

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

PRINTED: 01/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505362	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/17/2014
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NAME OF PROVIDER OR SUPPLIER FOREST VIEW TRANSITIONAL HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5129 HILLTOP ROAD EVERETT, WA 98203
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INITIAL COMMENTS

This report is the result of an unannounced Abbreviated Survey conducted at Forest View Transitional Health Center on January 7, 9, 10 and January 17, 2014. A sample of 8 current residents and 1 former or discharged resident was selected from a census of 58.

The following were complaints investigated as part of this survey:

2931164

The survey was conducted by:

Nadyne Krienke, R.N., M.S.N.

The survey team is from:

Department of Social and Health Services
Aging and Disability Services Administration
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David Parker 01/27/14
Residential Care Services Date

F 000

Preparation and/or execution of this plan of correction does not constitute the provider's admission of or agreement with the facts alleged or conclusions set-forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

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FEB 14 2014
ADSA/RCS
Smokey Point

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Donna Backman</i>	TITLE RVP	(X6) DATE 2/11/14
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to thoroughly assess and develop an individualized plan of care for pressure relief measures and interventions for pressure sore/ulcer healing for 3 of 3 residents (Resident 1, 2, 3) who were at risk for skin breakdown. Failure to develop, implement and evaluate interventions for wound healing resulted in actual harm for Resident 1 who developed avoidable painful pressure sores and placed Residents 2 and 3 at risk for delay in healing of existing pressure sores.</p> <p>Findings include:</p> <p>The facility's procedure for the Weekly Ulcer Report directed staff to complete an incident report for acquired wounds, and to update care plans for monitoring and services for residents with pressure ulcers.</p> <p>The facility's policy read: " To ensure that residents who enter the facility without a pressure ulcer do not develop pressure ulcer unless their</p>	F 314	<p>F314</p> <p>Resident: Resident #1 Plan of Care was updated regarding skin conditions and prevention.</p> <p>Resident #2 Plan of care was updated regarding skin conditions and prevention.</p> <p>Equipment was added for additional skin intervention.</p> <p>A follow up appointment for wounds was made for Resident # 2</p> <p>Resident # 3 is no longer at the facility.</p> <p>All residents: :</p> <p>Current residents will be reviewed by DNS or designee to ensure skin sweep is complete on residents and that any changes in condition have been reported to the physician and documented in the resident's clinical record.</p> <p>System Review/Education: On 01/28/14 LN's were educated on facility policies for initial ulcer assessment, weekly ulcer evaluation, and non-ulcer skin condition evaluations. Weekly skin checks will be completed on all residents and documented. Skin Team consisting of designated nurses will assess wounds weekly, report assessment of wounds to MD, and implement changes as directed. Care plan will be updated to reflect the implemented changes as ordered by the MD.</p>	3/18/14

