

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

PRINTED: 03/11/2013
FORM APPROVED
OMB NO. 0938-0391

1448

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505525	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2013
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - LACEY	STREET ADDRESS, CITY, STATE, ZIP CODE 4524 INTELCO LOOP SE LACEY, WA 98503
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Manorcare - Lacey on 2/11/13, 2/12/13, 2/13/13, 2/14/13, 2/15/13, 2/16/13, 2/19/13, 2/20/13, 2/21/13, 2/22/13, 2/25/13 and 2/26/13. A sample of 40 residents was selected from a census of 55. The sample included 36 current residents and the records of 4 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████ RD CD ██████████ RN BSN ██████████ RN BSN ██████████ RN MSN</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, District 3, Unit C P.O. Box 45819 Tumwater, WA 98504-5819</p> <p>Telephone: (360) 664-8428 Fax: (360) 664-8451</p> <p><i>Jan Peice</i> 3-11-13 Residential Care Services Date</p>	F 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">MAR 28 2013</p> <p style="text-align: center;">DSHS/ADSA/RCS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sharon Holmer</i>	TITLE Administrator	(X6) DATE 3-28-13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 155 SS=G	<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>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to assess the reason for resident refusal or offer alternative treatments in 1 of 1 resident (#41) investigated for refusal of care. This failure did not allow him to maintain or attain the highest practicable physical, mental and psychosocial well-being in the context of making the refusals and caused harm through skin breakdown and unnecessary pain.</p> <p>Findings include:</p> <p>Resident #41 was admitted on [REDACTED] 12 for [REDACTED]. On the MDS (Minimum Data Set) dated 09/19/12, he was judged to be cognitively intact, scoring 14 out of a possible high score of 15 for mental status. The MDS also indicated that he had no issues with mood and communicated well with clear speaking ability. Per Social Services assessment, he was his own decision maker, though he deferred to a family member for some decisions.</p> <p>The initial social services assessment on 09/17/12 by Staff G, Social Services Director noted Resident #41 had a history of refusal of</p>	F 155	<p>155</p> <p>Manor Care of Lacey strives to provide care and services that support the resident's right to refuse treatment, refuse to participate in experimental research, and to formulate an advance directive.</p> <p>Resident #41 is no longer a patient in the facility.</p> <p>Residents who refuse care have the potential to be affected by this practice. Residents identified as having refused care have been reassessed with referrals made when indicated. Care plans were modified to reflect personalized approaches when indicated.</p> <p>Residents are educated on risk and benefit of refusal of care and underlying reason for refusals are investigated.</p> <p>Audits of care plans and documentation for refusals of care will be completed weekly for four weeks by the ADNS or designee and forwarded to the QAPI committee for review and recommendations.</p>	

On going compliance will be ensured by ADNS or designee

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F 155 Continued From page 2
care and declining therapy services. If refusal of care occurred, per the assessment, Staff G would meet with Resident #41 as needed to educate him about the importance of achieving a certain level of independence in order to be able to live in an assisted living facility.

On 02/20/13 at 8:30 p.m. Staff C, Director of Nursing Services, stated Resident #41 did not participate in therapy. She stated that on 10/01/12 Resident #41 was discharged from Occupational Therapy due to "non-participation." On 10/17/12, a Physical Therapy Summary documented by Staff EE, Director of Rehab - PT, physical therapy services were discontinued as the patient had not met goals due to "self-limiting behavior and inconsistent participation, variable mood and lack of energy/lethargy."

Per record review, on 10/30/12 Staff G met with Resident #41 to discuss refusal of care. The meeting is documented in the progress notes, but no specific strategies to minimize refusals are documented there or elsewhere in the medical record as an outcome of the meeting. No care plan for addressing the refusal of care was developed, thus Resident #41 was disallowed the opportunity to have his physical and emotional needs met.

On 02/20/13 at 1:30 p.m., Staff G said she was responsible to develop resident care plans for mood and behavior, but that the care plan was an interdisciplinary approach. Staff G further stated Resident #41 had a history of refusal of care, even at other facilities. She stated she offered him mental health services through Senior Services, but he refused.

