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PRINTED: 12/06/2013
FORM APPROVED
OMB NO. 0938-0391

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

1434

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/23/2013
NAME OF PROVIDER OR SUPPLIER PUYALLUP NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372		
(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 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Off-Hours Quality Indicator Standard Survey conducted on consecutive days at Puyallup Nursing and Rehabilitation Center on 11/17/13, 11/18/13, 11/19/13, 11/20/13, 11/21/13, 11/22/13, and 11/23/13. The survey included data collection on Sunday 11/17/13 beginning at 9:45 a.m. to 2:25 p.m. A sample of 36 residents was selected from a census of 88. The sample included 28 current residents and the records of 8 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>Marilyn Edwards, RN, MN Ruth Futch, RN, MBA Sandra Mayes, RN, BSN Karyn Rich, RN, BSN, MN</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Long-Term Support Administration Residential Care Services, District 3, Unit B PO Box 45819, MS: N27-24 Olympia, WA 98504-5819</p> <p>Telephone: (253) 983-3800 FAX: (253) 589-7240</p> <p><i>[Signature]</i> 12/6/13 Signature Date</p>	F 000	<p>F000 Initial Comments</p> <p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Puyallup Nursing and Rehabilitation Center does not admit that the deficiencies listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiencies. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, facts, and conclusions that form the basis for the deficiencies."</p>		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE
<i>[Signature]</i>			Administrator		12/19/2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 155 SS=D	<p>483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES</p> <p>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, it was determined the facility failed to ascertain and address the resident's reason for refusal of care and services to promote healing in a pressure ulcer for 1 of 3 sampled residents (#17) reviewed for pressure ulcers. This failure placed the resident at risk for worsening or delayed healing of an existing pressure ulcer, development of new pressure ulcers and diminished quality of life.</p> <p>Findings include:</p>	F 155	<p>F155</p> <p>Corrective Actions for resident identified to have been affected:</p> <p>Resident #17 has been assessed by PT for ability to use a Sit- to- Stand lift for transfers and is successfully being transferred via this method. He agrees that this transfer is acceptable to him and that he does not fear or dislike it. He continues to choose to spend extended periods of time up in his wheelchair. He has been assessed for the reasons for this and reports that he enjoys being up socializing and participating in activities and does not like to nap. He has been offered alternative plans (activities in room, short rest periods) and has agreed to try them. His wheelchair cushion is new and is appropriate for a stage III wound. He and his spouse have been informed of the risks of sitting up for extended periods, and understand and accept the risk to skin integrity. Plan of Care is updated. Resident #17 is receiving therapy services for transfers and is standing with extensive assistance to reposition for pressure relief when up. Resident #17's wound is healing rapidly.</p>	12/31/13

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F 155	<p>Continued From page 2</p> <p>Facility Policy and Procedure for Skin Breakdown stated that upon discovery of a pressure ulcer, licensed nursing staff were to: 1) conduct weekly rounds to evaluate the pressure ulcer, plan of care, the resident's compliance with plan of care, and review with the resident the risks and benefits of non-compliance with plan of care; 2) when non-compliance occurs, complete a Deviation of Care Form; and 3) update the resident's care plan to include noncompliance with the treatment plan.</p> <p>Resident #17 was originally admitted to the facility from the hospital with diagnoses to include diabetes and osteoarthritis on [REDACTED] 13 following surgery to repair a fractured hip and was readmitted on [REDACTED] 13 after 3 days in the hospital.</p> <p>The Minimum Data Set (MDS), dated 8/26/13, indicated Resident #17 was alert, oriented and able to make needs known. The resident was non-ambulatory, used a wheelchair for locomotion and required extensive assistance of 2 persons with bed mobility and transfers.</p> <p>The MDS indicated the resident was at risk of developing pressure ulcers but did not currently have any pressure ulcers.</p> <p>The pressure ulcer over Resident #17's left sacrum was first documented in a progress note, dated 9/11/13, which identified "two open areas" on Resident #17's "left buttock, with some dark red area around open areas."</p> <p>The progress note, dated 9/25/13, indicated Resident #17's physician was called on 9/24/13 requesting "treatment on Stage 2 coccyx.</p>	F 155	<p>Identification of residents with the potential to be affected:</p> <p>Residents who choose to spend prolonged time up in a chair or wheelchair have the potential to be affected by this finding. Residents at risk were identified by the multidisciplinary team. Identified residents were assessed to determine reasons for their choice and provided with alternative choices and education on the risks and benefits. Pressure relieving cushions were evaluated for effectiveness and replaced, as needed, and plans of care updated.</p> <p>Measures to prevent recurrence:</p> <p>Nursing, Social Services, and Therapy staff were re- educated on assessment and education of residents who are refusing care and services. Re-education was provided by the Regional Nurse Consultant and Director of Nurses on 12/10, 12/12, and 12/17/13.</p>		

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F 155	<p>Continued From page 3</p> <p>Awaiting call back from MD, also processed order for air mattress."</p> <p>The resident was sent to the hospital for a minor procedure on [REDACTED] and returned on [REDACTED] 13.</p> <p>Resident #17's physician's orders, dated 9/28/13, instructed staff to reposition the resident every 2 hours.</p> <p>Documentation for Resident #17's left sacral pressure ulcer on the weekly Skin Grid for Pressure Ulcers (SGPU) reflected the following:</p> <p>Spaces for indicating the date the ulcer was first identified and whether or not the ulcer was present on admission were left blank.</p> <p>The earliest documentation on the SGPU was on 10/2/13, indicating the ulcer was identified as Stage 3, measuring 2 x 3 centimeters (cm) and 0.05 cm deep. The resident was not experiencing pain from the ulcer.</p> <p>On 10/16/13: Stage 2, measuring 1.8 x 1.5 cm and 0.05 cm deep. The resident was not experiencing pain from the ulcer.</p> <p>On 10/24/13: Stage 2, measuring 1.5 x 1.5 cm and 0.1 cm deep with 25% slough. The resident was experiencing pain from the ulcer.</p> <p>On 10/31/13: Stage 3, measuring 3.0 x 2.0 cm and 0.1 cm deep. The resident was experiencing pain from the ulcer.</p> <p>On 11/6 and 11/13/13 the ulcer remained at Stage 3 and the resident continued to experience pain from the ulcer.</p>	F 155	<p>Monitor for Corrective Action:</p> <p>Social Services will maintain a list of residents identified, through the RAI process, as refusing care and services. Audits of identified residents' records will be conducted to assure that assessment of each situation, risk and benefit education, offering of alternative services, documentation, and care planning have been completed. Audits will be conducted by the identified resident's care manager and results will be reported to the Quality Assurance / Performance Improvement Committee for review and identification of need for additional education and /or intervention.</p> <p>The Director of Nursing will ensure compliance.</p>	
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F 155	<p>Continued From page 4</p> <p>On 11/20/13: Stage 3, measuring 1.8 x 1.6 cm and 0.2 cm deep. (A progress note, dated 11/20/13, indicated the resident had pain.)</p> <p>On 11/22/13: Stage 3, measuring 2.0 x 1.5 cm and 0.1 cm deep, 80% pink/red with 20% thin yellow slough. The resident was not experiencing pain from the ulcer. The physician was notified of changes.</p> <p>The Restorative Nursing Assessment and Referral (RNAR), dated 10/2/13, documented Resident #17 received Occupational Therapy (OT) and Physical Therapy (PT), reached his/her maximum potential and was referred for restorative nursing services for upper and lower extremity range of motion (ROM) exercises to "prevent losses." The referral stated Resident #17 required use of a Hoyer (hydraulic lifting device) with assistance of 2 persons for all transfers and used a wheelchair for locomotion.</p> <p>Additional PT services were initiated for Resident #17 on 10/8/13 for stand and pivot transfers. The PT Discharge Summary, dated 10/30/13, indicated the resident was discharged from PT on 10/29/13 because s/he was unable to progress with transfers, requiring 90-100% maximum assistance. During this period, restorative nursing provided services only for upper extremity ROM.</p> <p>The RNAR, dated 11/6/13, indicated PT had again referred Resident #17 for restorative nursing services for both upper and lower extremity ROM. The RNAR again stated the resident required use of a Hoyer with assistance of 2 persons for all transfers.</p>	F 155		
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F 155	<p>Continued From page 5</p> <p>Progress notes indicated a Hoyer lift was consistently used for transfers with Resident #17.</p> <p>Beginning on 10/30/13, Resident #17's progress notes indicated the resident was refusing to lie down between meals in order to relieve pressure on the sacral ulcer, instead remaining in his/her wheelchair from breakfast until going to bed sometime after dinner.</p> <p>Resident #17's Comprehensive Care Plan did not address transfers, use of the Hoyer lift, or the resident's noncompliance with repositioning every 2 hours.</p> <p>Each day of the survey, 11/17 through 11/23/13, Resident #17 was observed spending the entire period between breakfast and dinner sitting in his/her wheelchair. Each observation revealed the resident was sitting on the nylon sling used with the Hoyer lift.</p> <p>On 11/20/13 at 3:04 p.m., Staff Y stated Resident #17 usually got out of bed at 7:30 a.m. and preferred to spend the entire day in his/her wheelchair, declining to go back to bed until after dinner. Staff Y said s/he tried to convince the resident to spend time each day repositioned in bed so as to take pressure off the left sacral ulcer but the resident refused, choosing to spend the entire day in the wheelchair. Staff Y said the resident "hates to go in and out of bed because he hates the Hoyer lift."</p> <p>On 11/21/13 at 7:30 a.m., Resident #17 was observed lying in bed, on a Hoyer sling, leaning slightly to the left. Staff Y agreed with the surveyor that it appeared that the thick nylon webbing edges of the Hoyer sling, which were</p>	F 155		
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F 155	<p>Continued From page 6</p> <p>crisscrossed under the resident's pelvis, appeared to press against the area where the pressure ulcer was located.</p> <p>The resident yelled out loudly to Staff Y to hurry and get him/her up because the resident's "bottom hurts."</p> <p>During the dressing change, the ulcer on Resident #17's left sacrum was observed to be red/pink with yellow/white slough, measuring approximately 2 x 1.5 cm. Staff Y said the amount of slough had increased over the past 3 weeks.</p> <p>When asked if s/he would spent time during the day out of the wheelchair, lying in bed to keep pressure off his/her "sore bottom," the resident said, "No, because of that thing they use [the Hoyer]. It drives me nuts; I can't stand it." The resident said it was hard to explain why s/he hated the Hoyer so much and said, "There's something about it I can't stand. It's mostly the hook-up part."</p> <p>The resident said s/he wished PT had not terminated services to work on stand/pivot transfers.</p> <p>Staff Y said, "I think if [the resident] was able to transfer without the Hoyer [s/he] would agree to spend time in bed during the day. But [s/he] won't do it because of the Hoyer."</p> <p>As Resident #17 was transferred from bed to wheelchair with the Hoyer lift, the resident was observed to appear tense, grimacing and silent as staff hooked the sling to the lift, raised the resident off the bed in a horizontal position, and swung the resident away from the bed. Then,</p>	F 155		
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F 155	<p>Continued From page 7</p> <p>after the resident was adjusted in the sling to a sitting/upright position, the resident said, "See, now this part is okay."</p> <p>On 11/22/13 at 9:43 a.m., Staff K, the Charge Nurse, said Resident #17's sacral ulcer was not healing because the resident refused to spend time in bed during the day to take pressure off the ulcer. Staff K said s/he was not aware the resident had an aversion to the Hoyer lift "until yesterday." Staff K said, "Yesterday, Staff Y told me [Resident #17] told you s/he hated the Hoyer lift. If I had known this sooner, I would have asked PT to assess the resident for transfer methods."</p> <p>Staff K said yesterday Resident #17 self-propelled in the wheelchair to the therapy room and asked PT to evaluate the resident for transfers. PT evaluated the resident and wrote a communication to nursing saying Resident #17 could now use a sit to stand lift device instead of the Hoyer.</p> <p>The "Communication to Nursing on Ambulation/Transfer Level," written by PT staff, dated 11/21/13, indicated Resident #17 demonstrated an ability to tolerate a "sit to stand" lift for transfers and requested nursing to modify the plan of care accordingly.</p> <p>At 10:11 a.m., Staff C, the Resident Care Manager (RCM), said Resident #17 had been non-weight bearing and required a Hoyer lift for transfers throughout the resident's entire stay at the facility. Staff C said after 10/25/13, when the resident was informed s/he would not be able to discharge to a more independent setting, the resident became depressed, less compliant with the plan of care and more resistant to spending</p>	F 155		
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F 155	<p>Continued From page 8</p> <p>time in bed during the day to relieve pressure on the sacral ulcer.</p> <p>Staff C said Resident #17 told Staff C the resident did not want to use the Hoyer lift and Staff C did not explore the reason why with the resident. Staff C said s/he assumed it was because the resident wanted to be able to do standing transfers, to be more independent. No one told Staff C it was because the resident hated the Hoyer itself. Staff C said staff should have informed Staff C the resident hated the Hoyer.</p> <p>Staff C said when the resident refused to go to bed during the day to relieve pressure from the sacral ulcer, Staff C should have asked the resident the reason for the refusal and explored alternative interventions. Staff C said, "[The resident] did tell me [s/he] didn't want the Hoyer. I didn't explore that with [Resident #17]." Staff C said s/he never observed Resident #17 during a transfer in the Hoyer lift.</p> <p>At 11:55 a.m., Staff JJ, a physical therapist, said s/he worked with Resident #17 previously and was not able to advance the resident functionally. Staff JJ said once PT has discharged a resident, it was up to nursing to determine when a reassessment is needed and make a referral.</p> <p>Staff JJ said, "[Resident #17] came in yesterday and asked about getting back on therapy. I noticed a Hoyer sling on the wheelchair. I asked [the resident] to stand and [s/he] stood, had the range of motion and strength to stand. I thought adding a standing frame activity to the resident's restorative nursing regimen might help increase or maintain strength. If [the resident] improves with that, I would like to pick [him/her] up for more</p>	F 155		
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F 155	<p>Continued From page 9</p> <p>functional rehab. But just standing/sitting is not skilled. Transfers can be worked on through restorative nursing."</p> <p>At 1:50 p.m., Staff HH, a restorative nursing assistant, said Resident #17 received restorative nursing for ROM 6 days per week. Staff HH said the resident actively participated and "always looks forward to it." Staff HH said s/he always worked with Resident #17 in the wheelchair, "never in bed because [s/he] is always in the wheelchair."</p> <p>Licensed staff documented on Resident #17's Treatment Flowsheet for November 2013 that the resident was consistently repositioned every 2 hours each day.</p> <p>At 2:05 p.m., when presented with documentation on the Treatment Flowsheet indicating Resident #17 was being repositioned every 2 hours, Staff Y stated it was not accurate. Staff Y said the resident was only repositioned while in bed and usually spent nearly the entire day in the wheelchair.</p> <p>There was no documentation reflecting "weekly rounds to evaluate the pressure ulcer, plan of care, the resident's compliance with plan of care, and review with the resident the risks and benefits of non-compliance with plan of care" for repositioning every 2 hours, as indicated in the facility policy.</p> <p>Although staff was aware Resident #17 was refusing to reposition every 2 hours, no Deviation of Care Form was completed as indicated in facility policy.</p>	F 155		
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F 155	Continued From page 10 Resident #17's Comprehensive Plan of Care was not updated to include noncompliance with the treatment plan as indicated in the facility policy. The facility failed to ascertain Resident #17's reasons for refusing to lie in bed during the day in order to take pressure off the ulcer on his/her left sacrum and failed to explore alternative interventions with the resident. This failure placed the resident at risk for worsening or delayed healing of an existing pressure ulcer and development of new pressure ulcers.	F 155		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156	F156 Corrective Actions for residents identified to have been affected: Resident #46 is no longer a resident of the facility. Resident #105 has been issued a Skilled Nursing Facility Advance Beneficiary Notice and has been informed, in writing, of the services that will be provided under Medicaid at no charge to the resident, and services that are offered at a charge, and what the charge for those services will be. Identification of residents with the potential to be affected: Other residents whose care in the facility is no longer covered by Medicare, but who stay in the facility, have the potential to be affected.	12/31/13