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F 314	<p>Continued From page 2</p> <p>clinical condition demonstrates the pressure ulcers was unavoidable, the facility with have care plan development to prevent skin breakdown and monitor interventions to determine effectiveness".</p> <p>The policy guidelines for the implementation of care and services to prevent residents from developing pressure ulcers included the following interventions to minimize pressure for residents in bed: (1) repositioning, at a minimum, every 2 hours, (2) use wedges and pillows to maintain good body alignment and avoid skin-to skin contact, (3) use pressure redistribution mattresses, (4) keep heels off bed 's surface, (5) limit the number of layers between the resident and pressure redistribution mattresses.</p> <p>For residents in wheelchairs: (1) "Instruct resident to shift position every 15 minutes if able, (2) reposition every 1-2 hours if resident unable to reposition independently, (3) use pressure redistribution cushions, (4) maintain good body alignment in wheelchair".</p> <p>RESIDENT 1: Resident 1 was admitted [redacted] 11 with a diagnoses including chronic pain (knee, hip & back) and diabetes. The quarterly nursing assessment, dated 10/23/13, documented the resident' s skin was in good condition and she was continent of bladder and bowel.</p> <p>A nursing note entry, dated 11/1/13, documented Resident 1 had no skin integrity issues this quarter. The Skin assessment scale for 8/23/13 and 10/23/13 revealed she was at low risk for skin breakdown.</p> <p>The quarterly Minimum Data Set (MDS), dated</p>	F 314	<p>Residents being treated by the wound clinic, will be treated as ordered by the wound clinic. Care Plan will be updated to reflect the implementation of the Wound Clinics orders.</p> <p>Monitoring:</p> <p>Residents will be reviewed at clinical meeting to ensure changes in resident skin conditions are reported to the physician and appropriately documented in the plan of care.</p> <p>Responsibility:</p> <p>The DNS or designee will audit charting and notifications for residents with changes in skin condition to ensure Licensed Nurses are following facility policies and procedures.</p> <p>Results of audits will be reviewed in Q.A. & A for the next 60 days and or as further needed by the determination of QA committee.</p>	
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F 314	<p>Continued From page 3</p> <p>10/23/13, documented the resident had no pressure ulcers and required 2 person assistance with bed mobility, transfers and toileting. The MDS indicated she was at risk for pressure sore development due to immobility, had a pressure reducing device in her chair and bed. The Care Plan goal was for the resident to have no avoidable pressure ulcers/sores.</p> <p>On 1/7/13 at noon, Resident 1 was observed seated in her wheelchair. The seat of her wheelchair had a cushion covered with a bath towel that was double folded on the seat of the cushion. She stated she had the towel on her cushion as she was unable to get positioned correctly due to the sore on her bottom. The resident stated she was unable to get into bed on her own, she required one person assistance of staff for transfers and she needed help for repositioning in bed.</p> <p>During this interview, the resident informed the surveyor that she had recently been " dehydrated and " laid in bed for 4 days ". She stated she had a sore on her buttock and it "hurt" and "burns all the time," especially when changing the dressing covering the wound. She also stated her bed had a foam type pad which sat on top of her mattress, which a family member had provided.</p> <p>Review of the clinical record revealed the resident had cellulitis of her lower extremities, swelling of ankles and foot pain beginning 11/2/13. Nursing notes indicated antibiotics and pain medication were initiated for this change in condition. Nursing notes entries from 11/12 to 11/14/13, documented the resident's condition changed. She required antibiotics, she experienced nausea, an elevated temperature, confusion, low blood pressure</p>	F 314		