F 155
Date of compliance is 04/08/2013

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F 155	<p>Continued From page 3</p> <p>His condition generally declined after 11/01/12 and on 12/12/12 [REDACTED] care was initiated related to a diagnosis of [REDACTED]. He continued to refuse food and incontinent care regularly.</p> <p>On 02/06/13, the Hospice nurse documented a discussion with the facility staff regarding the resident's unwillingness to let staff do incontinent care. The nurse also noted the healing challenges for the open area due to the resident's resistance to accept incontinent care. Staff II, NAC (facility staff) indicated to the hospice nurse the resident seemed more open to care with male staff and older staff. The hospice nurse requested this information be placed on the residents care plan. Staff V, LPN Nurse Supervisor agreed. As of 02/22/13, this information could not be found on the care plan.</p> <p>On 02/11/13 at approximately 5:15 p.m. Resident #41 was observed refusing his evening meal. He was in his room in at the time. Staff offered fluids and he took some. Staff member Q, RN Nurse Supervisor, stated he "often refuses" food. She stated they just keep offering.</p> <p>The facility failed to assess Resident #41 for refusal of care. They did not care plan strategies to provide care in a way he would accept. Social Services met with him only once about his refusing behavior. No alternative therapies were instituted after Occupational and Physical Therapy was discontinued due to non-participation. Suggested alternatives that might have mitigated refusals were not followed up. The Kardex (the resident-specific instructions</p>	F 155		

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F 155	Continued From page 4. for direct care staff) only had the information that the resident may refuse care, but nothing that indicated what to do if he did refuse.	F 155	157	
F 157 SS=E	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157	<p>Manor Care of Lacey strives to provide resident, physician, and family with notification of changes in condition.</p> <p>Physicians were updated and orders received during survey when indicated for residents #40, 41 and 76.</p> <p>Residents receiving care and services have the potential to be impacted by this practice. Review of charts for changes in condition was completed and notifications were completed when indicated.</p> <p>Physicians are notified of changes in condition, residents are informed of new orders and when indicated families are updated on changes in condition and orders. Notifications are documented in the medical record.</p> <p>Monitoring for notifications will be completed five times weekly by the ADNS or designee through established facility QAA processes</p> <p>Findings will be reviewed by the Administrator or designee and</p>	

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F 157	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to notify the physician about significant physical changes that occurred in 3 of 3 residents (#'s 41, 40, and 76) in 2 of 4 units. This failure resulted in delayed treatment in potentially prolonging infections and creating unnecessary pain.</p> <p>Findings include:</p> <p>Resident #41 Resident #41 was admitted on [REDACTED] 12 for [REDACTED]</p> <p>Record review revealed on 01/10/13, Hospice nurse noted the hospice aide had identified a "dime sized open area" on Resident #41's [REDACTED] buttock. The hospice nurse documented "Staff T, RN Nurse Supervisor" was notified of the open area and the need for turning and repositioning to provide pressure relief.</p> <p>On 01/17/13, 7 days later, the facility started a PUSH (Pressure Ulcer Scale for Healing) form. The form documented the size and depth of the pressure ulcer on his [REDACTED] ([REDACTED]) area, between [REDACTED] described as [REDACTED] [REDACTED].</p> <p>On 02/07/13 the facility started another PUSH form documenting a second pressure ulcer in the area of the [REDACTED] (area below the [REDACTED] but still on the [REDACTED]). A note on 02/13/13 indicated that the two pressure ulcers had merged into one unstageable (an ulcer that is</p>	F 157	<p>forwarded to the QAPI Committee for review and recommendation.</p> <p>On-going compliance will be ensured by administrator or designee</p> <p>Date of compliance is April 8, 2013</p>	

