." Resident #9 continued that she realized if she requested her narcotic pain reliever that it "stopped the itching immediately and almost everything else too."</p> <p>On 3/5/14, the February and March Shower Aide flows sheets were reviewed. Resident #9 was to have weekly showers, hair shampoo and nail care. It was documented the resident had not had staff assistance to wash her hair since greater than 6 weeks, and was given one bed</p>	F 312			

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F 312	<p>Continued From page 12 bath in that time frame on 2/15/14.</p> <p><Resident #11> Resident #11 was admitted to the facility originally on [redacted] 10 and most recent on [redacted] 13 with diagnoses to include [redacted] a [redacted] a history of yeast skin infections and was dependent on staff for activities of daily living.</p> <p>On 3/4/14, Resident #11 was observed sitting in her wheelchair in her room. Her hair was uncombed and her face had patches of dry skin and some patches of oiliness. There was a foul odor emanating from her body. She asked the investigator to return later or another day because she did not feel well.</p> <p>On 3/5/14, Resident #11 was observed sitting in her wheelchair watching television in her room. She stated she had not had a shower or bath in weeks, but did occasionally get a "wet rag," that was not warm but never a bed bath where her back and bottom were washed. She stated she had been experiencing discomfort under her breasts, and under her abdominal fold and groin on the right side.</p> <p>The shower was repaired on 3/4/14. On 3/6/14, Resident #11 was observed sitting in her wheelchair watching television in her room as the day previous. Resident #11 stated she had received a shower, stating "Finally! It was wonderful." She stated she did experience itching and discomfort during the construction project, but was unsure if the staff were aware because she was not asked.</p> <p>Review of the February and March TAR</p>	F 312		

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F 312	<p>Continued From page 13</p> <p>documented Resident #11 was to have a [redacted] applied to her [redacted] twice weekly to coincide with her shower days, but had not received it greater than 5 weeks.</p> <p>Review of the Shower Records for February and March revealed inconsistent documentation indicating a bed bath had/had not been given with documentation on the back of the record stating the opposite.</p> <p><Resident #13> Resident #13 was admitted to the facility on [redacted] to with diagnoses of [redacted] impairments and was dependent on staff for all activities of daily living.</p> <p>On 3/4/14, Resident #13 was observed sitting in his wheelchair in the dining room. His hair was oily with white debris and pulled back in his usual fashion, several fingernails were elongated and underneath several of them was a brown material, his face was unshaven and appeared oily. His glasses were dirty with a gray film on one of the lenses. There was a foul odor emanating from his body.</p> <p>On 3/6/14, Resident #13 was interviewed in his room. He stated the facility bathing/shower had been under construction for several weeks. He stated he really hadn't had a bed bath, but he had refused at times because he preferred a shower. He had noticed his scalp was starting to itch, especially by his ears. He stated "I'm sure I smell but so did everyone else, I don't know what could have been done but I guess that was up to them."</p> <p>On 3/5/14, the February and March Shower Aide</p>	F 312			

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F 312	<p>Continued From page 14</p> <p>flows sheets were reviewed. Resident #13 was to have weekly showers, hair shampoo and nail care. It was documented the resident had not had staff assistance to wash her hair since 2/15/14, and last received a bed bath on 2/19/14.</p> <p><Resident #14> Resident #14 was admitted to the facility on [REDACTED] 13 with diagnoses to include [REDACTED] and required extensive assistant from staff with activities of daily living.</p> <p>On 3/4/14, was observed sitting in her wheelchair in her room appearing asleep, she did not rouse when her name was called. Her hair was uncombed, sticking up in the back and her face had patches of dry skin. Her clothes had dried skin flakes and food particles on them.</p> <p>On 3/6/14, Resident #14 stated she had received a shower the day prior, but she was having problems with under her breasts, the left side was worse than the right. She stated she sometimes received assistance from the staff but it was not as often as she wanted.</p> <p>On 3/5/14, the February and March Shower Aide flows sheets were reviewed. Resident #14 was to have weekly showers, hair shampoo and nail care. It was documented the resident had not had staff assistance to wash her hair since for greater than 5 weeks.</p> <p><Resident #15> Resident #15 was admitted to the facility on [REDACTED] 14 with a history [REDACTED] and was dependent of staff</p>	F 312			