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F 314	<p>Continued From page 4 requiring oxygen and intravenous fluids (IV).</p> <p>In addition to these changes, she was noted to have changes to her skin on her buttock. The skin was described on 11/14/13 as being "purple in color, non blanchable" on her coccyx area. At this time, Resident 1 was also refusing to eat, was less responsive and spent more time in bed.</p> <p>Even though Resident 1 had a condition change with a decrease in bed mobility and was identified to have alterations in skin integrity, there was no documented evidence a plan of care was developed to prevent pressure on her coccyx and/or to avoid further skin breakdown.</p> <p>There was no documented measurement of the Stage 1 pressure ulcer to her buttock. (Stage 1 pressure ulcer-area of persistent redness, the ulcer may appear with persistent red, blue, or purple hue).</p> <p>The nursing note, dated 11/17/13, documented Licensed Nurse (LN) applied barrier cream on the Resident 's buttock and coccyx due to skin breakdown and episodes of loose stool.</p> <p>The Treatment Administration Record (TAR) for November 2013 revealed the resident was on weekly skin checks. On 11/19/13 the Licensed Nurse (LN) documented the resident now had a Stage 2 pressure ulcer on her buttock which was assessed to be still present on 11/27/13. (Stage 2-partial thickness loss of dermis, presenting as a shallow open ulcer with a red-pink wound bed without slough.)</p> <p>Review of the facility's Weekly Ulcer Measurement Tool, dated 11/18/13 documented</p>	F 314		
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F 314	<p>Continued From page 5</p> <p>the resident had a Stage 2 pressure ulcer that measured 0.5 by 0.3 in size and the wound bed contained 100% granulation, without any drainage. On 11/21/13, the Stage 2 pressure ulcer had decreased in size. By 11/25/13 the ulcer was documented as healed, but the periwound area (tissue around wound area) was described as fragile with purple discoloration.</p> <p>Nursing notes, dated 11/25//13, documented the resident complained of pain to her coccyx and upon assessment of the skin, the pressure ulcer on her coccyx was enlarged to 4 centimeters (cm) by 2 cm in size. There was no description of the wound bed, if drainage was present or the periwound skin condition. Another entry, dated 11/30/13, documented the wound had increased in size and depth. Barrier cream was applied and the physician was notified regarding the wound with a request to "culture " the area.</p> <p>The Weekly Ulcer Measurement Tool, dated 12/4/13, documented the resident had developed two Stage 3 pressure ulcers (Stage 3-full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed) while in the facility. The Stage 3 on the left buttock was 3.2 cm by 1.5 cm in size, the wound bed contained 100% slough (dead tissue) and had periwound erythema (redness). The right buttock/coccyx pressure ulcer measured 3 cm by 2.5 cm with 0.2 depth and contained 30% slough. The periwound area around each pressure ulcer was " purple " in appearance.</p> <p>Not until the pressure area(s) deteriorated from Stage 1 to Stage 3 ulcers did the facility assess the resident' s wheelchair cushion. The physician's order was obtained on 12/4/13 for a</p>	F 314		
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F 314	<p>Continued From page 6 wheelchair speciality cushion (roho).</p> <p>On 1/7/13 at 1:15 p.m., the Director of Nursing (DNS) was interviewed regarding how Resident 1 developed pressure sores. She stated the pressure ulcer was a result of Resident 1 ' s immobility due to her cellulitis and being bedridden. The plan to prevent further decline included a special cream to the skin and LNs were to monitor the area. The DNS had no information regarding other care plan interventions to address the impact of the resident's decreased mobility on the resident's skin.</p> <p>The Director of Nursing stated the pressure ulcer deteriorated and was unavoidable due to the resident's compromised positioning in her wheelchair, and preferring to lie on her "backside" when positioned in bed. The DNS verified the specialty cushion was not initiated on 12/4/13.</p> <p>On 1/7/14 at 2:30 p.m., the corporate consult (CC) reviewed the clinical record. She stated the resident had a decline from 11/14 to 11/19/13 and Resident 1 was noted to not be getting out of bed or eating. The skin assessment for 11/18/13 revealed a Stage 2 pressure ulcer with 100% granulation in the wound bed and on 11/25/13. The DNS and Resident Care Manager (RCM) noted the same area to be purple discoloration and when the resident complained of discomfort, the area was assessed as "reopening" and measured 4cm to 2cm in size. The Treatment Administration Records (TAR) and nursing notes revealed LNs documented application of a barrier/cream to her buttock/coccyx and special cream, along with daily shift monitoring of the coccyx area. By 12/4/13, the area being</p>	F 314			

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F 314	<p>Continued From page 7</p> <p>monitored had deteriorated. The two documented pressure sores's of the buttocks contained 100% slough (dead tissue).</p> <p>When the DNS and CC were asked on 1/7/14 about individually appropriate pressure relieving interventions, the DNS stated a specialty (roho) cushion was not placed in Resident 1' s wheelchair until 12/4/13 and the resident had a pressure reducing mattress on her bed (foam overlay provided by her family).</p> <p>At 3:30 p.m., Resident 1's wheelchair cushion and mattress were observed with the DNS and CC. During this observation, the resident stated her wheelchair cushion was uncomfortable. When the CC assessed and lifted her wheelchair cushion, it was discovered the resident had two cushions in her wheelchair. The foam mattress pad was observed on top of her pressure relieving mattress.</p> <p>On 1/9/14, the DNS verified the specialty cream was not ordered by the physician until 1/8/14 which was being applied by LNs every shift for the Stage 2 pressure area. The specialty cream order was hand written on the TAR for November and December 2013, however the monthly signed physician orders for November and December 2013 did not include this cream.</p> <p>The DNS had no additional information regarding the lack of timely and appropriate interventions to address skin breakdown for Resident 1.</p> <p>RESIDENT 2: Resident 2 was re-admitted on [REDACTED] 13 with diagnoses including diabetes, neuropathy and pressure ulcers on both heels. The wound</p>	F 314		