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F 157	<p>Continued From page 6 covered by [REDACTED] or [REDACTED] and the wound bed is not visible) pressure ulcer.</p> <p>On 02/22/13 at 10:26 a.m. Staff E stated there was no documentation that showed the physician was notified about the pressure ulcer before 02/12/13, when the physician was contacted for a treatment for the unstageable pressure ulcer. Staff E stated he talked with the physician about offloading (reducing pressure on/around the wound through repositioning of the resident or other measures). Staff E did not document the conversation with the physician and did not recall the date of the conversation. Staff E acknowledged there was no documentation of a rationale for trying offloading for a month before choosing another treatment approach when the size and severity of the pressure ulcer was worsening.</p> <p>Resident #40 Resident #40 was admitted on [REDACTED]/12 with multiple diagnoses including [REDACTED] and a history of a [REDACTED].</p> <p>Record review revealed on 02/08/13 Resident #40's stool culture was positive for an infection of [REDACTED], a species of [REDACTED] that causes severe diarrhea and other [REDACTED] when competing bacteria in the intestinal tract have been wiped out by antibiotics. At 12:33 p.m., Staff H wrote in the progress notes: "Lab called to report positive C. Diff results. Physician to be notified and POA (power of attorney) when available....." There is no documentation of any communication with the physician about the positive lab result until 02/10/13, when a telephone order for an antibiotic was received for</p>	F 157		

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F 157	<p>Continued From page 7 Resident #40 to treat her [REDACTED]</p> <p>Resident #76 Resident #76 was admitted to the facility November 2012 with [REDACTED]</p> <p>A review of Resident #76 chart was conducted. A urinalysis (a physical, chemical and microscopic test of the urine) was collected on 02/14/13 due to foul smelling urine. The final urine test was completed on 02/16/13. Resident's #76 doctor was notified of the results on 02/19/13 at 8:30 p.m. by Staff N, 3 days after the completion of the urinalysis while she continued to have symptoms of a [REDACTED]</p> <p>Staff interviews revealed no physician notification.</p>	F 157	<p>226 Manor Care of Lacey strives to ensure policies and procedures that are implemented are followed and that policies prohibit and prevent mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Requests for background checks were resubmitted and returned for Staff K and X.</p>	
F 226 SS=E	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to implement all components of their written abuse prevention policy. Failure to scree 2 of 6 (Staff K, X) and ensure 7 of 10 (Staff Q, Y, Z, AA, BB, CC, DD) staff were aware of the facilities abuse policy and</p>	F 226	<p>An audit of employee files has been completed and background checks resubmitted if indicated.</p> <p>A tracking tool is being utilized by HR to ensure background checks and abuse training are completed. Staff education has been initiated on mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Weekly audits of staff knowledge will be completed by Administrator or designee. The Administrator or designee will conduct weekly random audits of employee files for the next</p>	

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F 226	<p>Continued From page 8: procedure placed residents at risk of abuse, neglect and exploitation.</p> <p>Findings include:</p> <p>Employee screening: Prior to employees working unsupervised with a vulnerable adult a criminal background check must be performed using the Background Check Central Unit (BCCU). BCCU conducts background checks for agencies providing services to vulnerable adults.</p> <p>A review of the facilities "PATIENT PROTECTION PRACTICE GUIDE" dated 11/2011, identified the facility would screen employees to identify information from:</p> <ul style="list-style-type: none"> o Previous and current employers, with applicant permission o State licensing boards and registries o Criminal background checks <p>Staff K was hired 10/02/12 and did not have a criminal background check from BCCU. A review of Staff K employee file revealed the background check was originally sent on 09/24/12 with no further response.</p> <p>Staff X was hired on 10/24/12 and did not have a criminal background check from BCCU. A review of Staff X employee file revealed the background check was originally sent on 10/23/12 and again on 11/29/12. There was no further follow up.</p> <p>On 02/25/13 at 11:28 a.m., Staff B, the cooperate representative, was interviewed on the facilities</p>	F 226	<p>four weeks to validate files have current checks.</p> <p>Findings will be reviewed by the Administrator or designee and forwarded to the QAPI Committee for review and recommendations.</p> <p>On-going compliance will be ensured by administrator or designee</p> <p>Date of compliance is April 8, 2013</p>	

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F 226 Continued From page 9
system for obtaining background checks on employees. The facility lacked capability to submit in the beginning (when they open) so they used a "sister" facility to obtain background checks through BCCU. There was no follow through on ensuring background checks were received. Staff B stated as a part of the quality assurance committee, employee files are audited every 3-6 months to ensure accuracy.

On 02/25/13 at 4:15 p.m., Staff A (administrator) and B stated Staff K and X background checks have been resubmitted to BCCU.

Employee Training:
A review of the facilities "PATIENT PROTECTION PRACTICE GUIDE" dated 11/2011, identified the facility process for abuse, neglect and misappropriation of patient property as the facility would: Screen, Train, Prevent, Identify, Investigate, Protect and Report/respond. All alleged violations "are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures (including to the state survey and certification agency)."