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F 156	<p>Continued From page 11 and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification</p>	F 156	<p>Measures to prevent recurrence:</p> <p>CMS form #10055 will be used to inform residents of costs when Medicare covered services end. Use of this form was trained to Business Office, Admissions, Social Services, Resident Care Managers, and the Director of Nursing. Training was conducted on 11/25/13 by the Administrator.</p> <p>Monitor for Corrective Action:</p> <p>The Business Office Manager will maintain a list of residents who are discharging from Medicare covered services and remaining in the facility and will audit to assure that CMS form #10055 is used to inform them of their costs following coverage. Results of the audits will be reviewed in the QA / PI committee meeting for 3 months.</p> <p>The Administrator will assure compliance.</p>	
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F 156	<p>Continued From page 12</p> <p>agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to provide a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) for 2 of 4 sampled residents (#'s 46 & 105) who were reviewed for Liability Notice & Beneficiary Appeals Rights. This failure placed residents at potential risk of not being able to exercise their rights regarding liability and appeal reviews of services not covered under Medicare.</p> <p>Findings include:</p> <p>RESIDENT #46</p>	F 156		
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F 156	<p>Continued From page 13</p> <p>On 11/23/13 at 3:05 p.m., Staff P stated Resident #46 was admitted on [REDACTED] 13, and discharged [REDACTED] 13 with 64 Medicare days remaining and stayed in the building as private pay. When asked whether the resident received a SNFABN or denial letter to explain charges and billing responsibilities, Staff P stated it had not been given; the resident had signed on admission their responsibility for private pay.</p> <p>RESIDENT #105</p> <p>On 11/22/13 at 11:17 a.m., Resident #105 stated she/he had applied for Medicaid and waiting to hear whether had been approved. The resident said she/he said had heard the charge was \$300.00 a day but would not be asked for payment until a letter was received from Medicaid. The resident also stated a bill was received for the month of October; part was paid by supplemental medical coverage.</p> <p>On 11/22/13 at 1:00 p.m., Staff P reported that until Medicaid was approved the resident was not paying anything towards her care; participation had to be determined by the Department of Social and Health Services (DSHS). Staff P confirmed the resident was receiving a monthly statement under Medicaid pending stating if Medicaid did not pick up this is what will be due under Medicare. The resident was currently receiving custodial care services.</p> <p>Pub 100-04-Medicare Claims Processing update (30/261-Expedited Determination Notice Association with Advance Beneficiary Notices) dated May 24, 2013 with an effective date of 8/26/13 reports some situations that may require two notices at the end of Medicare covered care.</p>	F 156		

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F 156	Continued From page 14 One included when the beneficiary's Part A stay is ending because skilled level care is no longer medically necessary and the beneficiary wishes to remain in the SNF receiving custodial care. The beneficiary must receive the Notice of Medicare Non-Coverage (NOMNC) two days prior to the end of coverage. A SNFABN must also be delivered before custodial care begins. Review of the records revealed a Notice of Medicare Non-Coverage (NOMNC) Quality Improvement Organization (QIO) Agreement letter dated 10/1/13 upheld the determination to terminate services. The letter records the resident was notified of the determination by telephone on 9/28/13 and Medicare services would no longer be provided beginning 10/1/13. Records also revealed a Medicare Expedited Appeal Request response letter dated 11/3/13 stating the appeal decision was unfavorable. The resident remained in the facility after receiving the unfavorable decision. Neither a SNFABN nor Denial Letter as required were provided by the facility in the record of documents given to the resident to inform her/him of potential liability for payment for continued to stay in the facility. On 11/23/13 T 4:05 p.m., Staff A stated the facility only issues the NOMNC. Staff A explained she/he was unfamiliar with the requirement or document and did not know the facility needed to provide a SNFABN.	F 156		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written	F 226		

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F 226	Continued From page 15 policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure staff were accurately trained regarding the requirement to report resident abuse to the state agency when 3 direct care staff, 2 front-line supervisors, the Social Services staff responsible for staff abuse training, and the Director of Nursing Services were unable to accurately identify state reporting requirements. This failure placed residents at risk for abuse. Findings include: The facility Policy and Procedures on Abuse stated that "incident reporting" was to occur according to the February 2012, 5th Edition of the Nursing Home Guidelines AKA "The Purple Book." The facility policy section entitled "Procedures," item # 13, stated, "All staff members are considered mandatory reporters and as such are obligated to report using the Washington State Abuse Hotline." The Nursing Home Guidelines AKA "The Purple Book," 5th Edition, February 2012, page 15, identified nursing home employees as mandated reporters as described in RCW 74.34.035-053 and stated:	F 226	F226 Corrective Action for Resident identified to be affected: There are no affected residents. Identification of residents with the potential to be affected: Residents who are known or suspected victims of abuse, neglect, or exploitation have the potential to be affected by this finding. Measures to prevent recurrence: Re-education was provided to staff on mandated reporting requirements. Re-education on locating the hotline number and placing the hotline call was also provided. Education was conducted by the staff development nurse on 12/8/13 and 12/9 through 12/13/13.	12/31/13
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F 226	<p>Continued From page 16</p> <p>"For the purposes of reporting abuse, abandonment, neglect, financial exploitation, sexual assault and physical assault, a nursing home employee (or other mandated reporter) is required to make a report if he or she: Observes the incident or hears the victim state it happened; or Hears about an incident from a permissive reporter who has direct knowledge of the incident."</p> <p>The Purple Book instructed mandated reporters to call reports of abuse to the Department abuse hotline number at: 1-800-562-6078.</p> <p>On 11/21/13 during interviews between 1:00 and 3:00 p.m., 3 direct care staff, Staff NN, Staff S and Staff T, were unable to identify their responsibility as a mandated reporters to call the Department hotline, stating it was optional as long as they reported to a facility nurse manager.</p> <p>At 3:30 p.m., when asked what s/he trained staff to do if they witnessed abuse, Staff K, a front-line supervisor, said staff must report to a nurse but do not need to call the hotline, and said, "If they report to me I will call the hotline and they don't need to. But they can if they want."</p> <p>At 3:45 p.m., when asked what s/he trained staff to do if they witnessed abuse, Staff C, a front-line supervisor, said all staff are mandated reporters, which meant they must report to managers but don't need to call the hotline unless they want to.</p> <p>On 11/22/13 at 8:57 a.m., Staff B, the Director of Nursing Services, stated staff received abuse training during orientation and annually. Staff MM was responsible for abuse training.</p>	F 226	<p>Monitor for Corrective Action:</p> <p>Supervisors have been trained to remind staff who report possible abuse, neglect, or exploitation of a resident that they are mandated to call a report to the abuse hotline. The names of the reporting individual (if known) and of the individual who places the facility call to the hotline will be logged together on the State reporting log. The log will be audited monthly as part of the QA process. Abuse and Neglect training will be conducted with orientation and annually, or more often as need is identified.</p> <p>The Director of Nursing will assure compliance.</p>	
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F 226	Continued From page 17 Staff B said facility employees who witness resident abuse must report to a nurse manager or Staff B who will call the hotline. When asked if staff witnesses were required to call the hotline themselves, Staff B said, "They can if they want but they are not required to as they long as they report to a nurse manager. It's their choice." At 3:58 p.m., Staff MM said, "I do the staff abuse training segment." Staff MM said during trainings s/he tells staff they are all mandatory reporters of abuse and provides the hotline number. When asked if staff are required to call the hotline when they witness abuse, Staff MM said it was the staff's choice and said, "I tell them they can call the hotline if they want but they are not required to as long as they report to a nurse manager." The facility failed to ensure staff were accurately trained regarding the requirement to report resident abuse to the state agency when staff were instructed that, as long as they report to a nurse manager, they do not need to call the state hotline. This failure placed residents at risk for abuse.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		

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F 241	<p>Continued From page 18</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview it was determined the facility failed to maintain dignity during dining in 1 of 3 dining rooms that included lack of timely assistance, inattention to the resident during the meal and attitude of the staff during meal. This failure placed the resident at risk for unmet nutritional needs and decreased quality of life due to lack of a dignified dining experience.</p> <p>Findings include:</p> <p>Refer to F282 for medical history, interview and record review.</p> <p>On 11/20/13 at 11:55 a.m., Resident #111 was observed at a table in the east dining room with four other residents. Each resident required various levels of assistance with meals.</p> <p>At 12:11 p.m., the main entrée was served. After assisting another tablemate for several minutes, Staff I went to the other side of table to Resident #111 and placed the nutritional supplement in hand and returned to assisting the tablemate. Between 12:16 p.m. and 12:23 p.m. Staff I offered Resident #111 two spoonful's of mashed potatoes.</p>	F 241	<p>F241</p> <p>Corrective Actions for resident identified to be affected:</p> <p>Resident #111 continues to be assisted with meals in the east dining room. He has been assessed for self-feeding ability and requires extensive assistance and cueing at meals. He shares a table with other residents and feeding assistance is provided. His care plan has been updated.</p> <p>Identification of residents with the potential to be affected:</p> <p>Residents who require assistance with meals have the potential to be affected.</p> <p>Measures to prevent recurrence:</p> <p>Staff who provide assistance in the dining room have been retrained on maintaining dignity during the dining process and providing adequate assistance to assure that nutritional needs are met. Training was conducted on 12/18/13 by the staff development nurse.</p>	12/31/13	

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F 241	<p>Continued From page 19</p> <p>At 12:23 p.m., Staff Z sat at table beside Resident #111. Once seated Staff Z placed left elbow on the table and rested chin in the palm of left hand while offered a spoonful of mashed potatoes to the resident with right hand. The potatoes smeared onto the resident's face as the spoon was placed into her/his mouth. After a few moments Staff Z saw the food on the resident's face and removed own face from hand and wiped the potatoes from the resident's face and the resumed the position with elbow on the table with her/his face resting in the palm of left hand.</p> <p>Resident #111 had documented diagnosis of [REDACTED] with the [REDACTED] and [REDACTED]. Resident #111 was also documented to require 1:1 assist with meals. The resident was positioned slightly to right in wheelchair. Staff Z's sitting position to the left of the resident placed her/him out of resident's line of sight requiring the resident to turn head to left out of alignment with body position toward Staff Z.</p> <p>During this time Staff Z did not talk to the resident and faced away from the resident for most of the time; occasionally talking with Staff I assisting the same tablemate. After offering 2 spoonfuls of food to Resident #111, Staff Z left the table. The resident was documented to turn head away and/or shake head "no" when not want to eat. Neither behavior was presented by the resident.</p> <p>On 11/21/13 at 8:57 a.m., Staff Z stated had rested face in hand during lunch dining because had a headache. Stated she usually talks with the</p>	F 241	<p>Monitor for Corrective Action:</p> <p>Supervisory staff monitor the dining process on a rotating basis. Concerns related to dining will be logged and brought to the Quality Assurance / Performance Improvement Committee for development of further training and intervention.</p> <p>The Director of Nursing will assure compliance.</p>	
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F 241	Continued From page 20 residents but did not because of the headache. When asked whether her/his posture appeared as lack of interest in the resident, Staff Z replied, "wasn't sure that anyone noticed". When talking with the resident about the dining experience, the resident was not able to verbalize thoughts. On 11/22/2013 8:43 a.m., Staff DD explained that staff were to stay with residents requiring 1:1 feeding assistance to provide personal eating assistance with the focus on that person. Staff DD said staff was to help residents concentrated on meal and assist with or offer each item allowing resident to help as he/she could. When a resident refuses an item, staff was to stop and assess, if the resident did not want to eat any more of that food, then to offer another food item.	F 241			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280	F280 Corrective Actions for residents identified to be affected: Resident #93 has been assessed for assistance needed with oral hygiene and care plan updated. He is scheduled to be seen by the dental hygienist on 1/3/14. Orders for Resident #12's oral rinse were verified with the dental hygienist and rinse started on 12/3/13. He is scheduled to be seen by the dental hygienist on 1/3/14. His plan of care has been updated.	12/31/13	