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F 312	<p>Continued From page 15 for all activities of daily living.</p> <p>On 3/4/14, Resident #15 was observed sitting in his wheelchair in the television room. His hair was oily appearing with white debris in it, his fingernails were elongated, with several of them with a brown material underneath them, his face was unshaven, with a build up of dead skin around his nose, corners of his mouth and his face appeared oily. His mouth was open and there was a thick white film on his tongue and yellowish material on his visible teeth. There was a foul odor emanating from his body in addition to a yeast like smell.</p> <p>On 3/5/14, the February and March Shower Aide flows sheets were reviewed. Resident #15 was to have weekly showers, hair shampoo and nail care. It was documented the resident had not had staff assistance to wash his hair greater than 6 weeks and was given a bed bath by nursing staff once since his admission on 2/21/14.</p> <p><Resident #16> Resident #16 was admitted to the facility on 11/9/13 with diagnoses to include a skin treatment cream twice daily to her coccyx and required limited assistance from staff with activities of daily living.</p> <p>On 3/4/14, was observed lying in her bed, appearing asleep, and she did not rouse when her name was called. Her hair was uncombed and her face had patches of dry skin.</p> <p>On 3/6/14, Resident #16 stated she had not received any shower for an extended time. She stated she had been offered disposable wipes to clean herself but did not like them, she had been</p>	F 312			

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F 312	<p>Continued From page 16 taking sponge baths and at the sink.</p> <p>On 3/5/14, the February and March Shower Aide flows sheets were reviewed. Resident #16 was to have weekly showers, hair shampoo and nail care. It was documented 2/21/14, the NA documented "unable to perform bed bath due to time constraints." The resident had not had staff assistance to wash her hair greater than 5 weeks. On 2/4/14 and 2/25/14 she had given herself a bed bath without assistance.</p> <p><Resident #17> Resident #17 most recent admit to the facility was on [REDACTED] 12 with multiple medical issues, was dependent on staff for transfers and toileting, and required supervision from staff for bathing and hygienic care.</p> <p>On 3/4/14, Resident #17 was observed lying in her bed, appearing asleep, and she did not rouse when her name was called. Her covers were drawn up and her face was not observable.</p> <p>On 3/5/14, Resident #17 was observed lying in her bed, on her left side, she did not rouse when her name was called. Her face appeared dry and with crusted dead skin and her hair was uncombed.</p> <p>On 3/5/14, the February and March Shower Aide flows sheets were reviewed. Resident #17 was to have weekly showers, hair shampoo and nail care. It was documented the resident had not had staff assistance to wash her hair or body the entire month of February or March until 3/6/14.</p> <p><Resident #18> Resident #18 was admitted to the facility on</p>	F 312			

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F 312	<p>Continued From page 17</p> <p>█/14 with diagnoses to include █ recent treatment with four times daily soaks for a skin issue, and was dependent on staff for activities of daily living.</p> <p>On 3/4/14, Resident #18 was observed lying in her bed, appearing frail, asleep, and she did not rouse when her name was called. Her face was dry with flaking skin, her hair was uncombed, and her teeth had a sticky gray material over them. There was a foul odor emanating from her body.</p> <p>On 3/5/14, was observed lying in her bed, on her left side, she had a difficult time hearing the investigator speak. She could not recall if she had received a shower but stated she would like to have one to get warm.</p> <p>On 3/5/14, the February and March Shower Aide flows sheets were reviewed. Resident #18 was to have weekly showers, hair shampoo and nail care. It was documented the resident had not had staff assistance to wash her hair greater than 5 weeks and received two bed baths the last on 2/15/14.</p> <p>The Director of Nursing Services (DNS) stated since her arrival at the facility as the new DNS on 2/18/14, she had not, nor was aware that the Interim Director of Nursing Services (IDNS) had ensured staff were providing bed baths to the facility residents.</p> <p>On 3/6/14, the Medical Director (MD) stated she brought her concerns to the ADM questioning why the construction was taking an extended amount of time. The MD stated she was told construction was going to be completed "soon," and she was</p>	F 312			

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F 312	Continued From page 18 never notified by staff of residents not receiving their physician ordered treatments for skin/scalp conditions. On 3/11/14, the Resident #3's physician was interviewed. His progress note dated 1/31/14 documented Resident #3's stated complaints to him that the shower was not operational and Resident #3 had stated to him "I can't take much more!" The physician continued he began having the same concerns regarding bathing and hygiene and had discussed the issue that day with the Interim Director of Nursing (IDSN) who told him the shower would be fixed "soon."	F 312			
F 328 SS=G	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure proper treatment and care for 1 of 1 residents (#1) reviewed for respiratory care. The facility failed to	F 328	F328 How the nursing home will correct the deficiency as relates to the resident: Resident 1 was evaluated to determine needs for [redacted] equipment and ability to self [redacted] Physician was contacted and Physician order obtained. Education was provided to the resident on the process of safe [redacted] practices, care plan was updated, and the appropriate equipment and supplies provided.		4-2-14