On 02/15/13 and 02/16/13 staff were interviewed regarding responding and reporting to abuse and neglect. Staff interviews revealed that 7 out of 10 (Staff Q, Y, Z, AA, BB, CC, and DD) did not acknowledge the process how to protect the resident or notify the state abuse and neglect reporting hotline when they had knowledge of abuse.

On 02/25/13 at 2:51 p.m., Staff D, Staff Development Nurse, was interviewed regarding

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F 226	Continued From page 10 the facilities training on abuse and neglect. Staff D stated all employees are trained on abuse, neglect, and misappropriation of residents during employee general orientation and then annually. A review of the facilities training log with Staff D, revealed the last training involving abuse and neglect was April 2012. There was no evidence staff were aware of the facilities policy and procedure regarding abuse, neglect and exploitation of residents.	F 226	242 Manor Care of Lacey strives to provide care and services to ensure resident's right to make choices about aspects in his or her life that are important to the resident. Residents #48, 14, 172, and 83 were interviewed, care plans were modified when indicated, and personal preferences added to care plans.	
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure 4 of 4 (#s 48, 172, 14, and 83) current sampled residents reviewed for choices, the right to exercise their autonomy regarding when to get up in the morning (#48, 172 and 83) and when to shower (#14). This failure placed residents at risk for a diminished quality of life. Findings Include:	F 242	Residents currently residing in the facility were interviewed and modifications were made to care plans when applicable. Care plans were updated to reflect personal preferences. Upon admission a care plan will be implemented based on known diagnoses. Upon completion of the MDS assessment and CAA's the care plan will include personalization. Audits regarding personal preferences will be completed weekly by ADNS or designee and forwarded to QAPI committee for review and recommendations.	

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F 242	<p>Continued From page 11</p> <p>Resident #48 - Resident #48 was admitted September 2012 with [REDACTED] and [REDACTED].</p> <p>On 02/12/13 at 09:05 a.m., Resident #48 was interviewed regarding choices. When asked if he was offered what time to get up in the morning he replied "no, they (the staff) just get me up and get me dressed and take me to dining." When asked what time he would prefer to get up, he stated "around 6-7" in the morning.</p> <p>A review of the resident chart was conducted. According to the Minimum Data Set (MDS), an assessment tool, dated 09/28/12, the resident indicated choices were very important to him. This information was not on his care plan (CP) or the Kardex.</p> <p>Resident #172 Resident #172 was admitted February 2013 for therapy after a [REDACTED]</p> <p>On 01/13/13 at 9:28 a.m., the resident was interviewed regarding choices. She was not offered any choices in participation in her schedule for therapy. She was told when she was to receive therapy. On the day of the interview, she pointed out the schedule of her therapy for the day. She was to start therapy at 6:05 in the morning. She stated "they (the therapist) did not come in my room until after 7 a.m." The resident stated she never gets up at 6 a.m. and was not offered the opportunity to have a later therapy session.</p> <p>A review of her temporary CP was performed.</p>	F 242	<p>On-going compliance will be ensured by ADNS or designee Date of compliance is April 8, 2013</p>	

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F 242	<p>Continued From page 12</p> <p>Her preference on when to get up was not addressed on the CP or the Kardex.</p> <p>Resident #14 Resident #14 was admitted January 2013 with [REDACTED] and [REDACTED]</p> <p>On 2/13/13 at 1:52 p.m., the resident's representative was interviewed regarding choices. When asked if the resident was offered the choice in how many showers or baths she took, the representative stated "no."</p> <p>According to the MDS dated 01/31/13, it was important for her to choose her bath schedule. The CP or kardex did not reflect her choices.</p> <p>Resident # 83 On 02/13/13 at 2:00 p.m. interview with Resident # 83 stated he has no choice when to wake up in the morning, " they knock on the door and say time to get up".</p> <p>Per record review MDS choices and preferences were recorded as very important.</p> <p>On 02/19/13 at 2:20 p.m. resident # 83 stated the staff is no longer waking him up in the morning at all, and he almost missed a therapy appointment. He stated he wished the issue had been discussed with him and would just like some consistency.</p> <p>Per record review of Resident's Kardex, no wake up or bed time preferences found.</p> <p>Staff Interviews:</p>	F 242		