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F 280	<p>Continued From page 21 and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review it was determined that the facility failed to revise the plan of care to identify interventions to address dental and oral health needs for 2 of 3 Sampled Residents (#s 12 & 93) reviewed with dental conditions. This had the potential to place these residents at risk for dental needs to not be met and/or to develop an oral and/or systemic infection.</p> <p>Findings include:</p> <p>RESIDENT #93</p> <p>Refer to F 412 for additional interviews related to failure to timely follow up with dental recommendations.</p> <p>On 11/22/13 at 9:03 a.m. Staff G set up dental supplies and handed a toothbrush to Resident #93. The resident brushed his/her teeth gently in a side to side motion and not up and down teeth next to the gum line. After brushing teeth, the resident opened his/her mouth which contained visible white matter on the lower teeth above the gum line.</p> <p>Two previous dental consults dated 8/29/12 and 9/18/13 identified the resident had wall to wall plaque and recommended dental hygiene</p>	F 280	<p>Identification of residents with the potential to be affected:</p> <p>Residents who receive dental and hygienist care have the potential to be affected.</p> <p>Measures to prevent recurrence:</p> <p>Resident records were reviewed to assure that residents had received dental and dental hygiene care at recommended intervals. Residents who are due for care have been scheduled for a dental hygiene visit. Care plans are updated to include recommendations for dental and hygienist care. Re-training was provided for nursing staff on maintaining the dental care plan and following dental recommendations. Training was provided on 12/17/13 and conducted by the Director of Nursing.</p>	
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F 280	<p>Continued From page 22</p> <p>cleaning. The resident ' s record did not contain evidence the resident received dental hygiene cleaning since consultants made the first or second recommendation.</p> <p>On 11/21/13 at 1:11 p.m. Staff B reported the facility used multiple sources of information to identify dental concerns that included a Resident Assessment Instrument (RAI, a required assessment tool), quarterly assessments and interviews with residents and family members. Staff B also reported if a resident had a dental issue identified it should be care planned.</p> <p>On 11/21/13 at 3:22 p.m. Staff E reported residents who had dental concerns usually had their own dental care plan. General dental needs were usually written under Activities of Daily Living or Nutritional Care Plans.</p> <p>Resident #93 ' s Alteration in Nutrition care plan contained an " approach: that identified the resident ' s teeth were natural and to provide oral care. A care plan for Impaired ADL (Activities of Daily Living) function directed staff to see in room care plan for hygiene and grooming.</p> <p>On 11/21/13 at 3:30 p.m. Staff T reviewed the aide care plan in Resident #93 ' s with the surveyor which directed staff to assist the resident to brush teeth twice a day. Staff T reported staff provided oral care twice a day as a standard of care.</p> <p>On 11/21/13 at approximately 4:00 p.m. Staff E reviewed Resident #93 ' s dental consults and confirmed the dentist documented the resident had wall to wall plaque. Staff E reported nursing did not keep track of residents who needed</p>	F 280	<p>Monitor for Corrective Action:</p> <p>Audits of initial and quarterly care plans are conducted by the nursing management team. Care plans will be audited for development of dental care plans and compliance with interventions. Audit findings will be reported to the Quality Assurance / Performance Improvement Committee to identify further need for training.</p> <p>The Director of Nursing will assure compliance.</p>	
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F 280	<p>Continued From page 23</p> <p>additional dental appointments and the resident 's care plan did not identify the resident needed additional dental follow up.</p> <p>Failure to develop a plan of care with interventions, specific goals and target dates that specified dental follow up Resident #93 needed prevented staff from readily identifying the resident did not receive an annual dental hygiene cleaning as recommended by the dentist to ensure dental needs were timely met.</p> <p>Based on observation, intervui and record review it was determined the faciity failed to update the pland of care related to dental needs to track dental recommendations for hypiene dental cleaning for 2 of 3 sampled residents (#93, 12) reviewed.</p> <p>Based on interview, observation and record review the facility failed to implement dental hypienist recommendations for 1 of 2 sampled residents (#12) reviewed for dental care.</p> <p>MDS Annual Assessment dated 2/9/13 lists dx aphasia, LE cerbvas disease, hemiplig afctg, unspec side LE derbvas CAA trigger for dental insue: Obviiious or likely cavity or broken teeth = Problems-cannot remember steps to complete oral hygiene, cognitive deficit. Requires extensive assist r/t cog anf func deficits. Funct+loss of voluntary arm omvmt, mpaire hand dexterity, funct limit i UE and ROM, resists assist w adl's. Denies dry mouth.Review: triggered due to having broken/missing teeth and cavities. He routinely sees the house dentist. Was last seen 11/21/12.</p>	F 280			

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F 280	<p>Continued From page 24</p> <p>He is noted by dentis to decline any further extractions or dentures at this time. Has denied having any mouth pain, chewing or swallowing difficulty. Tolerating reg tex diet well. Assisted w oral hyg and monitore for non vebal sign/symp of dental pain. At risk for infetion r/t this care area.</p> <p>11/20/2013 10:13:55 AM Sandra reported can communicate but slow to get out, gets frustrated. Ex mother in law now the contact for resident not POA. - no POA listed. thinks has children, not visit.</p> <p>Total assist for ADL, sits at feeder table to encourage to eat. can propel self in w/c w good let. likes to sit by fireplace. If is warmth or payroll person previous bond with her. Always pale, labs done. Hx low H & H, get folic acid, thought on iron at one time. RD note dated 5/7/13 iron dc'd r/t iron panel.</p> <p>Dental note dated 11/21/12 reports not want extraction or dentures. Stated seen yearly, sooner if problems. Dentist visits recorded. Hygenist role and frequency of visits not known will ask. Updated that hygienist visits every 6 months to see residents listed by dentist. Teeth not appear to interfere with eating.</p> <p>11/21/2013 4:05:36 PM Care Plan Problem alteration in nutri/hydra lists - missing and broken teeth, follow dental recommendations.</p> <p>4/12/13 Smile Seattle Dentured -Nursing home cleaning form by hygienist. Findings include missing teeth approx 14 missing teeth and 7 broken/decayed and slight plaque, claculus, decay inflammed gums, stains of dk decay and bleeding. Notes resident needs daily assist to</p>	F 280		

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F 280	<p>Continued From page 25</p> <p>brush along gumline and use flouride rinse. Needs checked for resident includes 0.2% Sodium bloride dialy swish. Information regarding daily swish no t located in chart or computer documents,</p> <p>11/23/132:30 at Sandra, RCM said would look in overflow chart to confirm was initiated. Stated has not reports for aides that resident refuses adl care or oral hygiene.</p> <p>11/22/13 at 4:18 sandra, RCM said unable to find any documentation regarding recommendaton for oral swish in residents chart. Stated if not documented was not done. Not on April or May TAR so we know if not documented not done. Try to call hygienist for information.</p> <p>QP216 1) Based on general observations, did you see any of the following? (Mark all that apply) = 4 (E: Teeth broken/loose, or inflamed/bleeding gums, or problems with dentures) Surveyor: 32390 RelevantFindings: ()</p>	F 280		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review it was determined that the facility failed to</p>	F 281		

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F 281	<p>Continued From page 26</p> <p>either timely clarify, obtain, follow physician orders and/or timely follow up with consultant recommendations or obtain communication from an outside provider for 2 of 36 Sampled Resident (#s 120 & 218) reviewed for physician orders. This had the potential for the resident to not receive treatment as determined necessary by their physician and/or for residents to not achieve greatest therapeutic results from their treatments.</p> <p>Findings include:</p> <p>RESIDENT # 218 Refer to F 309 and F 325 for observations, medical history, dialysis information and interviews for Resident # 218.</p> <p>1. Physician orders dated 11/8/13 directed nursing staff to check Resident #218's blood glucose levels before meals and at bedtime and administer insulin according to a sliding scale. Sliding scale insulin amounts varied depending on the level of the blood glucose.</p> <p>A "Diabetic Flowsheet" contained instructions for staff to check blood glucose levels before the evening meal at 4:15 p.m. and again at bedtime at hour of sleep. On 11/9/13; 11/12/13; 11/14/13; 11/16/13; 11/19/13 and 11/21/13 staff did not document they obtained a blood glucose level for Resident #218 before the evening meal and documented the resident was at dialysis at that time.</p> <p>On 11/22/13 at 12:26 p.m., Staff C reported Resident #218 returned from dialysis as late as 7:30 p.m. and staff held the dinner tray and offered it then. When asked if staff checked Resident #218's blood glucose before the</p>	F 281	<p>F281</p> <p>Corrective Actions for residents identified to be affected:</p> <p>Resident #218's orders for blood glucose checks on dialysis days were clarified with the physician and plan of care updated.</p> <p>Resident #120's orders were clarified to allow the [REDACTED] to be administered together with the a.m. medication pass.</p> <p>Identification of residents with the potential to be affected:</p> <p>Residents with orders that include special instructions on timing or with orders that conflict with treatment times outside of the facility (such as during dialysis) have the potential to be affected.</p>	12/31/13	

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F 281	<p>Continued From page 27</p> <p>evening meal Staff C reported he/she thought the resident often refused. The diabetic record did not indicate the resident refused.</p> <p>On 11/22/13 at approximately 3:00 p.m. Staff M reported when the resident returned from dialysis around 7:30 p.m., staff warmed the dinner and served it to the resident. Staff M reported he/she did not check the resident ' s blood glucose level before the meal because the MAR directed staff to check it about 5:00 p.m. Staff M stated since the resident arrived late from dialysis he/she waited until bedtime to check the blood glucose level.</p> <p>According to Clayton, Stock, Herroun (2007) entitled, Principles of Medication Administration, "If any part of the order is vague, the prescriber who wrote the order should be consulted for clarification. Patient safety is the primary importance and the nurse assumes responsibility for verification and safety of the medication order. If the prescriber cannot be contacted or does not change the order, the nurse should notify the director of nurses, the nursing supervisor on duty or both."</p> <p>Licensed staff failed to follow physician orders to check Resident #218's blood glucose before the evening meal and administer insulin coverage if needed when the resident returned from dialysis treatment and failed to clarify the order with the physician to determine if the order needed to be adjusted due to delay in eating the evening meal following return from dialysis.</p> <p>2. Facility staff failed to timely obtain communication from the dialysis center when resident #218 returned to the facility following</p>	F 281	<p>Measures to prevent recurrence:</p> <p>Physician orders were reviewed to assure that orders with special instructions for timing were timed appropriately on the Medication Administration Record. Nursing staff were trained to be aware of unclear orders and to seek physician clarification of the order to assure safe and accurate administration of the medication or treatment. Training for nursing staff was provided by the Pharmacist Consultant on medications that require special conditions for administration (ex: give on an empty stomach). Training was provided on 12/20/13. Training for nursing staff on clarifying unclear orders was provided by the Director of Nursing on 12/17/13.</p>	
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F 281	<p>Continued From page 28 dialysis treatment.</p> <p>During interviews on 11/20/13 at 12:52 p.m. with Staff C and on 11/20/13 at 1:05 p.m. with Staff K, both reported nursing staff did not communicate they did not always receive communication dialysis flow sheets back from the dialysis center.</p> <p>Staff K also reported a miscommunication occurred between nurses, medication nurses and the Resident Care Manager. Staff K also reported nursing should have placed the information into a communication book at the nursing station and the book did not contain communication evening shift nurses did not receive information needed from the dialysis center.</p> <p>According to "Lippincott Manual of Nursing Practice," ninth edition, the nursing process is a "deliberate, problem-solving approach to meeting the health care and nursing needs of patients." The process "involves assessment (data collection), nursing diagnosis, planning, and evaluation, with subsequent modifications used as feedback mechanisms to promote the resolution of the nursing diagnoses. The process as a whole is cyclical, with the steps being interrelated, interdependent, and recurrent". Implementation includes coordinating care with other health team members.</p> <p>Licensed nursing staff did not timely coordinate with other team members important information from the dialysis center necessary for monitoring the resident's condition was not always returned to the facility.</p> <p>Refer to F 309 for failures related to post dialysis monitoring for Resident #218.</p>	F 281	<p>Monitor for Corrective Action:</p> <p>Medication orders will be double checked on admit for accuracy and clarity by the RCM and the admitting nurse. Medication orders will be double checked by the RCM and a licensed nurse with monthly recaps. Any medication order that is unclear will be clarified with the physician.</p> <p>The Director of Nursing will assure compliance.</p>	
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F 281	<p>Continued From page 29</p> <p>3. On 11/11/13 a dietary consultant recommended Resident #218 receive an additional dose of a medication named Renvela prior to eating snacks. Nursing staff did not timely process the recommendation and obtain a physician order to implement the recommendation until nine days later.</p> <p>On 11/22/13 at 12:26 p.m. Staff C confirmed nursing staff did not obtain the physician order to implement the dietary recommendation until 11/20/13.</p> <p>Refer to F 325 for failure to timely follow up and obtain physician orders for dietary recommendations.</p> <p>RESIDENT #120 On 11/12/12 the physician ordered for staff to administer medication Metolazone to Resident #120 thirty minutes after administration of medication Lasix. The Medication Administration Record (MAR) identified to give both medications in the "a.m." and did not indicate specific times either medication should be given.</p> <p>During observation of medpass on 11/21/13 beginning at 8:02 a.m., Staff H administered Metolazone and Lasix to Resident #120 at the same time and did not wait to give Lasix 30 minutes after administration of Metolazone.</p> <p>On 11/21/13 at 8:42 a.m. Staff E reported Staff H filled in for another staff that was off since 11/4/13. Staff E reported a.m. and p.m. were standard times designated for medication administration and specific times "probably should" have been designated for a medication</p>	F 281		
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F 281	Continued From page 30 required to be given a half an hour before others and did not pick this up during recap. On 11/21/13 at 11:35 a.m. Staff H reported after administering Metolazone he/she realized it needed to be given a half an hour before Lasix. Staff H also reported it would have been easier to identify the need to wait to give Lasix if the medication record indicated a specific time to give the medication. According to Smith, Duell and Martin, Clinical Nursing Skills, Sixth Edition, pages 518-521, nurses are to administer medications as ordered by the physician. Additionally nurses are to document the time of administration, route, dosage, and assess and document the resident's response to the medication. Nurses are to review the Medication Administration Records daily to validate all medications are in accordance with the physician's order. Refer to F 332 for resulting medication error related to inaccurate timing of medication Metolazone.	F 281			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by:	F 282			

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F 282	<p>Continued From page 31</p> <p>Based on observation, interview and record review it was determined that the facility failed to consistently follow the care plan for positioning, medication monitoring, and assistance with dining for 2 of 35 sampled residents (# 44 & 111) reviewed for implementation of care plans. This failure placed the residents at risk for inadequate care/services and decreased quality of life.</p> <p>Finding Include:</p> <p>Resident #44</p> <p>POSITIONING Resident # 44 was admitted to the facility on 7/5/13 with the diagnosis of heart failure, Non-Alzheimer Dementia, and [REDACTED]</p> <p>A quarterly Minimum Data Set (MDS, an assessment tool) identified Resident # 44 as needing extensive assist with bed mobility and transfers with two person physical assistance. For personal hygiene and toilet use the resident required extensive assist with one person physical assist.</p> <p>Resident # 44's care plan dated 7/16/13 with the focus of pressure ulcer identified; the resident being at risk for pressure ulcers related to decreased mobility, history of prolonged hospitalization, recently resolved pressure ulcer to the left heel, incontinence, frequent diarrhea, oxygen use, chronic obstructive pulmonary disease (COPD), and [REDACTED] use. The long term goal was the resident ' s skin will remain intact. Two interventions listed were to</p>	F 282	<p>F282 Corrective action for residents identified to be affected:</p> <p>Resident #44 remains on a negative heel mattress to relieve pressure to the heels. She is on a turning / repositioning plan when in bed. Her care plan and in-room care plan have been updated. Caregivers are trained to inform nursing staff of refusals to re-position using the Stop and Watch form. Risks have been reviewed with the resident and her family. She has no skin breakdown.</p> <p>The order for the [REDACTED] used for [REDACTED] and insomnia has been discontinued. Dosages of other [REDACTED] medications have been reduced. Sleep patterns are being monitored, as are mood and signs and symptoms of [REDACTED]. Resident #44 continues to sleep much of the time and is encouraged to be up, at least for meals, and to come out of her room occasionally. She is agreeing to get up for two meals on most days and continues to resist coming out of her room. A follow-up with mental health has been scheduled and medication reviews have been completed by the Pharmacy and by the Physician. Education of potential risks of spending prolonged time in bed has</p>	12/31/13
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/23/2013
NAME OF PROVIDER OR SUPPLIER PUYALLUP NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372		
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F 282	<p>Continued From page 32</p> <p>keep bony prominences from direct contact with one another with pillows and to turn and reposition the resident every 2 hours.</p> <p>The "Nursing Care Directives" that is followed by the aides providing care for the resident listed the resident to have heel floated, and repositioning at minimum of every 2 hours. The " Nursing Care Directive " listed Resident # 44 as having weakness in all four extremities and required 2 person assistance with bed repositioning and transfers.</p> <p>On 11/18/13 at 12:55 p.m. Resident # 44 was observed resting supine in bed with no pillows under bony prominences.</p> <p>On 11/19/13 at 2:16 p.m. Resident # 44 was resting supine in bed with eyes closed and oxygen in place.</p> <p>On 11/20/13 at 9:06 a.m., 10:07 a.m., 10:45 a.m., 11:10 a.m., 11:44 a.m., 12:19 p.m., 1:48 p.m., and 2:43 p.m. Resident # 44 was observed resting supine with eyes closed and no pillows under bony prominences.</p> <p>Resident # 44's treatment administration record (TAR) identified to float heels every shift starting 7/5/13. Documentation of heels being floated was completed for each shift up to the evening of November 20th. Heels were never observed being floated from 11/18/13-11/21/13.</p> <p>On 11/20/13 at 2:46 p.m. Staff V reported that Resident # 44 is always sleepy and that he/she was to be changed and turned every two hours. Staff V reported that the off going aides reported the resident was last turned at around 2:00 p.m.</p>	F 282	<p>been provided to Resident #44 and to her son.</p> <p>Resident #111 continues to be assisted in the dining room. He is seated at a table with other residents who require feeding and / or cueing. Staff who assist with feeding have been trained to encourage intake of solid food prior to offering the supplement and to stay near and monitor the resident as he eats. His plan of care has been updated. He remains on Hospice services with the nutrition goal of receiving food and fluids as desired. Staff have been trained to verify with him that he has received all that he wants of each meal before removing the tray.</p> <p>Identification of residents with the potential to be affected:</p> <p>Residents who require assistance with positioning due to decreased mobility and risk for skin breakdown have the potential to be affected. Residents who receive psychotropic medications have the potential to be affected. Residents who require assistance with feeding have the potential to be affected.</p>	