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F 314	<p>Continued From page 8</p> <p>specialist's note, dated 8/19/13, documented the pressure ulcer on the right heel measured 5 centimeters (cm) by 6cm in size and there were two pressure ulcers on her left heel. One measured 4cm by 4.5 cm and the other measured 2 cm by 2cm in size. The wound specialist recommended Resident 2 be followed weekly.</p> <p>The Minimum Data Set (MDS) assessment, dated 11/5/13, indicated Resident 2 was dependent on staff for repositioning in bed and transfers, was at risk for skin breakdown and had pressure ulcers on admit.</p> <p>On 1/7/14 at 10:00 a.m., Resident 2 was observed in bed. Both heels rested against the surface of the mattress. A cushion device was under her knees. She stated her heels hurt. When she lifted her legs, two areas of black eschar were noted on her left heel and one area of eschar on her right heel.</p> <p>The physician's order, dated 8/24/13, directed the Licensed Nurses (LN) to send Resident 2 to the wound clinic due to her bilateral heel wounds and to use a specialty cushion when in bed to ensure floating of her heels.</p> <p>Review of the facility's pressure ulcer healing chart from 8/20/13 to 12/4/13 indicated the pressure ulcers on the right heel and the two pressure ulcers on the left heel remained unchanged since admission on 8/20/13. The three pressure sores contained 100% eschar (dead tissue) and revealed there was no improvement in the last 5 months. According to the care plan and physician's orders, the LNs were to monitor the unstagable pressure ulcers</p>	F 314			

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F 314	<p>Continued From page 9 and apply a special ointment to the pressure sore on the right heel.</p> <p>The facility's weekly ulcer measurement tool documented the pressure ulcers on her heels were Stage 4 pressure ulcers and their wound beds contained 100% eschar (black, brown, or tan tissue that adheres firmly to the wound bed).</p> <p>On 1/9/14 at 10:45 a.m. during an interview with the DNS, she stated the treatment plan for Resident 2's pressure ulcers had not changed since October 2013. On 1/10/14 at 9:25 a.m., the DNS verified the physician's order, dated 8/24/13, for Resident 2's pressure ulcers to be evaluated by a wound specialist had not been followed.</p> <p>On November 6, 2013, the resident was seen by a podiatrist for evaluation of her feet as she was at risk of skin breakdown due to her neuropathy and diabetes. The podiatrist recommended the facility continue to observe the residents' feet, provide heel support, a foot cradle in bed and follow up for wound care for her heel ulcers. There was no documented evidence, the LNs had coordinated care with the podiatrist regarding care and intervention to promote wound healing.</p> <p>Even though the resident's physician ordered a wound consult 8/13/13, and a podiatrist recommended a follow up on 11/6/13 due to her heel ulcers, there was no documented evidence the facility had followed through on these orders/recommendations.</p> <p>The LNs directed treatment plans for Resident 2's pressure ulcers. The current Care Plan directed staff to "float heels" and the Care Guide read: "floating device under heels".</p>	F 314		

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F 314	Continued From page 10 There was no documented evidence the facility evaluated whether the plan of care was appropriate for the healing of Resident 2's heel ulcers or coordinated care (as ordered) with a wound specialist until 1/13/14. RESIDENT 3: The facility's policy for residents with pressure sores indicated that the Registered Dietitian (RD) needed to evaluate residents' daily caloric, protein and fluid needs. Resident 3 was re-admitted to the facility on [REDACTED] 13 with multiple pressure ulcers. Review of Resident 3's admit weekly ulcer measurement tools, dated 12/12/13, documented her right hip had a Stage 3 pressure ulcer. The pressure ulcer contained 100 % slough in the wound bed with maceration and discoloration around the ulcer. Three Stage 4 pressure ulcers (Stage 4- full thickness tissue loss with exposed bone, tendon or muscle) were assessed on the left hip, sacrum and right ischial area. On 12/13/13 her hemoglobin values were noted to be low. Record review revealed the resident frequently refused her medications, and her tray monitoring for Decmenber 2013, indicated refusal of meals or staff failure to document meal and fluid intake. Resident 3's nutritional and hydration needs for wound healing were not assessed by the RD until 12/24/13, almost 2 weeks after the resident was readmitted. At that time, the RD recommended health shakes with meals, a nutritional supplement three times a day and to check the	F 314			