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F 242	<p>Continued From page 13</p> <p>In an interview with staff R, a Nursing Assistant Certified (NAC), on 02/15/13 at 9:09 p.m. stated she knows what a resident wants and needs through the Kardex system.</p> <p>In an interview with Staff E, the Director of Care Delivery, on 02/16/13 11:20 a.m., indicated residents were asked their preferences of when to get up and go to bed within the first 24-48 hours of admission. There is no system in place on asking a resident their bathing preferences. It is "automatically a shower." Each resident is on a schedule according to their room number. This helps balance out the "work load." Showers were offered on the morning and afternoon shift, but it is up to the resident to indicate what time of day and type of bathing system they prefer. On a follow up interview with Staff E, on 02/19/13 at 3:40 p.m., the facility was working on a process to incorporate residents' choices into their plan of care. It is up to the resident to voice their concern and initiate the change.</p> <p>In an interview on 02/19/13 at 3:00 p.m. with Staff O, a NAC, stated she had a "routine with residents for their p.m. care." Staff O received information through the Kardex.</p> <p>On 02/19/13 at 3:20 p.m. Staff S, a LN, stated there was no system in place alerting the staff of resident's preferences. Staff S indicated that most of the residents were here under rehabilitation services and they (the resident) "have to adjust to their new schedule due to being in rehab."</p> <p>On 02/20/13 at 10:30 a.m. interview with Staff # JJ, LN stated staff is unaware of resident's</p>	F 242		

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F 242 Continued From page 14
choices upon admit. After a few days if the resident has a preference it is on the Kardex or they would communicate through report.

On 02/20/13 at 9:32 a.m., Staff X, a NAC, was interviewed about residents' choices. Staff X views the residents' preferences on the kardex. If it does not state what time they (the resident) wishes to get up, she goes into their room between "6 - 6:15 a.m. and wakes them up to ask what time they want to get up." If the resident does not want to get up at that time, she leaves them alone.

F 242 246
Manor Care of Lacey strives to provide care and services that allow for the reasonable accommodation of patient needs.

Resident #176 has continued to receive medications as ordered.

Medication availability has been reviewed for current residents and medications are available at this time.

F 246 SS=D 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES

A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined the facility failed to accommodate 1 of 1 (#176) residents reviewed related to administration of medications. This failure made the resident feel hopeless and a diminished quality of life.

Findings include:
Resident #176 was admitted in February 2013

F 246

Upon admission medications will be reviewed for availability and if unavailable the EKIT will be utilized and/or the physician will be notified.

Audits of new orders and start times for medications will be completed by ADNS or designee. Results of audits will be forwarded to QAPI committee weekly for review and recommendations.

ADNS or designee is responsible for ensuring on going compliance.

Date of compliance is April 8, 2013.

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F 246	<p>Continued From page 15 with [REDACTED] and a [REDACTED], [REDACTED] [REDACTED] characterized by [REDACTED]</p> <p>An interview was held on [REDACTED] 13 at 9:28 a.m. with Resident #176. She was admitted the day prior and arrived to the facility at approximately 6 p.m. Her spouse arrived at 8 p.m. and inquired to Staff Q, a License Nurse (LN), about what time her medication would be available. Staff Q told Resident #176 and her spouse she (the resident) came in after hours and when her medications arrive from the pharmacy they would be available for her to have. Staff Q further stated "tomorrow will be better."</p> <p>Resident #176 began inquiring "every hour" on the status of her medications. At approximately 1:00 a.m. on 02/15/13, Resident #176 asked Staff K, a LN, if her medications had arrived from the pharmacy. Staff K acknowledge the arrival of her medications. Resident #176 asked Staff K for her bed time medications which included her medication for [REDACTED]. Staff K told her "no" because she was not due for them and she (the resident) could not have her medications until "their scheduled time at 8:30 a.m.," and left the room. Resident #176 said Staff K "talked to me like I was a child" and was "dismissive."</p> <p>On 02/15/13 at 2:00 a.m., Resident #176 called for the nurse on duty. Staff K entered the room and Resident #176 told her she wanted her bed time medications. Staff K informed the resident to contact her physician if she wanted her medications and she was not going to have them until 8:30 a.m. Staff K left the room and came back with a printout copy of when her medications where scheduled. Resident #176</p>	F 246		