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F 282	Continued From page 33 On 11/20/13 at 3:06 p.m. Staff V confirmed that Resident # 44's heels were not floated. Resident # 44's heels were red and blanchable bilaterally. After Resident # 44 was cleaned up Staf V positioned the resident back in the supine position in which he/she was found. On 11/20/13 at 3:55 p.m. Resident # 44 resting in the supine position with eyes closed and no pillows under feet. On 11/21/13 at 9:56 a.m. Resident # 44 resting supine with eyes closed and heels not floated at this time. On 11/21/13 at 11:14 a.m. Staff D confirmed that Resident # 44 was in the supine position and heels were not floated and that the care plan was not followed. No alert charting or charting of refusals for care in the communication book (MACC) or in the aide activities of daily living (ADL) book. On 11/22/13 at 8:01 a.m. Staff J reported that Resident # 44 sometimes refuses to have heels floated but not that much, the resident did not have them floated at night but this morning he/she agreed to floating heels. Staff J confirmed no documentation of the resident refusing to have heels floated. Review of Resident # 44's TAR showed evidence that the floating of heels was discontinued on 11/21/13 at approximately 3:53 p.m. On 11/22/13 at 8:11 a.m. Staff J denied knowing that the floating of heels for Resident # 44 had	F 282	Measures to prevent recurrence: Retraining on positioning of residents with decreased mobility has been provided to nursing and nursing assistants. Training was conducted on 12/18/13 and was provided by the staff development nurse. Care plans for residents with decreased mobility have been reviewed and updated. Psychotropic assessments have been completed / updated for residents who receive psychotropic medications. Residents who are potentially having adverse side effects have been referred to the physician and pharmacist for medication reviews. Care plans have been updated, as needed, with interventions for monitoring for side effects of psychotropic medications. Re-training has been provided for nursing staff on accurate monitoring of psychotropic side effects. Training was provided by the Director of Nursing on 12/17/13.		

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F 282	<p>Continued From page 34 been discontinued.</p> <p>On 11/22/13 at 8:15 a.m. Staff K confirmed that after discontinuing the float of heels for Resident # 44 that the care plan and care directives should have been updated.</p> <p>On 11/22/13 at 8:18 a.m. Staff B reported that when care is refused the aides are supposed to communication to the nurses on the charts and next to the resident care managers (RCM). Staff B confirmed that when the order and/or intervention changed last evening that the care plan and care directive should have been changed.</p> <p>Failure to implement the care plan placed the resident at risk for pressure ulcers as well as decreased quality of life. When there is a change in the resident 's care the care plan and care directive should be updated to reflect the changes and the appropriate care needed for the resident.</p> <p>MEDICATION MONITORING</p> <p>Resident # 44's care plan dated 7/16/13 with the focus of [REDACTED] use listed two problems: Resident at risk for adverse consequences related to receiving [REDACTED] medication for treatment of anxiety. Long term goal was the resident will not exhibit signs of drug related side effects or adverse drug reaction. An intervention listed was, monitor for drug use effectiveness and adverse consequences.</p> <p>Resident at risk for adverse consequences related to receiving antidepressant medication for</p>	F 282	<p>Training has been conducted for staff who provide feeding assistance to residents and for staff who supervise dining services. Staff have been trained on attentiveness during feeding, maximizing intake, and focusing on the resident during the dining process. Training was provided by the Staff Development nurse on 12/18/13. Staff who supervise the dining process have been trained to monitor for residents who may need additional assistance with meals and to refer to nursing for evaluation of need to update the plan of care. Training was conducted by the Director of Nursing on 12/17/13.</p> <p>Monitor for Corrective Action:</p> <p>Positioning rounds will be conducted daily for two weeks, then weekly by the RCM, DNS, and/or charge nurse, along with the nursing assistant and nurse assigned to the area, to assure that immobile residents are positioned correctly. Rounds will be conducted at random times and will include each shift. Problems found will be corrected immediately and education provided to staff. Results will be reported to the Quality Assurance / Performance Improvement committee for 3 months to identify the need for further education.</p>		

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F 282	<p>Continued From page 35</p> <p>treatment of [REDACTED] and insomnia. The long term goal was that the resident will not exhibit signs of drug related side effects or adverse drug reaction. Interventions listed were to assess/record the effectiveness of drug treatment. Monitor and report signs of sedation, hypotension, or anticholinergic symptoms. Monitor resident ' s mood and response to medication.</p> <p>Failure to adequately monitor the resident's medications as ordered and care planned placed the resident at risk for decreased quality of life and decreased quality care.</p> <p>Refer to F 329 for more information on medication monitoring.</p> <p>RESIDENT #111</p> <p>The Resident Clinical Diagnosis dated 11/1/13 documented Resident #111 had [REDACTED] and [REDACTED].</p> <p>[REDACTED] The resident was placed on hospice care 11/7/13 with diagnosis of senile degeneration of brain and debility.</p> <p>A Nutritional Risk Review dated 10/14/13 reported Resident #111's weight was trending down over the last month from [REDACTED] pounds to stable from July to September. Overall the resident had a 9.9% weight loss over last 175 days and the family and physician were aware of the weight loss. The note also stated the resident's appetite varies and sits at a feeder table for assistance with meal intake.</p>	F 282	<p>Psychotropic assessments are reviewed and updated, as needed, in the Psychotropic committee meeting. Participants include the Pharmacist, Social Services, Resident Care Managers and DNS. Monthly reviews of the effectiveness and side-effects related to anti-psychotics, anti-anxieties, and hypnotics are done. Effectiveness and side-effects of anti-depressants are reviewed quarterly and as need is identified.</p> <p>A rotation of supervisory staff have been trained on monitoring the dining process. Results of monitoring will be reviewed by the Quality Assurance / Performance Improvement committee to identify the need for further education.</p> <p>The Director of Nursing will assure compliance.</p>		

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F 282	<p>Continued From page 36</p> <p>A recent Medical Nutrition Quarterly Note dated 11/12/13 listed Resident #111 was admitted to hospice [REDACTED] 13. The Summary note stated the Resident receives 1:1 assist in Main Dining Room for assistance with meals and can self-feed liquids. The diet was likely adequate if accepted. Also noted was the weight continues to decline significantly over the past 6 months and oral intake remains highly variable but overall poor. Remeron was given to stimulate the resident's appetite but it had not been effective and was discontinued. The Nutritional Interventions listed included to continue the same plan of care to honor the residents preferences as able with a goal for satiety of hunger and thirst and to deter weight loss as able however may be unavoidable as diagnosis progresses. The care plan was to be updated to reflect current goals.</p> <p>On 11/20/12 at 9:30 a.m., Staff E, stated Resident #111 had a diagnosis of failure to thrive and hospice was initiated related to weight loss, poor intake. Staff were to offer meals, work with the resident's diet to improve intake with a dysphasia/pureed diet, try softer foods that may be more appealing and offer supplements and fortified food. Staff E stated supplements were to replace intake if less than 50% meal was eaten. Additionally, Staff E said Remeron was given and appeared to help. Resident #111's weight had stabilized, then she/he would start to turn head away when attempted feeding and weight loss resumed despite interventions. Staff E stated the resident takes shakes 120 cc, offered four times a day. Shakes were given at medication pass, shakes may be given before or after meals. A review of the medication flow sheet dated 11/1-11/31/13 records the resident was offered and accepted 120cc supplement 4 times a day.</p>	F 282			

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F 282	<p>Continued From page 37</p> <p>MEAL OBSERVATIONS</p> <p>On 11/20/13 11:55 a.m., Resident #111 was seated at a table in the east dining room. At 12:01 p.m. was sitting looking around room with a bowel of food in front on table. At 12:11 p.m., the main entrée was served with no 1:1 assistance offered. At 12:12 p.m. Staff "I" placed the nutritional supplement in resident's #111 hand that she/he began to drink. A spoonful of mashed potatoes was offered by Staff I at 12:16 p.m. and again at 12:23 p.m. At this time, Staff Z sat down at the table to assist the resident, offering a couple of spoonful's of the meal then stopped offering assistance and walked away. Resident #111 drank 90% of supplement and less offered less than 25% of the meal. Resident was not observed to turn away or refuse to eat.</p> <p>On 11/21/13 at 12:45 p.m., Resident #111 was seated in the east dining room at a table alone without feeding assistance. Lunch was ending with most residents no longer in the dining room. The resident had drank 90% of the supplement and eaten 25% of food. When the surveyor asked "how was lunch", the resident replied "was good". Resident #111 responded when asked what had for lunch, pointed and said chopped meat, and potatoes and not could identify orange/yellow pureed substance. Resident picked up the spoon and attempted to scoop potatoes but hand was very shaky and placed spoon on table. Resident #111 replied when asked by surveyor what was in the cup said "chocolate milk" and picked up the cup and drink remaining liquid.</p> <p>On 11/22/13 at 7:54 a.m. the resident was again seated in east dining room at table looking around with mug of liquid. At 8:12 a.m. the</p>	F 282		
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F 282	<p>Continued From page 38</p> <p>resident sat with breakfast entrée on table looking around with no assistance offered by staff. Staff FF was seated at the table assisting another tablemate. Staff FF stood from the chair, reached over and moved cups of liquid closer to Residents #111's then resumed feeding the tablemate.</p> <p>Between 8:15 a.m. and 8:18 a.m. a student CNA sat and assisted the resident with the meal that consisted of scrambled eggs, hot cereal, toast, hot cocoa, juice and other liquids. The resident ate approximately 25% of meal. The nutritinal supplement was not included in the liquids with the meal.</p> <p>On 11/23/13 at 2:56 p.m., Staff GG stated residents on 1:1 has to have someone with the person during feeding. Staff have to stay with person during meals because they may have choking or swallowing problems, need to sit upright, help with the amount of food they eat and drink. "The expectation is that the attention of the person assisting at the table is with the 1:1 person".</p> <p>Failure to follow the care plan for 1:1 assistance with meals place Resident #111 at risk for increased weight loss, decreased quality of care and quality of life.</p>	F 282		
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in</p>	F 309		

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F 309	<p>Continued From page 39</p> <p>accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review it was determined that the facility failed to provide all necessary care and services for 1/1 Sampled Residents (# 218) who received treatment from an outside facility. These failures included lack of consistent review of dialysis communication and post dialysis monitoring. This had the potential for staff to not have all information necessary to assess Resident #218's medical condition upon return from dialysis and/or timely identify complications that required immediate attention.</p> <p>Findings include:</p> <p>On 11/20/13 at 12:37 p.m. Resident #218 sat in the dining room in front of a plate of food and did not finish the meal. The resident reported the food was good but he/she did not feel like eating. The resident placed the right elbow on the arm of the wheelchair and held his/her head in the right hand.</p> <p>On 11/22/13 at 10:52 a.m. the resident sat on the edge of bed with elbows on a moveable bedside table and held his/her head in the palms of both hands.</p> <p>Resident #218 admitted to the facility on [REDACTED] 13 following hospitalization. An infectious disease report dated 11/6/13 identified the resident had a</p>	F 309	<p>F309</p> <p>Corrective actions for resident identified to have been affected:</p> <p>Resident #218's dialysis communication sheets have been received from the dialysis center and are up-to-date. Pre and post-dialysis information is being communicated between the facility and the dialysis center by fax, as well as the original documents that are carried in a notebook, by the resident, from facility to dialysis and back. The dialysis access site is being monitored according to the dialysis policy. There are directives on the care plan and the MAR for care of the pressure dressing and access site following each dialysis treatment. There are also directives for post-dialysis monitoring of vital signs. Medications and diet are being given per Physician's orders.</p> <p>Identification of residents with the potential to be affected:</p> <p>Residents who receive dialysis services have the potential to be affected.</p>	12/31/13
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F 309

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history of renal disease requiring dialysis treatment three days a week. Additional diagnoses included diabetes, heart failure, previous cardiac surgery and sepsis. The front of the chart identified the resident went to an outside facility for dialysis on Tuesday, Thursday and Saturday each week.

During November 2013 between 11/9/13 and 11/21/13, Resident #218 received dialysis treatment on 11/9/13; 11/12/13; 11/14/13; 11/16/13 11/19/13 and 11/21/13.

POST DIALYSIS COMMUNICATION

On 11/20/13 at 12:52 p.m. Staff C reported the Resident #218 returned from dialysis with a binder that contained communication flow sheets completed by the dialysis center and nursing should obtain and review them.

The resident's medical record reviewed on 11/20/13 at 1:05 p.m. did not contain dialysis communication flow sheets for treatments received on 11/9/13; 11/14/13; 11/16/13 and 11/19/13. On 11/20/13 at 1:05 p.m. Staff K confirmed communication sheets were missing and information would have included resident weights, vital signs and medications given during dialysis treatment.

Staff K also reported he/she realized the facility did not get communication sheets returned from dialysis until 11/15/13. Staff K could not identify specific protocols that should be in place for residents who received dialysis and had not seen a facility policy and procedure that addressed them.

F 309

Measures to prevent recurrence:

Re-training on admission assessments and initial care planning for residents who are on dialysis was provided to nursing staff. Training was conducted on 12/5/13 by the nurse consultant for the facility.