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NAME OF PROVIDER OR SUPPLIER FOREST VIEW TRANSITIONAL HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5129 HILLTOP ROAD EVERETT, WA 98203	
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F 314	Continued From page 11 resident's iron panel due to the low hemoglobin laboratory values obtained on 12/13/13.	F 314		
F 327 SS=G	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assess, and/or monitor hydration status for two of 2 residents (Resident 1 and 3) who were at risk for dehydration due to gastrointestinal symptoms, infections, and/or fever. Failure to monitor, document, assess and care plan for hydration status resulted in harm for Resident 3 who developed acute renal failure that required hospitalization. Failure to accurately monitor Resident 1 placed the resident at risk for inadequate fluid intake to meet hydration needs. Findings include: RESIDENT 3: Resident 3 was re admitted to the facility on [REDACTED] 13 with multiple diagnoses including recent hospitalization for urinary tract infection (UTI) and sepsis. She had a supra-pubic catheter for urine drainage, a colostomy for stool collection and a peripherally inserted central catheter (PICC) for intravenous antibiotics. The IV order sheet, dated [REDACTED] 13, directed staff to monitor the resident's intake and output. The re-admit nursing assessment revealed	F 327	F327 Resident: Resident #3 is no longer at the facility Resident# 1 was assessed for adequate hydration and reported to physician. All residents : Current residents will be assessed weekly by Licensed Nurses to ensure adequate hydration. Fluid intake will be recorded daily. Resident with hydration concerns will be reviewed by the RD for recommendations. Resident with signs and symptoms of hydration concerns will be reported to the physician. Orders will be implemented as directed by the Physician in the plan of care. System Review/Education: An education was provided to Licensed Nurses on 01/28/14 regarding hydration monitoring and assessment.	3/18/14

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F 327	<p>Continued From page 12</p> <p>Resident 4 had multiple pressure sores, was dependent on staff for repositioning in bed and eating and received two intravenous (IV) antibiotics. Resident 3's blood levels were to be drawn from her PICC line to monitor and determine the effectiveness of the antibiotic. The laboratory (labs) levels were to be performed to ensure renal (kidney) function was not being affected by the IV antibiotics to avoid toxicity and possible renal failure. The resident's renal blood levels for 12/16/13 were within normal range.</p> <p>Review of the nursing notes, from 12/14 to 12/25/13, documented the resident had periods of lethargy, refusal of meals, loose stool, and episodes of nausea with vomiting.</p> <p>On 12/22/13 at 1330 the nursing notes revealed the resident was lethargic and had a drop in her systolic blood pressure (BP) to 100. The physician was notified. An order was received to monitor the blood pressure and if "blood pressure continues to drop, send to emergency room."</p> <p>Review of the facility vital sign flow sheet revealed the BP for 12/22/13 at 0900 was recorded, and the low pressure of 100 was documented in the nursing notes. There was no further documented evidence the LNs recorded the BP readings even though the Licensed Nurse (LN) documented "checked BP every hour".</p> <p>A nursing note entry, dated 12/23/13 at 0600, documented the resident's blood pressure was low (systolic of 98) at midnight and the BP was being checked hourly. There was no documented record regarding these BP readings. The physician was notified and an order was obtained to infuse fluids continuously per the resident's IV</p>	F 327	<p>Monitoring:</p> <p>Residents will be reviewed at clinical meeting to ensure changes in resident hydrations risks are reported to the physician and appropriately documented in the plan of care.</p> <p>Responsibility:</p> <p>The DNS and/or designee will audit charting and notifications for residents with changes in hydration and hydration tracking to ensure Licensed Nurses are following facility Policies and Procedures.</p> <p>Results of audits will be reviewed in Q.A. & A for the next 60 days or as further needed as determined by the QA committee.</p>	