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F 246	<p>Continued From page 16</p> <p>told Staff K she was overdue for her medications and "if you are going to hold my medications hostage, you are not going to get away with it." Staff K replied, "the medication dispense time is 8:30 a.m." and left the room.</p> <p>During Resident's #176 interview on 02/15/13, she stated she felt emotionally under stress and came to this facility for "recovery and to receive six weeks of antibiotics." She stated she "cannot afford to get kicked out of here" for standing up for her rights. Resident #176 felt she suffered from anxiety for not receiving her [REDACTED] medication [REDACTED] as per her normal routine. Resident #176 stated she felt "abandoned," "helpless," "totally screwed over" and her rights were lost when she entered the facility.</p> <p>An interview was conducted with Staff K on 02/15/13 at 11:36 p.m. what she would do if a resident was adamant about receiving their medications, she stated she would contact the physician and obtain the proper authorization. Staff K was asked how many times resident 176 inquired about her medications, including her [REDACTED]. She stated she (the resident) asked for them twice. When asked why she did not call the doctor and obtain the authorization, Staff K replied there is a concern with contacting the physician at times. This concern was directed to the Director of Nurses (DNS).</p> <p>On 02/16/13 at 12:15 a.m., Staff C was interviewed regarding administrating medication not available. The LN was to pull the medications from the e-kit with the prescription after verifying with the pharmacy and obtaining authorization. This was not done for Resident</p>	F 246		

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F 246	Continued From page 17 #176. On 02/19/13 at 10:45 a.m., Resident #176 stated she still remembered how she was treated and felt it was not right.	F 246	250 Manor Care of Lacey strives to provide medically related social services to attain or maintain the highest practicable level of functioning in physical, mental, and psychosocial wellbeing.	
F 250 SS=G	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide medically related social services to attain the highest level of physical, mental and psycho-social well-being for 1 of 1 resident (#41) investigated for social service support. The facility did not provide support for psychological adjustment difficulties related to grief about life changes and did not mitigate the circumstances causing the refusals of care. The failure to address the adjustment difficulties placed Resident #41 at risk for worsening depression and increased the likelihood he would refuse care. Failure to address the reasons for his refusal of care led to weight loss and skin breakdown, which resulted in a serious decline in health, infection and pain. Findings include: Resident #41 was admitted on [REDACTED]/12 with a	F 250	Resident #41 is no longer residing at the facility. Current residents have been reviewed for psychosocial decline related to significant life changes. Care plans were modified as indicated. Upon admission and with significant change residents are evaluated for potential decline in psychosocial status. ADNS or designee will audit documentation for behaviors and/or refusal of care and validate follow up is completed. Findings of audits will be reviewed by QAPI committee for review and recommendation. On-going compliance will be ensured by Administrator or designee. Date of compliance is April 8, 2013	

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F 250	<p>Continued From page 18 diagnosis of [REDACTED], [REDACTED], [REDACTED], [REDACTED] and a history of [REDACTED].</p> <p>On 09/17/12, in the initial Social Services assessment by Staff G, Social Services Director, it stated he had had a [REDACTED] placed during the summer of 2012. When he arrived at the facility in September, his primary reason for admission was for rehabilitation therapy and strengthening, as he had had some [REDACTED] episodes that resulted in a fall and had also had a [REDACTED] that had left him in a weakened condition. He had moved to the facility to be closer to his wife who lived in the assisted living facility next door. Staff G's assessment stated Resident #41 first entered a skilled nursing facility in April of 2012 and the move to this facility was his third skilled nursing facility since April. The resident's stated goal was to discharge to the assisted living facility to live with his wife. The assessment noted Resident #41 had a history of refusal of care and declining therapy services. Per the assessment, if refusal of care occurred, Staff G would meet with Resident #41 to educate him about the importance of achieving a certain level of independence in order to be discharged to the community.</p> <p>On 02/20/13 at 8:30 p.m. Staff C, Director of Nursing Services, stated Resident #41 did not participate in therapy. She stated that on 10/01/12 Resident #41 was discharged from Occupational Therapy due to "non-participation." On 10/17/12, a summary documented by Staff EE, Director of Rehab - PT stated that physical therapy services were discontinued as the patient had not met goals due to "self-limiting behavior</p>	F 250		