Dialysis policies and procedures were re-trained to nursing staff. Nursing staff have been trained to fax a communication sheet to the Dialysis center and to call the Dialysis center and request that any missing information be sent via fax so that effective monitoring of the resident can occur. Training was conducted by the DNS on 12/17/2013.

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F 309	<p>Continued From page 41</p> <p>Without timely and complete communication information from dialysis regarding treatment, nursing staff did not have all information necessary to reassess the resident's condition upon return from dialysis and advise the physician timely the resident refused antibiotic treatment at dialysis.</p> <p>INCONSISTENT MONITORING OF ACCESS SITE</p> <p>Physician orders dated 11/8/13 identified the resident had an access site surgically created on the left arm to enable dialysis treatment. Routine listening and feeling for a pulse at the access site is necessary to ensure it remained functional.</p> <p>A "Medication Administration Record" (MAR) for November 2013 documented nursing staff monitored the access site daily during day shift from 11/9/13 through 11/14/13. On 11/21/13 at 8:29 a.m. Staff Y reported staff monitored the access site once on day shift until 11/16/13 and then the order was changed.</p> <p>The November 2013 MAR beginning 11/16/13 directed staff to monitor Resident #218's dialysis access site three times a day during every shift. The MAR did not contain evidence staff documented they monitored the access site during evening shift on 11/18/13 through 11/21/13 or during day shift on 11/20/13.</p> <p>Facility Policy and Procedure for "Hemodialysis Care" directed staff to monitor the access site every shift while awake. Without consistent monitoring of Resident #218's dialysis access site, the facility may not readily identify if complications occurred that required immediate</p>	F 309	<p>Monitor for Corrective Action:</p> <p>Records of dialysis patients will be audited by the RCM or DNS immediately following completion of the admission process to assure that care plan interventions for post-dialysis monitoring, timing of medications and meals, proper diet and fluid orders, care and monitoring of the dialysis access site, and emergency procedures are in place. Any problems identified will be corrected, and additional training / intervention provided. The Quality Assurance / Performance Improvement Committee will review any problems identified with the dialysis process to determine the need for intervention.</p> <p>The Director of Nursing will assure compliance.</p>	
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F 309	<p>Continued From page 42 intervention.</p> <p>LACK OF CONSISTENT POST DIALYSIS MONITORING</p> <p>A "Dialysis Orders" sheet for November 2013 directed staff to document blood pressure and temperature upon return from dialysis and document when done. Neither the form nor progress notes contained evidence staff monitored Resident #218's vital signs following return from dialysis on 11/9/13; 11/12/13 and 11/14/13.</p> <p>On 11/21/13 at 12:59 p.m. Staff B reported vital signs would be documented in the computer system. It is unclear if vital signs recorded coincided with nurse monitoring of Resident #218's medical condition at the time the resident returned from dialysis.</p> <p>The November "Dialysis Orders" form directed staff to check the pressure dressing and remove it post dialysis. The form did not contain initials to indicate staff checked the dressing. Progress notes for 11/9/13; 11/14/13; 11/16/13; 11/19/13 and 11/21/13 did not indicate staff attended to the resident's dialysis dressing.</p> <p>On 11/21/13 at 12:59 p.m. Staff B reported the dialysis care plan should contain a schedule to identify what and when staff should monitor. Review of Resident #218's care plan at this time did not indicate when to check the pressure dressing and when to remove it.</p> <p>Failure to ensure staff timely monitored Resident#218's vital signs and condition immediately upon return from dialysis, had the</p>	F 309		
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F 309	Continued From page 43 potential to delay identification of potential complications if they occurred.	F 309	F314	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to consistently and accurately document resident clinical condition, define and implement interventions consistently, recognize standards of practice, monitor and evaluate the impact of interventions and/or revise interventions appropriately to provide timely necessary treatment and services to ensure that a resident without a pressure ulcer did not develop one, and to promote healing when a pressure ulcer did develop in 1 of 3 residents (#17) reviewed for pressure ulcers. This failure resulted in the development of a painful, ongoing Stage 3 pressure ulcer causing physical and psychosocial harm to the resident.	F 314	Corrective Action for resident identified to be affected: Resident #17 is receiving daily wound care to the resolving stage III pressure ulcer left of the sacrum. The wound is progressing well towards healing and will be staged as a "healing stage III" pressure area until resolved. Resident #17 has a new wheelchair cushion in place that is rated as effective for management of a stage III wound. His transfer has been changed to a sit-to-stand lift mechanical transfer, which he finds acceptable. He continues to refuse to lie down during the day and has been educated to the risks of spending prolonged periods up in his wheelchair and offered alternative plans for pressure relief. He is assisted to stand and reposition at least every two hours. He denies wound-related pain. He has an order for prn pain medication that effectively manages any reported pain and he consistently denies pain when up in his chair. He is working with therapy on increasing mobility and on pressure relief strategies. He continues to use an air mattress with pressure set to his comfort and setting marked on the TAR, the in-	12/31/13

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F 314	Continued From page 44 Findings include: Facility Policy and Procedure for Skin Breakdown indicated residents at risk of skin breakdown would receive weekly full body skin assessments by a licensed nurse using the Admission/Weekly Skin Observation Tool. Upon discovery of a pressure ulcer, licensed nursing staff were to do the following: 1) describe the pressure ulcer on the body outline, including color, size and pain; 2) notify the physician, obtain a treatment order and document treatments on the Treatment Administration Record; 3) document the pressure ulcer on the Skin Grid for Pressure Ulcers and continue to document weekly; 4) identify interventions to promote skin healing/resolution of skin impairment; 5) implement interventions and document on the resident's care plan; 6) document all previous actions in progress notes; 7) conduct weekly rounds to evaluate the pressure ulcer, plan of care, the resident's compliance with plan of care, and review with the resident the risks and benefits of non-compliance with plan of care; 8) when non-compliance occurs, complete a Deviation of Care Form; and 8) update the resident's care plan to include noncompliance with the treatment plan. The facility tool for weekly monitoring and documentation of pressure ulcers, "Skin Grid for Pressure [and other] Ulcers," defined staging of pressure ulcers as follows: Stage 1: reddened areas of tissue that do not turn white or pale (in light skinned people such as Resident #17) when firmly pressed. Stage 2: partial thickness skin loss presenting as a shallow open ulcer with a pink-red wound bed,	F 314	room care plan, and on the care plan. The mattress is monitored by nursing daily to assure that it is on and functioning within the comfort zone. The wheelchair cushion is monitored weekly as a part of weekly skin rounds by the Skin Team. Weekly skin checks by LN were completed from 9/28/13 to current and will continue. Identification of residents with the potential to be affected: Other residents who have been identified through assessment, diagnosis, or history and physical to be at risk for skin breakdown have the potential to be affected. Measures to prevent recurrence: Licensed nurses were educated to the following: 1. Notification to the physician and family of changes in the skin condition. 2. Implementation of interventions for residents at risk for or with current skin breakdown. 3. Communication of newly admitted or developed skin problems on the 24 hour report. 4. Completion of the Skin Grid. 5. Staging of pressure wounds. 6. Notification to physicians and		

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F 314	<p>Continued From page 45 without slough (dead tissue: yellow, tan, gray, green or brown).</p> <p>Stage 3: full thickness skin loss. Bone, tendon, muscle not exposed. Slough may be present but does not obscure depth of tissue loss. May include tunneling.</p> <p>Stage 4: full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (tan, brown, or black covering) may be present on some parts of the wound bed. Often includes tunneling.</p> <p>Resident #17 was originally admitted to the facility from the hospital with diagnoses to include diabetes and osteoarthritis on [REDACTED] 13 following surgery to repair a fractured hip and was readmitted on [REDACTED] 13 after 3 days in the hospital.</p> <p>The Minimum Data Set (MDS), dated 8/26/13, indicated Resident #17 was alert, oriented and able to make needs known. The resident was non-ambulatory, used a wheelchair for locomotion and required extensive assistance of 2 persons with bed mobility and transfers.</p> <p>The MDS indicated the resident was at risk of developing pressure ulcers but did not currently have any pressure ulcers.</p> <p>The progress note, dated 9/11/13, documented "two open areas" on Resident #17's "left buttock, with some dark red area around open areas."</p> <p>There was no indication of any intervention or action taken in response to the open areas on the resident's "left buttock" until 9/24/13. A progress note, dated 9/24/13, documented a facsimile was</p>	F 314	<p>families of wounds failing to respond to treatment after two weeks.</p> <ol style="list-style-type: none"> 7. Assessing pain related to wounds. 8. Monitoring of air mattresses. 9. Addressing resident refusals. 10. Assessing and maintaining wheelchair cushions. 11. Repositioning residents. <p>Training was conducted by the Regional Nurse Consultant on 12/10 and 12/12/13 and by the Director of Nursing on 12/17/13</p> <p>Resident care managers were educated on the development of a comprehensive care plan for skin at risk that includes interventions to decrease risk factors and promote healing. Training was conducted by the Regional Nurse Consultant on 12/12/13.</p> <p>Restorative referrals from OT and PT were reviewed to ensure that programs are in place.</p>	
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F 314	<p>Continued From page 46</p> <p>sent to Resident #17's physician requesting an "air bed to prevent skin breakdown, awaiting response."</p> <p>The progress note, dated 9/25/13, indicated Resident #17's physician was called on 9/24/13 requesting "treatment on Stage 2 coccyx. ... Awaiting call back from MD, also processed order for air mattress."</p> <p>The next documentation related to the condition of Resident #17's skin in the coccyx/sacral/buttock area was an assessment on [REDACTED] 13, when the resident returned from the hospital. The resident was sent to the hospital for a minor procedure on [REDACTED] and returned on [REDACTED] 13.</p> <p>Resident #17's "Admission and Weekly Skin Observation Tool (AWSOT)," dated [REDACTED] 13, documented a red, blanchable area over the left sacrum, measuring 3 x 3 cm.</p> <p>In contradiction to the AWSOT, Resident #17's "Skin Condition Sheet," dated [REDACTED] 13, indicated a 3 x 3 centimeter (cm) Stage 2 "pressure sore" over the left sacrum.</p> <p>Resident #17's physician's orders, dated [REDACTED] 13 (17 days after the "open areas on the left buttock" were first noted), instructed staff to reposition the resident every 2 hours, cleanse the left sacral wound with normal saline and apply a 6 x 6 inch Dermalavin adhesive foam dressing daily.</p> <p>Documentation for Resident #17's left sacral pressure ulcer on the weekly Skin Grid for Pressure Ulcers (SGPU) reflected the following:</p>	F 314	<p>Retraining was conducted for nursing assistant staff on repositioning of residents, following care directives for positioning, prevention of skin breakdown, and monitoring that air mattresses are on and set correctly. Training was conducted by the staff development nurse on 12/18/13. Residents who are transferred by mechanical lift were assessed for potential pain related to the sling and plans of care updated, as needed. The mechanical lift slings are being used per manufacturer's specifications.</p> <p>Monitor for Corrective Action:</p> <p>Weekly skin rounds are conducted by a team of nurses including the Director of Nursing, RCMs, licensed nurse providing care, and nursing assistant providing care. Residents with actual skin breakdown and other residents at risk are rounded. Rounds include assessment of wound treatment, wound condition, positioning, care plan, in-room care plan, pressure relieving devices, and risk factors. Skin round information will be logged and will be reviewed monthly in the Quality Assurance / Performance Improvement committee to determine the need for further training.</p>	

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F 314	<p>Continued From page 47</p> <p>Spaces for indicating the date the ulcer was first identified and whether or not the ulcer was present on admission were left blank.</p> <p>The earliest documentation on the SGPU was on 10/2/13, indicating the ulcer was identified as Stage 3, measuring 2 x 3 centimeters (cm) and 0.05 cm deep. The resident was not experiencing pain from the ulcer.</p> <p>On 10/16/13: Stage 2, measuring 1.8 x 1.5 cm and 0.05 cm deep. The resident was not experiencing pain from the ulcer.</p> <p>On 10/24/13: Stage 2, measuring 1.5 x 1.5 cm and 0.1 cm deep with 25% slough. The resident was experiencing pain from the ulcer.</p> <p>On 10/31/13: Stage 3, measuring 3.0 x 2.0 cm and 0.1 cm deep. The resident was experiencing pain from the ulcer.</p> <p>On 11/6 and 11/13/13 the ulcer remained at Stage 3 and the resident continued to experience pain from the ulcer.</p> <p>On 11/20/13, after the surveyor began asking about the resident's pain related to the ulcer, the SGPU documented the wound was Stage 3, measuring 1.8 x 1.6 cm and 0.2 cm deep. The space for documenting pain was left blank even though the resident reported pain during the dressing change observed by the surveyor that day.</p> <p>On 11/22/13: Stage 3, measuring 2.0 x 1.5 cm and 0.1 cm deep, 80% pink/red with 20% thin yellow slough. The resident was not experiencing pain from the ulcer. The physician was notified of</p>	F 314	<p>The Director of Nursing will assure compliance.</p>	
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F 314	<p>Continued From page 48 changes.</p> <p>Until the SGPU dated 11/22/13, no documentation was found to reflect that the physician was notified of changes in the ulcer condition: that the ulcer had advanced from Stage 2 to Stage 3.</p> <p>Resident #17's Comprehensive Care Plan, dated 8/30/13, identified the resident at high risk for pressure ulcers. Interventiions included "Use cushion for pressure reduction when resident is in chair."</p> <p>On 9/26/13, the Comprehensive Care Plan identified a "pressure ulcer on coccyx," 15 days after 2 open areas were noted on the resident's "left buttock" on 9/11/13. Interventions for the ulcer included an "air bed for pressure reduction" and "cushion for pressure reduction when resident is in chair." The care plan did not include to reposition the resident every 2 hours.</p> <p>Resident #17's Medication Administration Record for November 2013 documented the resident received oxycodone 5 milligrams (mg) for pain on November 1, 5, 7, 11, 14, and 18. The resident received Tylenol 650 mg for pain on November 3, 6, 10, 16, 21, and 22.</p> <p>The Restorative Nursing Assessment and Referral (RNAR), dated 10/2/13, documented Resident #17 received Occupational Therapy (OT) and Physical Therapy (PT), reached his/her maximum potential and was referred for restorative nursing services for upper and lower extremity range of motion (ROM) exercises to "prevent losses." The referral stated Resident #17 required use of a Hoyer (hydraulic lifting device)</p>	F 314		
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F 314	<p>Continued From page 49</p> <p>with assistance of 2 persons for all transfers and used a wheelchair for locomotion.</p> <p>Additional PT services were initiated for Resident #17 on 10/8/13 for stand and pivot transfers. The PT Discharge Summary, dated 10/30/13, indicated the resident was discharged from PT on 10/29/13 because s/he was unable to progress with transfers, requiring 90-100% maximum assistance. During this period, restorative nursing provided services only for upper extremity ROM.</p> <p>The RNAR, dated 11/6/13, indicated PT had again referred Resident #17 for restorative nursing services for both upper and lower extremity ROM. The RNAR again stated the resident required use of a Hoyer with assistance of 2 persons for all transfers.</p> <p>Progress notes indicated a Hoyer lift was consistently used for transfers with Resident #17.</p> <p>Beginning on 10/30/13, Resident #17's progress notes indicated the resident was refusing to lie down between meals in order to relieve pressure on the sacral ulcer, instead remaining in his/her wheelchair from breakfast until going to bed sometime after dinner.</p> <p>Resident #17's Comprehensive Care Plan did not address transfers, use of a Hoyer lift, or the resident's noncompliance with repositioning every 2 hours.</p> <p>Each day of the survey, 11/17 through 11/23/13, Resident #17 was observed spending the entire period between breakfast and dinner sitting in his/her wheelchair. Each observation revealed the resident was sitting on the nylon sling used with</p>	F 314		