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F 328	<p>Continued From page 19</p> <p>seek and provide physician directed care for [redacted] and provision of clean equipment for Resident #1 who was [redacted] himself. This failure created potential harm to Resident #1 who improperly used non-sterile [redacted] equipment for [redacted] site in the presence of on-going bleeding at his [redacted]</p> <p>Findings include:</p> <p>Resident #1's most recent admission [redacted] 14 from hospitalization for [redacted]</p> <p>[redacted] Resident #1 was cognitively intact with no memory problems.</p> <p>Resident #1's [redacted] which the resident had for four years, was observed with dried blood and some fresh blood, with no [redacted] the [redacted] He took a soiled washcloth with dried amber and dark red colored material from his lap and wiped his [redacted]</p> <p>The medical record was reviewed. The [redacted] 14 hospital admission note documented the resident reported multiple symptoms including blood tinged [redacted] that persisted for months, and was observed with dried blood [redacted] which was abnormal. The resident was diagnosed with pneumonia and a parapneumonic effusion (fluid between layers of the lung.)</p>	F 328	<p>How the nursing home will act to protect residents in similar situations</p> <p>Facility completed a full house audit to ensure any similar residents had the appropriate education, supplies, orders, and care plans in place.</p> <p>Measures the nursing home will take or the systems it will alter to ensure that the problem does not occur:</p> <p>An education will be performed with Licensed Nursing Staff on 03/28/14 regarding physician directed care for safe [redacted] and provision of clean equipment for Residents who have [redacted] care and [redacted] requirements.</p>		

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F 328	<p>Continued From page 20</p> <p>The hospital discharge orders documented, management per protocol; [redacted] 2/15/14, is reusable, needs to be cleaned daily, and as needed with sterile water."</p> <p>The nurses note dated [redacted] 14, documented Resident #1 had returned from the hospital, with "new [redacted] placed. To be cleaned with sterile water twice daily."</p> <p>On 3/4/14, Resident #1 was observed sitting upright in his bed with a breathing treatment machine and 3 ampules of medication to his right on a bedside table. The breathing treatment machine was operating and delivering medication via a mist [redacted]. On his bedside stand to his left was a clear graduated cylinder with a clear fluid in it, and [redacted] connected to a hose with a [redacted] (a firm plastic tip with a large opening surrounded by [redacted] designed to allow effective [redacted] without damage to tissue) lying uncovered next to some toiletries.</p> <p>He stated he [redacted] himself. He stated the nurses did not like to do it, and with one nurse for all residents in the facility, they did not come in a timely manner so he preferred to do it. "When I can't [redacted] I need to be [redacted] immediately, I can't wait."</p> <p>Resident #1 stated sometimes the Licensed Nurse (LN) was present during [redacted]. He stated he placed the [redacted] sometimes forcing it, [redacted] as far as he could get it go, to try to get [redacted]</p> <p>Resident #1 stated the [redacted] was the</p>	F 328	<p>How the nursing home plans to monitor its performance to make sure that solutions are substained:</p> <p>An audit will be performed weekly by the Director of Nursing and/or designee regarding physician directed care for [redacted] and provision of clean equipment for Residents who have [redacted] and [redacted] requirements. 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</p> <p>The title of person responsible to ensure correction</p> <p>Director of Nursing</p>		

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F 328	<p>Continued From page 21</p> <p>only one provided to him from the staff, but he was never given a sterile [redacted]. He was aware it was not the correct [redacted] but, "That's not my biggest worry, I'm only supposed to live a couple of more months, and when I can't breathe that's my biggest worry, not getting air. I know I'm going to die, but until that day, I want to be able to breathe."</p> <p>Resident #1 stated after he returned recently to the facility from staying in the hospital 10 days for pneumonia, and he currently was too tired to empty the collected material in the [redacted] of the [redacted]. He stated the nursing assistants (NAs) bring him the distilled water, but the NAs are scared of the machine and set up although currently he needed more distilled water "badly."</p> <p>There were no physician orders for [redacted] for Resident #1. The Treatment Administration Record (TAR) contained orders dated 2/26/14, documented as "Special instruction, daily as needed, [redacted] cleansed daily as needed with sterile water, omitting the discharge order "clean daily" from the hospital and no orders for [redacted]. The TAR revealed Resident #1's [redacted] had not been cleaned.</p> <p>On 3/5/14, Resident #1 was observed in his bed with the same [redacted] as the day prior with collected material in the [redacted] and the clear graduated [redacted] with the same amount of clear fluid. Resident #1 was observed with dried blood [redacted] a washcloth with dried colored material as the day previous. Resident #1 stated the [redacted] was the same one from the previous days.</p>	F 328			