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F 250	<p>Continued From page 19 and inconsistent participation, variable mood and lack of energy/lethargy."</p> <p>Per progress notes, on 10/24/12, Staff G met with Resident #41 and informed him he did not have enough money to pay for an assisted living facility for both he and his wife. The possibility of finding a less expensive assisted living was discussed with Resident #41.</p> <p>On 10/24/12, Staff G documented that per Resident #41 and his family member, the future plan of care for Resident #41 was to remain in a long term care facility. This was a significant setback for Resident #41, who had expressed a desire to live with his spouse in the assisted living facility.</p> <p>Per record review, on 10/30/12 Staff G met with Resident #41 to discuss refusal of care. The meeting is documented in the progress notes, but no specific strategies to minimize refusals are documented there or elsewhere in the medical record as an outcome of the meeting. Thus, Resident #41 was disallowed the opportunity to have his physical and emotional needs met.</p> <p>On 11/06/12 a care plan was developed by Staff C (who is not a part of the social service staff) for "indicators of depression/sadness." One of the interventions to address the concern was for social services to "discuss feelings of sadness/hopelessness and option of appropriate channeling of these feelings...." There was no documentation this intervention was ever done after the care plan was developed.</p> <p>On 02/21/13, when asked if anyone had talked to</p>	F 250		
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F 250	<p>Continued From page 20</p> <p>the resident about why he refused care, Staff C did not answer the question directly. She stated "He had a lot of losses in the last year. He lost his independence, his health, his ability to live with his wife. He didn't feel he had anything left to live for."</p> <p>Between 10/30/12 and 11/15/12, Resident #41 lost 25 lbs. The facility attributed the weight loss to poor intake and refusal of meals. Prior to this time period, his weights had been stable and after this time period his weight stabilized at the lower weight. Staff L, Registered Dietitian met with Resident #41 around the time of the weight loss. She worked with him to improve his intake. Staff L did not document any recommendation to consider other alternatives to oral intake, such as a tube feeding. (See related tag F325 Nutrition)</p> <p>Per progress notes on 12/03/12, Staff G met with Resident #41 to discuss his weight loss. She alerted the resident he would need to consider whether he wanted to start using a tube feeding or to have a hospice consult. After a discussion with family members, the resident told Staff G he would accept a hospice consult.</p> <p>On 12/12/12 hospice care was initiated related to a diagnosis of [REDACTED]. Frequent refusal of incontinent care and positioning continued. On 12/12/12 the hospice nurse documented skin breakdown on his toes. On 01/10/13 the hospice nurse noted an open area on his [REDACTED]. It was classified as a pressure ulcer on 01/17/13. On 02/07/13 a second pressure ulcer was noted, also located on his [REDACTED]. By 02/13/13, the two ulcers on his [REDACTED] had enlarged and merged into one</p>	F 250		

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F 250 Continued From page 21
pressure ulcer. Resident #41's facility care plan judged him to be "at risk for alteration in skin integrity related to non-compliance with preventative measures, impaired mobility, DM, declines incontinent care and poor nutrition." (see related tag F314, Pressure Ulcer)

Per Hospice progress note, on 02/06/13, the hospice nurse documented "Spoke with Staff II, evening CNA. Staff II indicated resident does much better with male staff or older staff when intimate care needs to occur." The progress note further stated that the resident's preference was discussed with Staff V, LPN Nurse Supervisor, who agreed to place this information on the resident's plan of care and work to get male staff with resident when possible. The facility care plan was not updated to reflect this preference, which could have negated some refusals of care. Further documentation from the hospice nurse stated that facility staff requires education related to addressing underlying reasons behind resident declining care rather than looking to medication to address the behavior.

On 02/11/13 at approximately 5:15 p.m. Resident #41 was observed refusing his evening meal. He was in his room in at the time. Staff offered fluids and he took some. Staff member Q, RN Nurse Supervisor, stated he "often refuses" food. She stated they just keep offering.