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F 314	<p>Continued From page 50 the Hoyer lift.</p> <p>On 11/20/13 at 3:04 p.m., Staff Y stated Resident #17 usually got out of bed at 7:30 a.m. and preferred to spend the entire day in his/her wheelchair, declining to go back to bed until after dinner. Staff Y said s/he tried to convince the resident to spend time each day repositioned in bed so as to take pressure off the left sacral ulcer but the resident refused, choosing to spend the entire day in the wheelchair. Staff Y said the resident "hates to go in and out of bed because he hates the Hoyer lift."</p> <p>On 11/21/13 at 7:30 a.m., Resident #17 was observed lying in bed, on a motorized air mattress with alternating cycles and pressure settings. The resident was lying on a Hoyer sling, leaning slightly to the left. Staff Y agreed with the surveyor that it appeared that the thick nylon webbing edges of the Hoyer sling, which were crisscrossed under the resident's pelvis, appeared to press against the area where the pressure ulcer was located.</p> <p>The resident yelled out loudly to Staff Y to hurry and get him/her up because the resident's "bottom hurts."</p> <p>Staff Y stated s/he gave the resident Tylenol for the pain a half hour earlier and said Tylenol did not effectively treat the resident's pain.</p> <p>During the dressing change, the ulcer on Resident #17's left sacrum was observed to be red/pink with yellow/white slough, measuring approximately 2 x 1.5 cm. Staff Y said the amount of slough had increased over the past 3 weeks.</p>	F 314		
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F 314	<p>Continued From page 51</p> <p>When asked if s/he would spend time during the day out of the wheelchair, lying in bed to keep pressure off his/her "sore bottom," the resident said, "No, because of that thing they use [the Hoyer]. It drives me nuts; I can't stand it." The resident said it was hard to explain why s/he hated the Hoyer so much and said, "There's something about it I can't stand. It's mostly the hook-up part."</p> <p>The resident said s/he wished PT had not terminated services to work on stand/pivot transfers.</p> <p>Staff Y said, "I think if [the resident] was able to transfer without the Hoyer [s/he] would agree to spend time in bed during the day. But [s/he] won't do it because of the Hoyer."</p> <p>As Resident #17 was transferred from bed to wheelchair with the Hoyer lift, the resident was observed to appear tense, grimacing and silent as staff hooked the sling to the lift, raised the resident off the bed in a horizontal position, and swung the resident away from the bed. Then, after the resident was adjusted in the sling to a sitting/upright position, the resident said, "See, now this part is okay."</p> <p>On 11/22/13 at 9:43 a.m., Staff K, the Charge Nurse, said Resident #17's sacral ulcer was not healing because the resident refused to spend time in bed during the day to take pressure off the ulcer. Staff K said s/he was not aware the resident had an aversion to the Hoyer lift "until yesterday." Staff K said, "Yesterday, Staff Y told me [Resident #17] told you s/he hated the Hoyer lift. If I had known this sooner, I would have asked PT to assess the resident for transfer methods."</p>	F 314		
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F 314	<p>Continued From page 52</p> <p>Staff K said yesterday Resident #17 self-propelled in the wheelchair to the therapy room and asked PT to evaluate the resident for transfers. PT evaluated the resident and wrote a communication to nursing saying Resident #17 could now use a sit to stand lift device instead of the Hoyer.</p> <p>The "Communication to Nursing on Ambulation/Transfer Level," written by PT staff, dated 11/21/13, indicated Resident #17 demonstrated an ability to tolerate a "sit to stand" lift for transfers and requested nursing to modify the plan of care accordingly.</p> <p>At 10:11 a.m., Staff C, the Resident Care Manager (RCM), said Resident #17 had been non-weight bearing and required a Hoyer lift for transfers throughout the resident's entire stay at the facility. Staff C said after 10/25/13, when the resident was informed s/he would not be able to discharge to a more independent setting, the resident became depressed, less compliant with the plan of care and more resistant to spending time in bed during the day to relieve pressure on the sacral ulcer.</p> <p>Staff C said Resident #17 told Staff C the resident did not want to use the Hoyer lift and Staff C did not explore the reason why with the resident. Staff C said s/he assumed it was because the resident wanted to be able to do standing transfers, to be more independent. No one told Staff C it was because the resident hated the Hoyer itself. Staff C said staff should have informed Staff C the resident hated the Hoyer.</p> <p>Staff C said when the resident refused to go to</p>	F 314		
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NAME OF PROVIDER OR SUPPLIER PUYALLUP NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372
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F 314	<p>Continued From page 53</p> <p>bed during the day to relieve pressure from the sacral ulcer. Staff C should have asked the resident the reason for the refusal and explored alternative interventions. Staff C said, "[Resident #17] did tell me [s/he] didn't want the Hoyer. I didn't explore that with [the resident]." Staff C said s/he never observed Resident #17 during a transfer in the Hoyer lift.</p> <p>When asked if Resident #17 had a pressure relieving device on the seat of his/her wheelchair, Staff C said, "No, [s/he] should have one, but I think it's just a regular cushion."</p> <p>At 11:55 a.m., Staff JJ, a physical therapist, said s/he worked with Resident #17 previously and was not able to advance the resident functionally. Staff JJ said once PT has discharged a resident, it was up to nursing to determine when a reassessment is needed and make a referral.</p> <p>Staff JJ said, "[Resident #17] came in yesterday and asked about getting back on therapy. I noticed a Hoyer sling on the wheelchair. I asked [the resident] to stand and [s/he] stood, had the range of motion and strength to stand. I thought adding a standing frame activity to the resident's restorative nursing regimen might help increase or maintain strength. If [Resident #17] improves with that, I would like to pick [him/her] up for more functional rehab. But just standing/sitting is not skilled. Transfers can be worked on through restorative nursing."</p> <p>At 1:50 p.m., Staff HH, a restorative nursing assistant, said Resident #17 received restorative nursing for ROM 6 days per week. Staff HH said the resident actively participated and "always looks forward to it." Staff HH said s/he always</p>	F 314		
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F 314	<p>Continued From page 54</p> <p>worked with Resident #17 in the wheelchair, "never in bed because [s/he] is always in the wheelchair."</p> <p>Licensed staff documented on Resident #17's Treatment Flowsheet for November 2013 that the resident was consistently repositioned every 2 hours each day.</p> <p>At 2:05 p.m., when presented with documentation on the Treatment Flowsheet indicating Resident #17 was being repositioned every 2 hours, Staff Y stated it was not accurate. Staff Y said the resident was only repositioned while in bed and usually spent nearly the entire day in the wheelchair. When asked if s/he had ever instructed Resident #17 to shift position while in the wheelchair, Staff Y said, "No, but I guess I could try that."</p> <p>On 11/23/13 at 3:34 p.m., Staff E and Staff KK, both licensed nurses, were asked what was meant by instructions on Resident 17's Treatment Flowsheet to "monitor air mattress." Both agreed it meant to make sure the air mattress was turned on and functioning properly. Neither was able to identify how to determine if the pressure and cycle settings were correct or if there were any specific instructions for pressure and cycle settings.</p> <p>At 3:43 p.m., the surveyor asked Staff LL, a physical therapist, if the cushion on Resident #17's wheelchair had functional pressure relieving properties. The surveyor observed as Staff LL and the physical therapy aide assisted Resident #17 to a standing position at the parallel bars in order to remove the cushion from the wheelchair. The resident appeared to tolerate this well.</p>	F 314		

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F 314	<p>Continued From page 55</p> <p>bearing weight with assistance at the parallel bars for about 20 seconds.</p> <p>Staff LL removed the outer casing from the cushion to reveal a yellow, foam pad with a thin blue plastic pad lying on top of the foam. The plastic pad was completely flat, about 1/4 to 1/3 inch thick. Staff LL said it was a gel cushion but looked "nearly empty" of gel. Staff LL said, "It's too flat. It needs more gel. You can tell it has disintegrated. [Resident #17] needs a pad with more gel but the facility has a limited supply. This one, the gel is depleted or evaporated or something and has no pressure reducing function. We need one with a good gel cushion. This doesn't have that."</p> <p>At 3:57 p.m., Staff Q, the Restorative Nursing Manager, said today s/he received a rehab recommendation for Resident #17 to work with a sit to stand lift for 30 seconds to one minute in 3 to 5 minute intervals. Staff Q said s/he would conduct an evaluation, write orders and develop a plan for the resident on 11/25/13.</p> <p>At 4:29 p.m., Staff B said when residents were receiving PT services, it was up to PT staff to monitor wheelchair cushions to assure they had functional pressure relieving properties, and when residents were not receiving rehab services, it was up to the Resident Care Managers.</p> <p>The facility failed to provide care and services necessary to prevent the sacral pressure ulcer from developing when Resident #17 was assessed to have high risk for pressure ulcers, yet no weekly skin assessments were conducted and a functional pressure reducing device was not placed in the resident's wheelchair.</p>	F 314			

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F 314	Continued From page 56 The facility failed to provide care and services to promote healing in the sacral pressure ulcer when the first evidence of skin breakdown was not timely reported to the physician, interventions were delayed, monitoring and documentation was inconsistent, the physician was not timely notified of changes in the ulcer and alternative interventions were not explored when the resident was unwilling to transfer using the Hoyer lift. These failures caused physical and psychosocial harm to Resident #17.	F 314			
F 315 SS=D	Refer to F155. 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to reassess for change in urinary incontinence for 2 of 3 Sampled Residents (#49 &124) reviewed for urinary incontinence. This had the potential to	F 315	F315 Corrective Action for resident identified to be affected: Resident #49 has been assessed for factors related to change in urinary continence and plan of care and in-room care plan updated. Resident #124 has been assessed for factors related to change in urinary continence and plan of care and in-room care plan updated. Identification of residents with the potential to be affected: Residents who experience a decline in urinary incontinence have the potential to be affected.	12/31/13	

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F 315	<p>Continued From page 57</p> <p>place these residents at risk to not receive services to assist them to restore as much normal bladder function as possible.</p> <p>Findings include:</p> <p>RESIDENT #49</p> <p>On 11/20/13 at 2:05 p.m. Resident #49 sat in a wheelchair in his/her room and reported he/she could tell staff when needing to void during the day or evening. The resident also reported during the night, he did not always wake up to urinate and wore a brief.</p> <p>A Resident Admission Record identified Resident #49 admitted to the facility on [REDACTED] 13 and readmitted on [REDACTED] 13 following hospitalization [REDACTED] 13 through [REDACTED] 13. Diagnoses identified [REDACTED] 13 included altered mental status, diabetes, a heart condition, chronic kidney disease and [REDACTED]</p> <p>A Care Area Assessment for Urinary Incontinence dated 7/8/13 identified the resident had functional incontinence and required extensive assistance with toileting due to physical factors. Analysis of findings documented the resident reported one episode of incontinence occurred during the review period because "he was unable to reach his urinal." The analysis documented the resident had no cognitive or sensory deficits that would increase risk for further incontinence and would use the call light to ask for assistance when needed.</p> <p>Review of additional Minimum Data Set (MDS, required assessment tool) assessments dated 7/15/13, 7/29/13 and 8/1/13 identified Resident</p>	F 315	<p>Measures to prevent recurrence:</p> <p>Residents are assessed for urinary incontinence on admission and quarterly through the RAI process and the quarterly nursing assessment. Re-training on assessing changes in residents and updating the plan of care was provided to nursing staff. Training was provided by the Director of Nursing on 12/17/13. Nursing assistants have been re-trained on using Stop and Watch forms for reporting changes in incontinence to licensed staff. Training was conducted on 12/18/13 by the Staff Development nurse.</p> <p>The MDS coordinator will maintain a log of residents who are assessed with changes in urinary continence through the RAI process. RCMs will assess residents who have declines in incontinence, and update care plans and in-room care plans.</p>	
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F 315	<p>Continued From page 58</p> <p>#49 had no episodes of incontinence during the review period. An MDS assessment on 9/2/13 identified the resident had occasional incontinence and a quarterly MDS assessment dated 9/25/13 identified the resident frequently incontinent.</p> <p>Resident #49's medical record did not contain evidence staff comprehensively reassessed the resident's urinary status to determine if a change in plan of care or toileting retraining program would help to improve bladder control.</p> <p>On 11/20/13 at 9:48 a.m. Staff N reported Resident #49 was continent during the day and used a urinal. Staff N also reported the resident had a wet brief in the morning and did not notice the resident had a change in incontinence.</p> <p>On 11/20/13 at 12:19 p.m. Staff C did not know Resident #49 had a change in urinary status and reported nurses aides and the MDS nurse usually inform me if there is a change. Staff C also reported if she/he had been told he/she would have interviewed the resident to discover the root cause. Staff C reported the resident recently had medical concerns that required hospitalization and did not know if the resident currently received a toileting program.</p> <p>On 11/21/13 at 12:21 p.m. Staff C reviewed the record with the surveyor and reported staff conducted reassessments on a quarterly basis. Staff C reported the assessment had not been completed in the computer which had a section to address changes in incontinence.</p> <p>Without reassessing why Resident #49 experienced increased episodes of incontinence,</p>	F 315	<p>Monitor for Corrective Action:</p> <p>A monthly audit of records of residents identified in the incontinence log will be completed by the Director of Nursing or designee with audit results brought to the Quality Assurance / Performance Improvement Committee to identify the need for additional training and / or intervention. Records will be audited for accuracy of the MDS, completion of assessment, and updating of care plans and in-room care plans.</p> <p>The Director of Nursing will assure compliance.</p>	
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F 315	<p>Continued From page 59</p> <p>staff did not have adequate information to determine if the resident required additional intervention to attempt to improve incontinence status.</p> <p>Resident # 124</p> <p>Resident # 124 was admitted to the facility on [REDACTED] 13 with the diagnosis of after care of hip fracture, heart failure, [REDACTED] and [REDACTED]. Resident # 124's admission Minimum Data Set (MDS, an assessment tool), dated 7/18/13 identified the resident as continent of bladder and bowel.</p> <p>Resident # 124's functional status from the admission MDS identified the resident needing extensive assistance for bed mobility and transfers with one person physical assist. Limited assistance is needed for walking in room, walking in corridor, locomotion on unit, toilet use and dressing with one person physical assist.</p> <p>The Care Area Assessment (CAA) dated 7/18/13 identified a need for care planning for urinary incontinence due to Resident # 124 needing extensive assist with toileting and functional losses related to decreased activity intolerance.</p> <p>The MDS on 7/25/13, 9/10/13, 9/25/13, 10/2/13, and 10/16/13 all identified Resident # 124's functional status for toilet use requiring limited to extensive assistance.</p> <p>On the 14 day MDS dated 7/25/13 documented that Resident # 124 was occasionally incontinent</p>	F 315		
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F 315	<p>Continued From page 60 with bladder and always continent of bowel</p> <p>A discharge MDS with anticipated return dated 9/10/13 identified Resident # 124 as being always continent for bladder and bowel.</p> <p>The readmission/ return MDS dated 9/25/13 documented Resident # 124 as occasionally incontinent of bladder and bowel.</p> <p>The 14 day MDS dated 10/2/13 identified Resident # 124 as frequently incontinent of bladder and bowel.</p> <p>The 30 day MDS dated 10/16/13 identified Resident # 124 as frequently incontinent of bladder and occasionally incontinent of bowel.</p> <p>On 11/20/13 Resident # 124 reported having trouble controlling bladder after fracturing hip when laughing or sneezing. Resident # 124 reported that he/she wore an incontinence brief, but was able to transfer with one person assist to use the toilet.</p> <p>On 11/20/13 at 12:09 p.m. Staff S reported that Resident # 124 was often incontinent, and that the resident would call to let staff know he/she had to use the toilet. Staff S reported that Resident # 124 wore an incontinence brief, but knew when he/she had to void.</p> <p>Resident # 124's care plan for impaired urinary elimination related to need for extensive assistance with toileting secondary to weakness was dated 7/24/13. The care plan had not been updated since 7/24/13 when it was initiated. The goal listed was resident will not exhibit signs or symptoms of urinary tract infection (UTI).</p>	F 315		
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F 315	<p>Continued From page 61</p> <p>Interventions listed included encouraging of fluid intake, encourage the resident to attempt voiding every 2 hours, diagnostic test as ordered, to provide 1-2 person assistance for toileting, and to report any signs or symptoms of UTI. The interventions listed do not address the resident's changes with incontinence.</p> <p>On 11/20/13 at 12:51 p.m. Staff D reported that the staff is responsible for keeping the resident from declining with continence from functional ability. Staff D reported needing to find out what was causing the decline with continence; it may have been due to the impacted that the fracture had on transfers or possibly diuretics. Staff D reported that the resident's care directive should reflect what the needs of the resident are at that moment to ensure the resident's needs are being met.</p> <p>On 11/20/13 at 1:55 p.m. Staff W reported that Resident # 124 knows when he/she had to go to the bathroom. Staff W reported that when Resident # 124 is incontinent he/she fills a brief or saturates the bed. Staff W reported that Resident # 124 will be wet and/ or soiled and then say "it was too late" meaning not able to wait for assistance.</p> <p>On 11/20/13 at 2:51 p.m. Staff C denied that the facility had an assessment for bladder and bowel function.</p> <p>On 11/20/13 at 3:36 p.m. Staff X reported that the facility used to have a bowel and bladder assessment, but since the facility went to the computer system there is no longer a formal assessment. Staff X confirmed that there was no bladder and bowel assessment documented in</p>	F 315		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	Continued From page 62 the computer for Resident # 124. On 11/21/13 at 10:14 a.m. Staff K reported not being aware of a change in incontinence for Resident # 124. On 11/21/13 at 10:21 a.m. Staff C confirmed that after review of records, that there was no bladder and bowel assessment completed for Resident # 124's change from continence to incontinence. On 11/22/13 at 8:36 a.m. Staff B confirmed that there was nothing in place to identify a change in continence. Staff B confirmed that an assessment of bladder and bowel was not completed to determine the cause of Resident # 124's incontinence. Upon return from discharge the facility failed to reassess factors that contributed a change in continence for bladder. The incontinence of bladder progressed from occasionally to frequently. The facility failed to reassess the cause/s of incontinence to determine if additional care/services needed to be provided to improve incontinence. This failure placed Resident # 124 at risk for UTIs, the potential for diminished restoration of bladder function and the potential for a decline in psychosocial well-being.	F 315			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional	F 325			