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F 327	<p>Continued From page 13 line.</p> <p>On 12/23/13, Resident 3's renal blood levels were found to be elevated. The Medication Administration Record (MAR) for December 2013, verified fluids for hydration were started on 12/23/13.</p> <p>Additional nursing notes, dated 12/23 and 12/24/13, documented the resident continued to have nausea with vomiting and an altered mental status. On [REDACTED] 13, when she was found to be unresponsive, she was transferred to the hospital.</p> <p>Review of the tray monitor (TM) for December 2013 was incomplete since her re-admit to the facility on [REDACTED] 13. The TM revealed she had refused meals from December 22 until December 25, 2013, when she was transferred to the hospital.</p> <p>Even though Resident 3 continued to refuse meals, her hydration status was not assessed or monitored. Her intake and output flow sheet was incomplete and had no adequate hydration parameters. Review of the plan of care revealed no evidence of identification of hydration status as an issue or concern for her, even though she required additional IV fluids, had vomiting, loose stools, multiple wounds and a change in level of consciousness.</p> <p>On 1/9/14 at 11:30 a.m., the Director of Nursing (DNS) was interviewed regarding the facility's policy and procedure for assessing and monitoring hydration status. The DNS stated if a resident received IV fluids, was at risk for dehydration, had poor intake, a urinary catheter, gastrointestinal symptoms such as nausea with</p>	F 327		
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F 327	<p>Continued From page 14</p> <p>vomiting or diarrhea, she expected nursing staff to assess the data for hydration status and develop a care plan.</p> <p>On 1/10/13 at 9:50 a.m., the Resident Care Manager (RCM) was interviewed regarding Resident 3' s hydration. She stated prior to the resident being discharged to the hospital on [REDACTED] 13, she had loose stools, watery vomit and IV therapy. The RCM stated Resident 3' s cognitive status had declined with medication changes and she now required staff to hold her emesis pan to contain her emesis. The RCM verified the LNs should have assessed and/or monitored the resident's hydration status.</p> <p>The hospital's emergency room history and physical , dated [REDACTED] /13, documented the resident was in acute renal failure and had an urinary infection related to dehydration due to poor intake and persistent nausea with vomiting. The hospital note revealed they aggressively hydrated Resident 3 to address her renal status and the antibiotic dosage was adjusted/changed.</p> <p>RESIDENT 1: Resident 1's quarterly nursing assessment for 10/23/2013 revealed her appetite was good and she was on a regular diet. The area for fluid intake was blank.</p> <p>Record review revealed the resident developed a Stage 1 pressure ulcer on 11/14/13 that deteriorated to two pressure ulcers which the facility documented as Stage 3 .</p> <p>Review of the nursing notes for November 2013, revealed the resident had received three antibiotics, had loose stools, refused meals and</p>	F 327			

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F 327	<p>Continued From page 15</p> <p>had a temperature. Nursing note entries for 11/13 and 11/14/13 revealed the resident exhibited cognitive changes, muscle tremors, weakness and fatigue.</p> <p>On 11/13/13, a referral to the Registered Dietitian (RD) was made due to Resident 1 ' s infection (cellulitis). The RD indicated her weight was stable at 131 pounds and her fluid goal was 1800 cc per day.</p> <p>On 11/14/13, the physician ordered a IV infusion to rehydrate Resident 1. The Medication Record for November 2013 indicated Resident 1 required a total of 3000 cc of IV fluids from 11/14 to 11/16/13 due inadequate oral intake, fever and cognitive changes.</p> <p>Review of the Resident 1's tray monitor for November 2013 documented her intake as follows: 420 cc for 11/12; 480 cc for 11/13; blank for 11/14 and 600 cc intake for 11/15/13.</p> <p>Review of Resident 1's intake and output (I & O) record for November 14, 15, 16, 2013, when she was receiving intravenous fluids was incomplete and did not reflect fluid intake at meals.</p> <p>There was no documented evidence the facility had assessed and/or monitored for adequate hydration status.</p> <p>On 1/9/14 at 11:30 a.m., the Director of Nursing (DNS) stated residents with IVs, poor intake, nausea and vomiting should be on I&O to assess residents' for adequate hydration.</p> <p>On 1/17/14 at 11:05 a.m., the DNS verified the</p>	F 327		
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F 327	Continued From page 16 facility did not have a hydration policy. She stated I&O flow sheets should be in place when residents need IV fluids.	F 327		
F 328 SS=D	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 observation, interview and record review, the facility failed to accurately document techniques necessary to maintain intravenous (IV) therapy for 2 of 2 residents (Resident 1 and 3), who required IV therapy for hydration, antibiotics and blood draws. Failure to manage IV lines appropriately placed the residents at risk for complications. Findings include: DOCUMENTATION OF INTRAVENOUS FLUIDS (IVF) INCOMPLETE: 1) Resident 1 had a intravenous catheter inserted on 11/14/13 by the IV team to infuse fluids for	F 328	F328 Resident: Resident #1 is back to her base line status. Resident # 3 is no longer at the facility. All residents : The pharmacy policy will be followed for maintaining and recording IV fluids. No current residents have IV's at this time. System Review/Education: Licensed Nurses received education on 01/28/14 for recording and monitoring IV fluids per Pharmacy policy and procedure.	3/18/14