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F 328	<p>Continued From page 22</p> <p>At approximately 2:45 pm, Resident #1 was observed sitting in a chair in the hallway after ambulating with a Physical Therapist (PT). He began to cough [REDACTED]</p> <p>When he finished coughing he appeared fatigued and placed the washcloth on his leg. Observed on the washcloth was a very large amount of sticky amber colored material with an approximate 1 inch diameter blood clot.</p> <p>LN B stated she was aware Resident #1 had [REDACTED] equipment in his room, stating she had assisted Resident #1 when [REDACTED] himself by putting her finger over the notch on the [REDACTED]. She stated she had never [REDACTED] Resident #1, but was aware of Resident #1 [REDACTED] himself for "at least 6 months." LN B reviewed Resident #'s 1 chart and stated there were no physician orders to [REDACTED] Resident #1.</p> <p>LN C stated Resident #1 [REDACTED] himself and would place the [REDACTED] as far as he could [REDACTED]</p> <p>The Director of Nursing (DNS) stated she was not aware that Resident #1 was [REDACTED] himself, with improper equipment or non-sterile equipment.</p> <p>On 3/6/14, the DNS stated the facility defers to the Lippencott Nursing Manual as guidance to care for residents for standards of nursing practice, but there was no facility policy to direct staff how to care for residents with special respiratory needs.</p> <p>On 3/7/14 at 12:10 pm, the physician (MD)</p>	F 328		
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NAME OF PROVIDER OR SUPPLIER OLYMPIA MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 1811 EAST 22ND AVENUE OLYMPIA, WA 98501		
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F 328	Continued From page 23 managing Resident #1's care was interviewed. The MD stated she was not consulted or notified Resident #1 was [redacted] himself, [redacted] improperly, bleeding [redacted] coughing up mucus with blood, or that staff were not administering breathing treatments or adequately monitoring the resident. The MD stated the information was the first time she had heard the resident was [redacted] himself with a [redacted] and it was concerning because there was no order for the resident to be [redacted]	F 328			
F 353 SS=H	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353	F353 How the nursing home will correct the deficiency as relates to the resident: All Residents identified were assessed for care needs, appropriateness of therapeutic approaches, skin conditions, and dignity. Any issues identified were addressed.	4-2-14	

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	<p>Continued From page 24</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to have sufficient qualified staffing to provide and supervise care for residents for 18 of 18 current residents (#1,2,3,4,5,6,7,8,9,10,11,12,13,14,15,16,17, &18) out of a census of 24. The facility failed to provide timely and needed care to residents. The care provided was not supervised in a manner to provide consistency in therapeutic approaches to avoid actual harm. Staff did not adequately assess, evaluate, report or document information needed to formulate effective and timely interventions. The harm resulted from a failure to provide care and services to maintain resident's highest practicable well being in the areas of; responding to avoidable changes in skin condition, ensuring dignity of all residents.</p> <p>Findings include:</p> <p>1) Refer to 42CFR 483.10(n), F-176 Resident Rights: The facility failed to ensure Resident self administration of drugs was deemed safe for Resident #1.</p> <p>2) Refer to 42CFR 483.25(a) (3), F-312 Quality of Care: The facility failed to ensure care was provided to dependent residents affecting Residents #'s 1,3,4,7,9,11,13,14,15,17 & 18.</p>		<p>How the nursing home will act to protect residents in similar situations</p> <p>An audit was conducted to evaluate the staffing needs of the facility to provide services to maintain the highest practicable, physical, mental, and psychosocial wellbeing of each resident. Any issues were addressed.</p> <p>Measures the nursing home will take or the systems it will alter to ensure that the problem does not occur:</p> <p>Direct Care staff were trained regarding their individual responsibilities, pertaining to the provision of care, therapeutic approaches, skin care protocol, and residents' dignity.</p> <p>Direct Care Staff were trained regarding the need for resident assessment, evaluation, reporting, and documentation.</p>		

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F 353	<p>Continued From page 25</p> <p>3) Refer to 42CFR 483.25(k) (4)(5)(6), F-328 Quality of Care: The facility failed to provide physician managed treatment/care for special needs which caused Resident #1 to sustain physical harm.</p> <p>4) Refer to 42CFR 483.65(b)(1)(2)(c), F-441 Infection Control: The facility failed to ensure adequate infection control to prevent the spread of infection, for Residents #'s 1 & 5 with the potential to affect all facility residents.</p> <p>5) Refer to 42CFR 483.75, F-490 Administration: The facility failed to ensure effective administration to provide the highest practicable physical, mental and psychosocial well-being of each resident residing in the facility.</p> <p>6) Refer to 42CFR 483.75, F-493 Governing Body: The facility failed to ensure effective governing body or designated persons legally responsible for the management and operation of the facility to ensure the highest practicable physical, mental and psychosocial well-being of each resident residing in the facility. The facility did not have a plan in place when the repairs to the only facility shower room was not completed for 7 weeks and proper supplies and direction to staff to provide the necessary bathing, showering and shampoo per the resident plan of care.</p> <p>During interviews with residents (1,3,4, 5,7,9,11,12,13,14, & 17) complained of problems with receiving care or assistance from staff due to lack of sufficient staffing. All 11 of these</p>	F 353	<p>How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <p>See POC for F176 Resident Rights</p> <p>See POC for F-312 Quality of Care</p> <p>See POC for F-441 Infection Control</p> <p>See POC for F-490 Administration</p> <p>See POC for F-493 Governing Body</p> <p>The title of person responsible to ensure correction</p> <p>Administrator</p>		