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F 325	<p>Continued From page 63</p> <p>status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review it was determined that the facility failed to timely follow up with therapeutic dietary recommendations for 1 of 4 Sampled Residents (#218) reviewed for nutritional needs. This had the potential for this resident to experience decline in nutritional status and/or medical condition.</p> <p>Findings include:</p> <p>On 11/20/13 at 12:37 p.m. Resident #218 sat in the dining room in front of a plate of food and did not finish the meal. The resident reported the food tasted good but he/she did not feel well and did not want to eat.</p> <p>Resident #218 admitted to the facility on [REDACTED] 13 following hospitalization. An infectious disease report dated 11/6/13 identified the resident had a history of kidney disease requiring specialized treatment three times a week to remove waste products from the blood that includes excessive phosphorous and sodium levels.</p> <p>A physician order dated [REDACTED] 13 identified at the time of admission the physician directed staff to</p>	F 325	<p>F325</p> <p>Corrective Action for resident identified to be affected:</p> <p>Resident #218 has re-admitted to the facility following a hospital stay [REDACTED] 13 through [REDACTED] 13 and is receiving a renal / no added salt diet with large protein servings, snacks at dialysis, and phosphate binders with meals and snacks, per physician's orders.</p> <p>Identification of residents with the potential to be affected: Other residents who have dietary or order changes recommended by the registered dietician have the potential to be affected.</p> <p>Measures to prevent recurrence:</p> <p>RCMs will assure that dietary recommendations are forwarded to the physician within 24 hours of receiving the recommendation, then will monitor for physician response and assure that orders are transcribed and communicated to the dietary department and that the Resident and family are notified of the change.</p>	12/31/13

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F 325	<p>Continued From page 64</p> <p>provide a regular diet for the resident and to administer a phosphate binding medication with each meal.</p> <p>On 11/11/13 a nutritional consultant identified Resident #218 needed additional protein and calories to meet dietary needs and made the following recommendations:</p> <ol style="list-style-type: none"> 1. Change the regular diet to a No Added Salt (NAS) diet, no tomato based sauces, bananas, orange juice or spinach. 2. Double sized portion of eggs at breakfast and double portion of meat at dinner 3. Provide Renvela (phosphate binding medication) with snacks as well as with meals 4. Send food preferences to the kitchen. <p>A telephone physician order obtained by nursing staff identified the physician added restrictions to Resident #218's diet and ordered a Renal/NAS diet with increased protein on 11/20/13, nine days after dietary recommendations were initially written.</p> <p>A "Diet Order & Communication" form identified dietary recommendations for a NAS diet and extra proteins with meals were not communicated to the kitchen until nine days later on 11/20/13. The communication slip did not identify meals should not include tomato based sauces, bananas, orange juice or spinach.</p> <p>On 11/22/13 at 12:16 p.m. Staff K reported when the resident admitted on a regular diet he/she would have questioned the diet (due to the resident's kidney illness). Staff K also reported when nutritional recommendations were made they were placed in a box on Mondays at the</p>	F 325	<p>Monitor for Corrective Action:</p> <p>Copies of Diet Order and Communication sheets are given to the Director of Nurses. The RCMs also receive a copy, and will date each recommendation with the date that it is forwarded to the physician and the date of response and initiation of the order. The Order and Communication Sheets will be compared to assure that recommendations have been followed in a reasonable period of time, and none missed. Any negative findings will be brought to the Quality Assurance / Performance Improvement Committee to identify the need for further training and/or intervention.</p> <p>The Director of Nursing will assure compliance.</p>	
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F 325	<p>Continued From page 65</p> <p>nursing station and staff usually followed up on Wednesdays. Staff K reported recommendations were faxed to physicians, reviewed Resident #218's medical record and did not locate evidence staff faxed dietary recommendations to the physician when they were initially made on 11/11/13. Staff K did not know why it took so long for nursing to follow up and implement dietary recommendations.</p> <p>On 11/22/13 at 12:26 p.m. Staff C confirmed dietary recommendations were made over a week ago and staff did not follow up until 11/20/13. Staff C also reported he/she did not yet follow up with the physician regarding the dietary recommendation for Renvela given with snacks. Staff C also did not know why it took so long for staff to respond to dietary recommendations.</p> <p>Failure to timely follow up with therapeutic dietary recommendations for Resident #218 had the potential to place the resident at risk for unnecessary elevations of certain waste products in the blood and decrease physical health and quality of life.</p>	F 325		
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F 329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any</p>	F 329		
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F 329	<p>Continued From page 66</p> <p>combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record, and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review it was determined that the facility failed to provide adequate monitoring for the effectiveness of medication and for side effects for 1 of 5 sampled residents (# 44) reviewed for unnecessary drugs in the Stage 2 sample. This failure placed the resident at risk for receiving substandard quality of care and decreased quality of life.</p> <p>Finding Include:</p> <p>Resident # 44 was admitted to the facility on [REDACTED] 13 with the diagnosis of [REDACTED]</p> <p>Review of "Medication Flow sheet" for November 2013 for Resident # 44 to be given [REDACTED] 0.5 milligrams (mg) twice a</p>	F 329	<p>F329</p> <p>Corrective action for resident identified to be affected:</p> <p>Resident #44 had a [REDACTED] consult completed on 11/20/13. At that time, she reported that [REDACTED] and [REDACTED] work well for her and requested that they not be discontinued. She agreed to dosage reductions. Dosages of [REDACTED] and [REDACTED] have been reduced. The [REDACTED] is being tapered to d/e. The [REDACTED] has been decreased. She continues to sleep much of the time and refuse to be out of the room, but does agree to get up for some meals. There has been no change in her sleep patterns. A [REDACTED] follow-up has been scheduled to review her response to the medication changes and her [REDACTED] medications / effects / side effects/ and behaviors are reviewed monthly by the Psychotropic Committee.</p> <p>Identification of residents with the potential to be affected:</p> <p>Residents who receive psychotropic medications have the potential to be affected.</p>	12/31/13	

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F 329	<p>Continued From page 67</p> <p>day by mouth, [REDACTED] 40 mg by mouth once a day [REDACTED] delayed release 500 mg by mouth at bedtime, and [REDACTED] 10 mg at bed time by mouth.</p> <p>On 11/18/13 at 12:55 p.m. Resident # 44 was resting supine with eyes closed, but awoke with knocking on door. Resident #44 appeared drowsy and would close eyes between answering questions during the resident interview.</p> <p>On 11/19/13 at 2:16 p.m. Resident # 44 was resting in bed with eyes closed. Upon knocking on the resident 's door he/she awoke. Resident # 44 reported being very sleepy, and not wanting to get out of bed due to feeling tired.</p> <p>On 11/20/13 at 9:06 a.m., 10:07 a.m., 10:45 a.m., 11:10 a.m., 11:44 a.m., 12:19 p.m., 1:48 p.m., and 2:43 p.m. Resident # 44 was observed resting supine with eyes closed.</p> <p>On 11/21/13 at 9:56 a.m. and 11:14 a.m. Resident #44 was observed resting supine with eyes closed.</p> <p>Review of the "Medication Flow Sheef" did not show any evidence of the resident's hours of sleep being monitored. The side effects for [REDACTED] and [REDACTED] for November 1-November 20th were documented as negative (meaning no side effects).</p> <p>On 11/20/13 at 11:47 a.m. Staff S reported that Resident # 44 was always sleepy, and that the resident rarely got out of bed.</p> <p>On 11/20/13 at 1:05 p.m. Staff D reported that</p>	F 329	<p>Measures to prevent recurrence:</p> <p>Other residents on psychotropic medications were audited to assure that psychotropic medication assessments are up-to-date and that care plans for monitoring the effectiveness and side-effects of psychotropic medications are in place. Psychotropic medications are reviewed in the monthly Psychotropic Committee meeting to assure that monitoring for adverse side effects, dosage reductions, and medication effectiveness occurs. The physician is updated after each psychotropic review and plans of care updated, as needed.</p> <p>Monitor for corrective action:</p> <p>The Social Services department will maintain a log of residents on psychotropic medications to assure that timely monitoring of side-effects, effectiveness, behaviors, and dosage reductions is occurring. Findings will be brought monthly to the Quality Assurance / Performance Improvement Committee by the Social Services Director x 3 months to identify the need for further training.</p> <p>The Director of Nursing will assure compliance.</p>	

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F 329	<p>Continued From page 68</p> <p>side effects such as sedation, mood, and change in level of activity are monitored for [REDACTED] medications. Staff D reported that when a resident is on a medication for insomnia, the resident's hours of sleep should be monitored. Staff D confirmed that there was no monitoring for the hours of sleep for Resident # 44. Staff D confirmed that the side effects are marked as negative on the "Medication Flow Sheet", but that Resident # 44 appears drowsy.</p> <p>On 11/21/13 at 11:30 a.m. Staff J reported that Resident # 44 was usually sleepy, and that he/she did not like to get up. Staff J reported thinking that Resident # 44's sleeping was just how the resident was. Staff J confirmed that Resident # 44's level of sedation and drowsiness could be a side effect of the medications. Staff J confirmed documenting negative to the resident having any side effects, when actually the resident appeared sleepy and drowsy. The listed side effects were sedation, drowsiness, dry mouth, tachycardia, agitation, urinary retention, skin rash, head ache, and muscle tremors.</p> <p>On 11/21/13 at 12:51 p.m. Staff U reported that a monthly meeting consisting of the social worker, resident care manager, physical therapies, the resident and or family, and the pharmacist met to review the resident's mood severity score, any behaviors, side effects to see if the resident has been sleepy, when the last decrease in medications had been done, and monitoring of bowel movements.</p> <p>Staff U reported that on 11/18/13 a monthly review for Resident # 44 was conducted and it was identified that the resident had some sleep issues, but preferred to stay in bed. The plan</p>	F 329		
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F 329	Continued From page 69 was to have a mental health evaluation done for Resident # 44 and possibly decrease the [REDACTED] and continue the [REDACTED] Resident # 44 was taking four medication that could cause sedation and drowsiness, three of which were given at the same time at night. The facility failed to adequately monitor for side effects of sedation and drowsiness as well as monitor the number of hours the resident was sleeping. Failure to adequately monitor placed the resident at risk for taking unnecessary medications for insomnia, anxiety, or mood as well as at risk for decreased quality of life.	F 329	F332 Corrective Action for residents identified to be affected: Resident #222 is receiving short acting insulin before meals, as ordered by her physician.	12/31/13	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation interview and record review it was determined the facility failed to maintain a medication error rate of less than 5%. Licensed staff failed to follow all physician orders for 2 of 7 Sampled Residents (#s 120 & 222) during observations of 3/25 medication administrations resulting in an error rate of 12%. These failures had the potential to diminish therapeutic effectiveness of medication for Resident #120 or to diminish effective control of blood sugar levels for Resident #222.	F 332	Resident #120's orders for the two diuretics were clarified to allow the two to be administered together in the morning. She is instructed in using her inhaler with each dose and the two puffs are being given one minute apart. She is receiving her medications, as ordered by her physician. Identification of residents with the potential to be affected: Residents who receive medications ordered for specific times of administration have the potential to be affected. Residents who receive medications via hand held inhaler have the potential to be affected.		