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F 328	<p>Continued From page 17 hydration.</p> <p>Review of the Infusion Medication Administration (IVF) Record indicated Normal Saline (NS) was to be infused at a rate of 90 cc per hour from 11/14/13 to 11/15/13. This record did not indicate when (what time) the IV bags of NS were started.</p> <p>According to the nursing notes, after the NS infused, the Licensed Nurse (LN) drew blood from the IV site. The physician was notified of the laboratory results and changed the IV fluids to 1/2 NS. There IVF did not document the new order for 1/2 NS or document the blood draw and /or flushes prior to and after blood was withdrawn from the IV catheter.</p> <p>Nursing notes, dated 11/16/13, revealed the IV line was discontinued. There was no documentation as to the condition of the IV catheter, as to whether it was intact when removed from Resident 1's vein.</p> <p>2) Resident 3 had a central line catheter with two lumens/ports for antibiotic infusion and blood draws.</p> <p>Review of the Central Line Catheter Treatment Record for December 2013 was blank under the blood draw section. There was no documentation regarding which lumen was used for blood draws, antibiotic infusion or if the resident's medication flushes were given per facility policy.</p> <p>On 1/10/14, at 8:00 a.m., the Director of Nursing (DNS) stated, Licensed Nurses's skills were assessed at the time of hire. Review of the RN/LPN Skills Assessment Checklist did not have</p>	F 328	<p>Monitoring:</p> <p>The pharmacy policy will be followed for maintaining and recording IV fluids.</p> <p>Responsibility:</p> <p>The DNS and/ or designee will audit maintaining and recording IV fluids.</p> <p>Results of audits will be reviewed in Q.A. & A for the next 60 days and/or further needed as determined by the QA Committee.</p>	
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F 328	Continued From page 18 IV therapy as part of the checklist. Review of 7 LNs educational IV competencies was requested. Only 2 LNs had documentation of education and practicum regarding IV basics. Failure to ensure LNs were competent to flush IV lines, obtain blood draws and accurately document IV therapy per pharmacy recommendation and policy placed residents at risk for complications. On 1/10/14 at 11:00 a.m., the Director of Nursing verified that LNs needed education regarding IV care and that the documentation on the Infusion Medication Administration Records was incomplete to reflect accurate IV management.	F 328			
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 514	F514 Resident: Resident charts were addressed for maintaining clinical records on each resident in accordance to standard of practice. All residents : Current residents will be audited by Medical Records and/or designee for omissions in charting.	3/18/14	

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F 514 Continued From page 19
review, the facility failed to keep accurate and complete records for bathing schedules for 33 residents and/or document blood pressure, complete intake and output, laboratory values and skin condition for Resident 1 & 3's. Lack of consistent documentation to track Resident 3's vital signs, laboratory values, I&O and skin assessments may have delayed the LNs in recognizing her change in condition prior to becoming unresponsive.

Findings include:

SHOWER/BATHS NOT DOCUMENTED:
On 1/7/14 at 10:00 a.m., during an interview, Resident 2 stated she had not received a "bath or shower for 2-3 weeks...can't have showers as my feet hurt".

Review of Resident 2's bath/shower flow sheet revealed there was no documented evidence she had received a shower or bath yet for the month of January 2014.

At 10:43 a.m., the Nursing Assistant (NAC) who provided care for Resident 2 was interviewed. She stated the resident had a bed bath, but the NAC had not documented completion of the bed bath.

Review of the 2nd floors's shower/bath flow sheets documentation forms for January 2nd to January 6, 2013, revealed showers and/or bathes were not documented. There was no documented evidence the residents in the following rooms had received their showers and or baths: Room 201 A& B, 203 A, 206 A, 207 B,

F 514 Results will be reported to the DNS and/or designee for follow up.

System Review/Education:

An education will be provided on 02/20/14 to staff on documentation in residents clinical record.

Responsibility:

Medical Records and/or designee will audit clinical records for omissions weekly with results given to the DNS. DNS will follow up with omissions noted.