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F 353	Continued From page 26 residents gave examples of prolonged waits for assistance or lack of assistance when they requested help from staff either verbally or by activating their call light. On 3/6/14, the Regional Consulting Nurse (RCN) stated the staffing in the building was based off of facility census and what the facility felt was appropriate. The facility failed to take into account the needs of the resident population to ensure their needs were met.	F 353			
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to provide a physician ordered therapeutic diet for 1 of 2 current Residents (#3) reviewed for dietary needs. This had the potential for this resident to experience decline in nutritional status and/or medical condition. Findings include: <Resident #3> Resident #3 was admitted to the facility on [redacted] 12 with diagnoses to include [redacted]. Resident #3 was cognitively intact, and required extensive staff	F 367	F367 How the nursing home will correct the deficiency as relates to the resident: Resident #3 diet was changed to reflect physician order for therapeutic diet. Care Plan was updated accordingly. Physician was notified of event of Resident #3 event on 02/14/14. Resident #3 was seen by Speech Therapist for [redacted]	4-2-14	

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NAME OF PROVIDER OR SUPPLIER

OLYMPIA MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE

1811 EAST 22ND AVENUE
OLYMPIA, WA 98501

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F 367

Continued From page 27
assistance for activities of daily living.

The medical record was reviewed. The physician orders documented Resident #3 was to receive a mechanical soft diet with regular thin liquids, small portions. The resident's Minimum Data Set (a comprehensive assessment conducted by the facility) dated 1/1/14 identified the resident to be on a Mechanically altered diet.

On 3/4/14, Resident#3 stated she was not happy with the quality of food she was receiving. She stated the meat she received was tough, having recently choked on a piece of steak. Another incident was when she choked on some salad and vomited. She brought it to the staff's attention. She stated she was given coleslaw instead of the salad. When she told the dietary person it was the same as salad. Resident #3 stated the staff was snide and responded, "No it's not. It's cabbage, not salad."

On 2/14/14, the nurses notes documented the resident, "choked on her lunch, she stated she vomited for several hours." The resident called her family member who came to the facility to check on her. The LN documented the resident refused to go to the emergency room. The family member stated, "she choked on steak and was concerned Resident #3 might have traumatized the stricture in her esophagus." The LN documented the family member recommended trying a 1/2 teaspoon of meat tenderizer which the resident took. LN further documented, "LN held all oral meds secondary to choking and unable to swallow."

There was no evidence the physician was notified regarding the incident which resulted from the

F 367

How the nursing home will act to protect residents in similar situations

An audit will be completed by the Dietary Manager and/or designee to ensure diet orders reflect physician orders. Diets will be corrected to reflect physician order, care plans updated as necessary, MD notified of any changes, and referrals given to speech therapy as needed and/or required.

Measures the nursing home will take or the systems it will alter to ensure that the problem does not occur:

Education will be performed with Staff on 03/28/14 regarding diet orders to reflect physician orders, assessment of dysphagia needs, updating care plans regarding diet orders, following physician orders, and communicate and resident changes appropriately.

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F 367	<p>Continued From page 28 resident receiving the incorrect diet.</p> <p>The Registered Dietician (RD) was asked what type of diet Resident #3 was to receive. The RD reviewed the record stating the resident was to receive a mechanical soft diet with regular thin liquids with small portions which was requested and ordered in January.</p> <p>The Dietary Manager (DM) was interviewed in the kitchen prior to lunch. She stated Resident #3 was receiving a regular diet with thin liquids and small portions. The slip documenting that had just been printed and placed on the resident's lunch tray that was observed for regular food. The DM stated she did not know anything about the resident needing a special diet.</p> <p>On 3/11/14, Resident #3's physician was interviewed. The facility had contacted the physician only in January 2014 to request small portions, but he was not aware the resident was not receiving the therapeutic mechanical soft diet he ordered, or of the choking episodes.</p> <p>Failure to timely follow up with physician orders and dietary recommendations placed the resident at risk for inability to eat the foods provided and swallowing difficulty.</p>	F 367	<p>How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <p>An audit will be performed weekly by the Dietary Manager and/or designee regarding diet orders to reflect physician orders, assessment of dysphagia needs, and following physician orders. 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.</p> <p>The title of person responsible to ensure correction</p> <p>Dietary Manager</p>		
F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p>	F 441		4-2-14	

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F 441 Continued From page 29

(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 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, interview and record review, it was determined the facility failed to ensure infection control practices to prevent the development and transmission of disease and

F 441 F441

4-2-14

How the nursing home will correct the deficiency as relates to the resident:

Resident 1's [redacted] was cleaned per infection control practices, [redacted] equipment was replaced with appropriate equipment, resident was educated on appropriate [redacted] techniques per facility process and best practices.

Resident 5 Linens were replaced, care plan updated with current infection control procedure, and notification to staff/visitors of current infection status per CDC guidelines.