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F 332	<p>Continued From page 70</p> <p>Findings include:</p> <p>RESIDENT #222 Resident #222 recently admitted from the hospital on [REDACTED] 13. A hospital report dated 10/27/13 identified the resident had a cardiac condition and diabetes.</p> <p>Upon admission the physician directed staff to administer long acting insulin at bedtime daily. The physician also directed staff to check the resident's blood sugar level before meals and at bedtime and administer additional short acting insulin based on the level of elevation of the resident's blood sugar. Short acting insulin given just prior to the meal assisted to lower an elevated blood sugar level at the time of the meal to assist with glucose control.</p> <p>Resident #222's Diabetic Flowsheet indicated for staff to administer 2 units of short acting insulin at 7:30 a.m. before meals for a blood sugar level between 151 to 200.</p> <p>On 11/21/13 at 8:54 a.m. Staff J entered Resident #222's room and administered 2 units of insulin to Resident #222 at 8:54 a.m. Staff J reported the resident ate breakfast earlier approximately at 8:30 a.m. When asked why the resident did not receive insulin before the meal, Staff J reported a dressing change needed to be done on another resident before they went to therapy and did not know of another staff that could help with the dressing change. Staff J reported he/she usually gave short acting insulin at 8:00 a.m.</p> <p>failure to administer short acting insulin prior to consumption of the meal had the potential to raise the blood sugar level higher for Resident #222</p>	F 332	<p>Measures to prevent recurrence:</p> <p>Physician orders have been reviewed by the Consultant Pharmacist and licensed nursing staff to assure that medication administration times are coded correctly on the Medication Administration Record. Licensed Nurses have been re-trained to administer medications per the time codes on the MAR. Licensed nurses have been re-trained on administration technique for hand-held inhalers. Licensed nurses have been retrained on resources available for assistance when conflicting needs result in a potential delay in administering a timed medication.</p> <p>Monitor for corrective action:</p> <p>Routine medication pass audits will be conducted with Licensed Nursing staff monthly. Audits will be conducted by the pharmacy nurse consultant with results to the Director of Nursing for correction of errors. Results and trends will be reviewed in the Quality Assurance / Performance Improvement Committee to identify need for further training / intervention.</p> <p>The Director of Nursing will assure compliance.</p>	
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F 332	<p>Continued From page 71 and diminish control of diabetes.</p> <p>RESIDENT #120</p> <p>1. Resident # 120 admitted to the facility in 2012. A hospital History & Physical dated 8/16/12 identified the resident had diagnoses that included worsening of congestive heart failure, hypertension, and additional heart disease requiring a pacemaker and chronic obstructive pulmonary disease.</p> <p>On 11/10/12 the physician directed staff to administer a diuretic, Lasix, to reduce fluid retention. On 11/12/12, two days later, the physician ordered a second and different diuretic, Metolazone, administered 30 minutes before Lasix. The second diuretic added potentiates the diuretic effects of Lasix to simplify the treatment of fluid retention to attempt to reduce high doses of medication.</p> <p>Resident #120's medication Flowsheet contained orders for both medications. The time to administer them was designated as "AM" and did not identify specific times to give them. Instructions to administer Metolazone were written below the order on the flowsheet and directed staff to give 30 minutes prior to Lasix.</p> <p>During observation of medpass on 11/21/13 beginning at 8:02 a.m., Staff H administered Lasix and Metolazone at the same time.</p> <p>On 11/21/13 at 8:42 a.m. Staff E reported the pharmacy stated Metolazone would enhance the effect of Lasix. Staff E also reported Staff H filled in for another staff that was off since 11/4/13. Staff H reported AM and PM were standard times</p>	F 332		
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F 332	Continued From page 72 designated for medication administration, specific times were not written but "probably should" have for a medication required to be given a half an hour before others. On 11/21/13 at 11:35 a.m. Staff H reported after he/she administered Metolazone it needed to be given a half an hour before Lasix and stated it would be easier if the medication record indicated a specific time for that medication. 2. A physician order dated 8/23/12 directed staff to administer two inhalations of an inhaler twice a day to treat chronic airway obstruction. "Special Instructions" included with the order stated to "Separate each puff by at least one minute." During the same observation of medpass on 11/21/13 beginning at 8:02 a.m., Staff H shook an inhaler and handed it to Resident #120. The resident took the inhaler from Staff H and inhaled two puffs one immediately after the other, without waiting a minute in between each puff. On 11/21/13 at 8:42 a.m. staff h reported nursing should instruct and remind residents to wait between inhaled puffs of an inhaler. On 11/21/13 at 11:25 a.m. Resident #120 reported she thought she used the inhaler fine today.	F 332			
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with	F 412			

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F 412	<p>Continued From page 73</p> <p>§483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review it was determined the facility failed to ensure follow up with all dental recommendations occurred for 2 of 3 Sampled Residents (#s 12 & 93) reviewed with dental needs. This had the potential to place these residents at risk for development of oral and/or systemic infection.</p> <p>Findings include:</p> <p>RESIDENT #93 On 11/18/13 at 11:49 a.m. a family member reported Resident #93's teeth did not get cleaned routinely. The family member reported the resident had plaque on the teeth and had discussed the concern with the facility.</p> <p>A quarterly nursing assessment dated 10/16/13 identified the resident had diagnoses that included dementia and required extensive assistance from staff to brush teeth. On 11/21/13 at 1:11 p.m. Staff B reported when nursing conducted oral assessments initially and quarterly, the assessment included visual examination of resident's teeth.</p>	F 412	<p>F412</p> <p>Corrective action for residents identified to be affected:</p> <p>Resident #93 is scheduled to be seen by the dental hygienist on 1/3/14.</p> <p>Resident #12 is scheduled to be seen by the dental hygienist on 1/3/14.</p> <p>Identification of residents with the potential to be affected:</p> <p>Residents who require the services of a dental hygienist have the potential to be affected.</p> <p>Measures to prevent recurrence:</p> <p>Residents who require dental hygienist services will be seen by a dental hygienist. The Central Supply Coordinator will maintain a list of residents seen on each hygienist visit. Dental Care plans have been updated with hygienist information.</p>	12/31/13
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F 412	<p>Continued From page 74</p> <p>Dental consultant reports dated 8/29/12 and 9/8/13 documented Resident #93 had bleeding gums and heavy wall to wall plaque. The dentist recommended a hygienist clean the resident's teeth. The record did not contain evidence a hygienist cleaned the resident's teeth following both recommendations.</p> <p>On 11/21/13 at 3:22 p.m. Staff E confirmed the resident needed to see a hygienist and had been informed by Staff F the dental office handled hygienist appointments. Staff E reported the hygienist came to the facility about every six months.</p> <p>On 11/21/13 at 3:35 p.m. Staff F reported the dentist came to the facility every other month and saw residents annually close to the month of their birthday. Staff F reported the dental office kept track of residents referred for hygiene cleaning and did not keep a list of residents who needed them. Staff F did not know when the dental hygienist saw residents at the facility during the past year.</p> <p>On 11/21/13 at 3:45 p.m. Staff E telephoned Dental Staff O who reported Medicaid would pay for an annual dental hygiene cleaning for Resident #93. Staff O also reported Resident #93 was not on the list to see the hygienist when the hygienist saw residents in March 2013 and did not know why. Staff O reported the hygienist usually came to the facility every six to eight months. Staff O also reported the resident saw the dentist again in September 2013 and was placed on a list for hygiene cleaning in January 2014.</p> <p>On 11/21/13 at approximately 4:00 p.m., Staff E</p>	F 412	<p>Monitor for corrective action:</p> <p>The list of residents seen for each dental hygienist visit will be cross-referenced with the resident roster to assure that residents are seen at the recommended frequency. The Central Supply Coordinator will maintain a record and schedule additional hygienist visits to the facility, if needed, and notify the Quality Assurance Committee of the status of hygiene visits monthly.</p> <p>The Director of Nursing will assure compliance.</p>		

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F 412	<p>Continued From page 75</p> <p>reported nursing staff did not keep track of residents who needed dental follow-up.</p> <p>On 11/22/13 at 9:03 a.m. Staff G set up dental supplies and handed a toothbrush to Resident #93. After the resident brushed teeth, visible white matter was visible on the lower teeth above the gum line.</p> <p>Failure to maintain an internal facility tracking system to ensure dental recommendations were timely followed, resulted in Resident #93 to not timely receive hygiene cleaning in March 2013 and would further delay cleaning for another ten months until the hygienist was scheduled to return in January 2014.</p> <p>Refer to F 280 for failure to update Resident #93's dental plan of care.</p> <p>Based on observation, interview and record review it was determined that the facility failed to do timely follow up with dental recommendations for hygiene dental cleaning for 2 of 3 sampled residents (# 93, 12) reviewed.</p> <p>Based on interview, observation and record review the facility failed to implement dental hygienist recommendations for 1 of 2 sampled residents (#12) reviewed for dental care.</p> <p>MDS Annual Assessment dated 2/9/13 lists dx aphasia, LE cerbvas disease, hemiplig afctg, unspec side LE derbvas CAA trigger for dental insue: Obviiious or likely</p>	F 412		
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F 412	<p>Continued From page 76</p> <p>cavity or broken teeth = Problems-cannot remember steps to complete oral hygiene, cognitive deficit. Requires extensive assist r/t cog anf func deficits. Funct+loss of voluntary arm omvmt, mpaire hand dexterity, funct limit i UE and ROM, resists assist w adl's. Denies dry mouth.Review: triggered due to having broken/missing teeth and cavities. He routinely sees the house dentist. Was last seen 11/21/12. He is noted by dentis to decline any further extractions or dentures at this time. Has denied having any mouth pain, chewing or swallowing difficulty. Tolerating reg tex diet well. Assisted w oral hyg and monitore for non vebal sign/symp of dental pain. At risk for infetion r/t this care area.</p> <p>11/20/2013 10:13:55 AM Sandra reported can communicate but slow to get out, gets frustrated. Ex mother in law now the contact for resident not POA. - no POA listed. thinks has children, not visit.</p> <p>Total assist for ADL, sits at feeder table to encourage to eat. can propel self in w/c w good let. likes to sit by fireplace. If is warmth or payroll person previous bond with her. Always pale, labs done. Hx low H & H, get folic acid, thought on iron at one time. RD note dated 5/7/13 iron dc'd r/t iron panel.</p> <p>Dental note dated 11/21/12 reports not want extraction or dentures. Stated seen yearly, sooner if problems. Dentist visits recorded. Hygenist role and frequency of visits not known will ask. Updated that hygienist visits every 6 months to see residents listed by dentist. Teeth not appear to interfere with eating.</p> <p>11/21/2013 4:05:36 PM Care Plan Problem</p>	F 412		
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F 412	Continued From page 77 alteration in nutri/hydra lists - missing and broken teeth, follow dental recommendations. 4/12/13 Smile Seattle Dentured -Nursing home cleaning form by hygienist. Findings include missing teeth approx 14 missing teeth and 7 broken/decayed and slight plaque, claculus, decay inflamed gums, stains of dk decay and bleeding. Notes resident needs daily assist to brush along gumline and use flouriide rinse. Needs checked for resident includes 0.2% Sodium bloride dialy swish. Information regarding daily swish no t located in chart or computer documents, 11/23/132:30 at Sandra, RCM said would look in overflow chart to confirm was initiated. Stated has not reports for aides that resident refuses adl care or oral hygiene. 11/22/13 at 4:18 sandra, RCM said unable to find any documentation regarding recommendaton for oral swish in residents chart. Stated if not documented was not done. Not on April or May TAR so we know if not documented not done. Try to call hygienist for information. QP216 1) Based on general observations, did you see any of the following? (Mark all that apply) = 4 (E: Teeth broken/loose, or inflamed/bleeding gums, or problems with dentures) Surveyor: 32390 RelevantFindings: ()	F 412			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431			

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F 431	<p>Continued From page 78</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review it was determined that the facility has</p>	F 431	<p>F431</p> <p>Corrective action for resident identified to be affected:</p> <p>There are no identified residents.</p> <p>Identification of residents with the potential to be affected:</p> <p>Residents who receive medications with storage temperature parameters have the potential to be affected.</p> <p>Measures to prevent recurrence:</p> <p>Heating vents to the medication rooms have been closed. Locked storage in Central Supply is used to store overflow (extra stock) of medications. The pharmacy has updated the medication storage policy and is supplying thermometers for the medication rooms. The medication room temperature will be monitored daily by nursing staff and logged. A referral to Maintenance is made if temperature exceeds 77 degrees. Nursing staff were trained to this plan on 12/17/13 by the Director of Nursing.</p>	12/31/13	

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F 431	<p>Continued From page 79</p> <p>failed to store medications under proper temperature controls in accordance with the manufacturer's specifications in 1 of 2 medication rooms. This failure places resident at risk for receiving medications that are stored at improper temperatures which can result in possible decrease therapeutic effects.</p> <p>Findings include:</p> <p>On 11/17/13 at 11:16 a.m. Staff Q confirmed that the east medication room was warm and reported that maintenance was responsible for the temperatures of the room. Staff Q confirmed that there was no thermometer in the room.</p> <p>On 11/17/13 at 11:23 a.m. Staff O reported that the medication room temperatures are not monitored. Staff O reported not being aware that the medication room had to be a certain temperatures.</p> <p>On 11/17/13 at 11:26 a.m. Staff O used an infrared thermometer and identified that the room temperature in the east medication room was 88 degrees Fahrenheit. Staff O confirmed that the Claritin (to be stored at 36-86 degrees Fahrenheit), Tylenol, and Fexofenadine hydrochloride and Ranitidine 75 (to be stored at 68-77 degrees Fahrenheit), were to be stored below the temperature of the room.</p> <p>On 11/23/13 at approximately 4:30 p.m. Staff B reported that pharmacy policy said that medications could be stored at 86 degrees Fahrenheit, but some labels on the medication bottles stated 77 degrees. Staff B confirmed that there were conflicting medication storage temperatures. Staff B reported that the</p>	F 431	<p>Monitor for Corrective Action:</p> <p>Temperature logs are reviewed and maintained by the Maintenance Coordinator. The Maintenance Coordinator will report findings to the Quality Assurance / Performance Improvement Committee monthly for 3 months to determine need for further intervention.</p> <p>The Director of Nursing will assure compliance.</p>		

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F 431	Continued From page 80 medications in the east medication storage room had been discarded. Staff A reported that the medication room on the east was a tiny room and the heat from the refrigerator and the heater ducts causes the temperature to rise in the room when the door is closed. Staff A reported that the facility created a locked cabinet in the central supply room now to store the medications	F 431			