Results of audits will be reviewed in Q.A. & A for the next 60 days or as needed further by determination of the QA Committee.

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F 514	<p>Continued From page 20 209 A&B, 210A& B, 211, 213 A&B 214, 215 A&B, 216, 217 A&B, 218, 219 B, 220, 221 A& B, 223 A&B.</p> <p>Review of the 1st floor bath flow sheets revealed incomplete documentation regarding completion of showers. There was no documentation indicating completion of showers or baths for residents in rooms: 108 A, 109 A&B, 115 B, 116 A, 117 B, 119 A, 123 B.</p> <p>On 1/7/14, the Director of Nursing verified the charting for showers/bathes was not completed. She stated this documentation was not necessary as the facility was going to computerized charting.</p> <p>INCOMPLETE DOCUMENTATION FOR HYDRATION STATUS:</p> <p>1) Resident 3 was re admitted to the facility on [REDACTED] 13 with multiple diagnoses including recent hospitalization for urinary tract infection (UTI) and sepsis. She had a peripherally inserted central catheter (PICC) for intravenous antibiotics. The IV order sheet, dated [REDACTED] 13 directed staff to monitor intake and output.</p> <p>Review of the nursing notes, from 12/14 to 12/25/13, documented the resident had periods of lethargy, refusal of meals, loose stool, and episodes of nausea with vomiting.</p> <p>Review of the clinical record for December 2013, revealed there was no documented evidence of accurate and consistent recording of her intake and output, or meal intake was recorded to evaluate her hydration status.</p> <p>2) Resident 1's Intake and output record and Tray</p>	F 514		

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F 514	<p>Continued From page 21</p> <p>Monitoring data did not accurately reflect what the resident had consumed at meals to provide complete data regarding her hydration status.</p> <p>INCOMPLETE RECORDING OF VITAL SIGNS: 1) Review of Resident 3's clinical record indicated she had changes in her blood pressure which required Licenses Nurses (LNs) to monitor.</p> <p>On 12/22/13 at 1330 the nursing notes revealed the resident was lethargic, had a drop in blood pressure (BP) and change in her level of consciousness. Her BP was recorded in the nursing notes to be 100 systolic. The notes revealed the physician was notified, and informed the licensed nurses (LNs) to monitor resident "next 1-2 hours, BP and if the blood pressure continued to drop, the LNs were to send her to the emergency room".</p> <p>Review of the nursing notes dated 12/22/13 at 2200 indicated the resident blood pressure was checked every hour, however specific blood pressure readings were not documented.</p> <p>Another nursing note entry, dated 12/23/13 at 0600, documented Resident 3 continued to be lethargic and her blood pressure was low (systolic of 98) at midnight. This LN documented BP was checked hourly but the BP readings were not recorded.</p> <p>INCOMPLETE COUMADIN FLOW SHEET: 1) The medication administration record (MAR) for December 2013 revealed Resident 3 received both a blood thinner medication and antibiotics (ABO). The concurrent use of the ABO with the blood thinner could alter clotting levels</p>	F 514		

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NAME OF PROVIDER OR SUPPLIER FOREST VIEW TRANSITIONAL HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5129 HILLTOP ROAD EVERETT, WA 98203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	Continued From page 22 (INR). Review of the coumadin record revealed no documentation regarding the current coumadin order, INR results, or new INR orders for 12/18, 12/20 and 12/23/2013. SKIN SHEETS NOT COMPLETED: 1) An entry on 12/24/13 by skilled therapy documented Resident 3's left side of face and right heel were reddened and indicated nursing was notified. The following day, 12/25/13, the LN documented Resident 3 had a rash with redness on her lips, which traveled down her chin and under her neck. The physician was notified regarding the rash. There was no documented evidence, LNs had initiated a skin sheet to monitor the right heel or the rash. On 1/17/14, the RCM and Director of Nursing verified skin sheets should have been completed to ensure weekly assessment and monitoring for these areas. On 1/17/14 at 12:50 p.m., the Director of Nursing (DNS) was interviewed regarding documentation of vital signs, INR levels and I&O. She verified Resident 3's clinical record lacked consistent documentation to clearly identify if her condition was deteriorating. The DNS was not aware of the rash or status of her heel which was identified by staff on 12/24/13.	F 514			