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F 441	<p>Continued From page 30</p> <p>infection for 2 of 2 residents (#1 & 5) reviewed. This failure placed all residents at risk of disease transmission.</p> <p>Findings include:</p> <p><Resident #1> Resident #1's most recent admission on [REDACTED] 14 from hospitalization for [REDACTED]. Resident #1 was cognitively intact with no memory problems.</p> <p>On 3/4/14, Resident #1 was observed sitting upright in his bed and his bedside stand to his left was [REDACTED] machine connected to a hose with a [REDACTED] with a large opening surrounded [REDACTED] designed to allow effective [REDACTED] without damage to tissue) lying uncovered next to some toiletries.</p> <p>Resident #1's [REDACTED] was observed with dried blood and some fresh blood there. There was no [REDACTED]. He was observed wiping a soiled washcloth with dried amber and dark red colored material and wiped his [REDACTED].</p> <p>The nurses noted dated [REDACTED] 14, documented Resident #1 had returned from the hospital, with "new [REDACTED] placed. To be cleaned with sterile water twice daily."</p> <p>Resident #1's Treatment Administration Record</p>	F 441	<p>How the nursing home will act to protect residents in similar situations</p> <p>An audit will be completed by the Director of Nursing and/or designee regarding infection control procedure following the CDC guidelines, self-administration of suctioning, clean equipment and linen needs. Any identified residents have had their Care Plans updated accordingly to reflect necessary changes for infection control purpose.</p> <p>Measures the nursing home will take or the systems it will alter to ensure that the problem does not occur:</p> <p>An education will be performed with Staff on 03/28/14 regarding infection control procedures, notifying physician of self-administration of [REDACTED] clean equipment needs, and updating care plan to reflect changes as it relates to the facility process and regulatory guidelines.</p>		

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F 441	<p>Continued From page 31</p> <p>(TAR) contained orders dated 2/26/14, documented as "Special instruction, daily as needed, [redacted] cleansed daily as needed with sterile water, omitting the discharge order "clean daily" from the hospital and no orders for [redacted]. The TAR revealed that Resident #1's [redacted] or [redacted] had not been cleaned.</p> <p>On 3/5/14, Resident #1 was observed in his bed with the same [redacted] machine with collected material in the tank, [redacted] and the clear graduated [redacted] with the same amount of clear fluid. Resident #1 was observed with dried blood [redacted] and the same washcloth with dried colored material as the day previous. Resident #1 stated the [redacted] was the same one from the previous days.</p> <p>At approximately 2:45 pm, Resident #1 was observed sitting in a chair in the hallway after ambulating with a Physical Therapist (PT). He began to cough [redacted] with a washcloth after he finished he placed the washcloth on his leg. Observed on the washcloth was a very large amount of sticky amber colored material with an approximate 1 inch diameter blood clot. The PT took the washcloth not wearing gloves and stated he would get another wash cloth.</p> <p>LN B stated she was aware Resident #1 had [redacted] himself, as she was present at times, described how Resident #1 would take the [redacted] from the bed side table and [redacted] himself. LN B stated she did not have concerns regarding infection control because "He wants to do it himself and has for a long time."</p>	F 441	<p>How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <p>An audit will be performed weekly by the Director of Nursing and/or designee regarding infection control process and procedure of self-administration of [redacted] clean equipment and linen needs, and updating care plans to reflect changes. 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.</p> <p>The title of person responsible to ensure correction</p> <p>Director of Nursing</p>	

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F 441 Continued From page 32

LN C stated she had been present when Resident #1 [redacted] himself but did not know if it was a [redacted] but assumed it was sterile. LN C stated Resident #1 [redacted] himself and would place the [redacted] as far as he could [redacted]. LN C had not been trained at the facility on how to [redacted] residents, and did not know if how Resident #1 [redacted] himself was correct or not following infection control standards.

The Director of Nursing (DNS) stated she was not aware that Resident #1 was [redacted] himself, with improper equipment or non-sterile equipment.

<Resident #5>
Resident #5 was admitted to the facility on [redacted]/14 with diagnoses to include a history of [redacted] or wounds to his body, significant cognitive impairments and was dependent on staff for activities of daily living.

According to the facility documentation, the LN admission noted documented the resident had [redacted] located in [redacted].

On 3/4/14, the resident was observed in his room, lying in bed. His bed linens were observed with yellowish brown stains. There were bagged linens on the floor next to the door of the room. There was no sign on his door indicating any kind of precautions for staff or visitors regarding his care.

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F 441	<p>Continued From page 33</p> <p>On 2/25/14, the physician ordered to check Resident #5 for C-difficile (a contagious spore infection of the colon that is not killed with alcohol based hand rub). On 2/26/14, Resident #5 was found to have a positive test result.</p> <p>There was no evidence the facility had care plans directing staff how to prevent spread of the two infectious processes.</p> <p>On 3/5/14 the DNS stated the facility does not place signage on resident rooms to alert staff or visitors about infectious disease processes. The DNS stated she had told the staff about using universal precautions for Resident #5, and thought she had told staff to make sure his hands were washed because he leaves his room but did not document anything to direct the staff to do so.</p> <p>On 3/6/14, the facility provided an infection control policy and procedure including interventions the facility should implement to prevent the transmission of disease of infection, "Investigate, control and prevent infections in the facility; Decide what procedures, such as isolation, should be applied to an individual resident." It further documented in addition the policies that were designed to prevent the spread of infection interventions including: "Implementing appropriate precautions when a resident is identified with a communicable disease; requiring staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice and requiring personnel who handle, store, process and transport linens to do so in a manner to prevent the spread of infection."</p> <p>Nursing Assistants (NA) B,C,D and E were</p>	F 441			

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F 441 Continued From page 34
interviewed regarding Resident #5's infectious processes. NA B and D stated they had heard from other staff that Resident #5 had C-difficile, but it was not documented in his care plan. NA C stated she knew the day his lab result had come back positive because she obtained the sample for the nurse the day prior and was working. NA E stated she worked infrequently but had learned a couple of days prior. Each of the staff stated they could wear gowns and masks if they wanted when assisting Resident #5 in changing his briefs after incontinent episode, but indicated there were no other special considerations.

On 3/7/14 at 12:10 pm, the physician (MD) managing Resident #1's care was interviewed. The MD stated she was not consulted that Resident #1 was [redacted] himself, [redacted] improperly, bleeding from his [redacted] coughing up mucus with blood, not administering breathing treatments or adequately monitoring the resident.

The MD stated she was concerned and would address the lack of infection control when she was next at the facility.

F 441

F 490 SS=F 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced

F 490 F490

4-2-14

How the nursing home will correct the deficiency as relates to the resident:

The identified ADM and IDNS are no longer at the facility.

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F 490	Continued From page 35 by: Based on observation, interview, and record review, the facility failed to administer operations and use resources to ensure resident safety, health, and well being. The facility failed to implement an alternative plan when it became clear the repair of the only showering/bathing room equipment would take an extended period of time to ensure resident needs were met according to their plan of care. This failure resulted in the potential for widespread harm related to issues of skin care, infection control and quality assurance. Findings include: On 3/4/14, the facility's shower/bathing room used by all residents in the home was observed non-operational with construction work being done. The contractor working stated he had started the project 1/14/14. The remodel project was identified for "tile replacement of the shower and the floor." No alternate plan was implemented to ensure residents' plan of care for showering, bathing and shampooing was followed. There was no information found to indicate staff were educated regarding the need for thorough bed baths or that additional staff were provided to ensure dependent residents received additional assistance to thoroughly wash and shampoo. Refer to F-tag 353 and 441.	F 490	How the nursing home will act to protect residents in similar situations New ADM and DNS have been put in place to ensure resident needs are met. New ADM and DNS have received education regarding their responsibility to administer operations and se resources to ensure residents are provided care to maintain the highest level of resident safety, health and well-being. The shower repair is complete and showers provided per preference and care plan. ADM and DNS received education on process of shower room needs. Measures the nursing home will take or the systems it will alter to ensure that the problem does not occur:		
F 493	483.75(d)(1)-(2) GOVERNING BODY-FACILITY	F 493		4-2-14	

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F 493 SS=G	<p>Continued From page 36 POLICIES/APPOINT ADMN</p> <p>The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, it was determined the governing body failed to ensure that the facility was operated in a manner to maintain compliance with regulations related to the facility's maintenance and meeting the care planned activity of daily living needs of 24 residents related to access to working bathing facilities. When the only shower room in the facility was not immediately repairable, the governing body failed to ensure that it supplied resources sufficient to meet the on-going care planned hygiene needs of 24 of 24 residents.</p> <p>This failure caused a decrease in the quality of life of residents and placed residents at potential risk for developing skin changes.</p> <p>Findings include:</p> <p>On 3/4/14, the facility's shower/bathing room used by all residents in the home was observed non-operational with construction work being</p>	F 493	<p>How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <p>Monthly visits will be conducted by the corporate Regional Support team to provide oversight regarding the appropriate administration of the facility. Reports of findings will be provided to the ADM and DNS for correction and a review of corrections will be completed to ensure compliance.</p> <p>The title of person responsible to ensure correction</p> <p>Regional Team</p> <p>F493</p> <p>How the nursing home will correct the deficiency as relates to the resident:</p> <p>The identified ADM and IDNS are no longer at the facility.</p> <p>How the nursing home will act to protect residents in similar situations</p>	4-2-14	

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F 493	<p>Continued From page 37</p> <p>done. The contractor working stated he had started the project 1/14/14. The repair was scheduled for one day. The contractor stated the facility shower would be done later that afternoon (3/4/14 at 3:00 P.m.), and operating; but not the tub.</p> <p>The Administrator (ADM) stated there was no facility plan for the residents hygiene needs during the extended construction time. The ADM stated were no issues with the non-operational bathing/shower room for 7 weeks because the residents did not have any concerns regarding the non-operational bathing room because they were clean, and the DNS stated there were no skin issues.</p> <p>There was no plan in place to provide alternate equipment to provide residents with showers, bathing and shampooing once it was clear to administration the repair work was extensive and would not be completed within a week.</p> <p>On 3/4/14, the Facility Maintenance Director (FMD) stated he started employment at the facility on 2/10/14. He stated he brought to the ADM's attention shortly after his arrival at the facility, he could rent a portable shower for the residents but that had not occurred.</p> <p>On 3/5/14, the Social Services Director (SSD) and Minimum Data Set Coordinator (MDS) stated the lengthy unfinished construction of the only facility shower/bathing room was discussed nearly every day in a stand up meeting with</p>	F 493	<p>New ADM and DNS have been put in place to ensure resident needs are met. The resident council will be informed of any upcoming projects in the future.</p> <p>Training was provided to the ADM and DNS have received education regarding their responsibility to administer operations and se resources to ensure residents are provided care to maintain the highest level of resident safety, health and well-being.</p> <p>Measures the nursing home will take or the systems it will alter to ensure that the problem does not occur:</p> <p>The shower room is complete and residents are receiving showers per resident preference and care plan.</p> <p>ADM and DNS received education on process of shower room needs.</p>		

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F 493	<p>Continued From page 38</p> <p>department managers. The SSD stated there were grievances filed by residents in regards to the nonfunctioning shower room and/or not receiving bed baths.</p> <p>The facility resident concern/grievance log was reviewed. A resident concern dated 1/16/14 filed by a resident and family member documented the resident wanted a shower, but it was not working. On 1/20/14 the SSD spoke with the ADM and documented a contractor was fixing it, but was "unsure how long it would take to fix." The ADM signed the concern on 1/31/14 but had documented no findings or action recommendations to resolve the concern.</p> <p>On 2/17 and 2/19/14, Resident #3 voiced "frustration" that the shower was still not fixed. The follow up to Resident #3's concern was documented on 2/21/14, recommending the Nursing Assistant (NA) offer a bed bath or bath until the work was completed. The facility action to the concern was documented as discussed in the daily stand up meeting on 2/24/14, and the construction work continued expected to be completed 3/3/14. The ADM signed the concern form on 3/3/14.</p> <p>On 2/28/14, Resident #3 voiced a concern stating she was told 2 days prior she would be given a bed bath, but had never received one. Resident #3 asked for a bed bath again on 2/27/14, and was told by staff she would receive one in the evening, but never did receive one. On 3/3/14, the ADM signed the concern report that day he was aware of the concern.</p>	F 493	<p>Training was provided to the Regional Director of Operations and Regional Nurse Consultant regarding their role in providing support and resources to the facility.</p> <p>How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <p>An audit will be performed weekly by the ADM and/or designee to ensure plans are in place when shower room is need of repair. Results will be turned in to the Quality Assurance committee for the next sixty days or further as determined by the Quality Assurance Committee. Social Services will report all grievances to the Quality Assurance committee for the next 60 days or further as determined.</p> <p>The title of person responsible to ensure correction</p> <p>Regional Team</p>		

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F 493	<p>Continued From page 39</p> <p>The proposed plan by management was to "just wait until construction was completed." The SSD stated she did not believe the ADM or management team had discussed with the residents the construction of the bathing room. The SSD and MDS staff stated nursing staff were to give residents bed baths, and the issue of residents not having their hair washed for greater than a month was addressed more than a month after construction of the shower remodel had started, when the facility obtained a portable hair washing basin system was implemented.</p> <p>There was no noted proactive response to implement solutions during the repair to ensure residents received showers, baths and shampooing according to each resident plan of care.</p> <p>On 3/6/14, the Resident Council President (RCP) stated the facility had not had a meeting with the residents to inform them of the repair of the bathing room, apprised them of the progress, or sought resident input regarding concerns.</p> <p>During the timeframe from January 2013 to March 6th 2013 the facility had two changes in the Administrative team. The Administrative team present at the time of the investigation was not fully informed of the current facility situation.</p> <p>On 3/18/14, the Corporate Representative (CR) was contacted. She stated the facility, Regional</p>	F 493			

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F 493	Continued From page 40 Consultant Nurse (RCN) and Regional Director of Operations (RDO) had notified her several weeks into the project approximately at the end January or beginning of February, that the shower room repair was more extensive, stopped the project and sought approval to continue, which was given. The CR stated the plan by the facility staff, RCN and RDO was to use the tub bath or offer bed baths until the project was completed, but the issue of hair washing was not brought to her attention. Refer to F-490	F 493			