On 02/20/13 at 1:30 p.m., Staff G said she was responsible to develop resident care plans for cognitive, mood, behavior, psychosocial well-being and discharge planning. Staff G stated the care plan was an interdisciplinary approach. Staff G further stated Resident #41 had a history

F 250

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F 250	<p>Continued From page 22</p> <p>of refusal of care, even at other facilities. She stated she offered him mental health services through Senior Services, but he refused. When asked how the facility supported Resident #41 through the life changes/losses he had experienced during the summer and fall of 2012, Staff G stated "He refused to meet about it. I met with him sometimes." When asked the question again, Staff G reiterated that Resident #41 had refused an outside mental health referral, but she did not define how staff within the facility helped him deal with life changes.</p> <p>The facilities "Mood and Behavior Practice Guide" stated "Report behavior and mood symptoms that present a safety risk to self or others, interfere with care delivery or are socially inappropriate or stressful to others" and "It is professional to regard these symptoms as treatable and not accept them as unavoidable. The goal is to work together to find the underlying cause."</p> <p>The facility was aware of Resident #41's significant life changes as well as his persistent refusal of care. Staff C attributed the refusals to the significant life changes. The facility failed to provide effective support to the resident about those life changes. While a referral to an outside agency for mental health was offered, in-facility social services support was rarely documented. A care plan was not developed to guide direct care staff about how to minimize the incidence of refusals and Social Services met with the resident only once about refusal of care. These refusals contributed to weight loss, skin breakdown and discomfort for Resident #41.</p>	F 250		

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F 279 SS=G	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to use the results of the assessment to develop the resident's comprehensive plan of care. For 6 of 29 residents (#41, 40, 163, 94, 20, & 146) reviewed in the areas of accidents, nutrition, skin condition, hospice and medication use, and for 4 of 4 units, the facility failed to develop a comprehensive care plan for each resident that includes resident specific interventions to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive</p>	F 279	<p>279</p> <p>Manor Care of Lacey strives to provide care and services that include the development, review and revision of the resident's comprehensive care plans.</p> <p>Resident # 41 no longer resides at the facility. Care plans for residents # 40, 163, 94, 20, and 146 were reviewed and revised to reflect the current conditions and preferences for these residents.</p> <p>Care plans for residents who have experienced a change in care needs were reviewed and modified as needed.</p> <p>Care plans are developed at admission and revised when MDS process is complete and when there is a change in condition reported.</p> <p>ADNS or designee will audit development, review and revision weekly for four weeks. Findings will be forwarded to the QAPI Committee for review and recommendations.</p> <p>On-going compliance will be ensured by ADNS or designee</p>	

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F 279	<p>Continued From page 24 assessment.</p> <p>Findings include:</p> <p>Resident #41 Resident #41 was admitted on [REDACTED]/12 for rehabilitation services to [REDACTED]</p> <p>Nutrition Per the initial Minimum Data Set (MDS), an assessment tool completed on 09/19/12, Resident #41 was assessed to need a nutrition care plan per the Care Area Assessment section. On that MDS, no weight loss was noted. Resident #41's weight was 167 lbs. No comprehensive plan of care was developed for Resident #41.</p> <p>Resident #41 had continued nutrition risk factors, including poor intake and weight loss. His diet was adjusted twice to try to encourage intake but no comprehensive care plan for nutrition was developed to address this change in nutrition status.</p> <p>Hospice At admission, the care plan developed for Resident #41 included potential for discharge to an assisted living facility (ALF). The care plan goal was to discharge Resident #41 to an ALF with wife, and that transportation would be arranged, future placement settings would be assessed and any special equipment needs would be investigated for the ALF.</p> <p>After admission, Resident #41 did not participate in therapy, had frequent pain and generally</p>	F 279		

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F 279	<p>Continued From page 25 declined. Between 10/30/12 and 11/15/12, Resident #41 lost 25 lbs.</p> <p>On 10/24/12 Staff G documented that the discharge plan for Resident #41 was to remain in a long term care facility.</p> <p>Resident #41's condition continued to decline and on 12/12/12 hospice care was initiated. The resident's care plan was not updated to this change in care status.</p> <p>Resident #40 Resident #40 was admitted on [REDACTED]/12 with multiple diagnoses, including several that placed her at nutrition risk: history of [REDACTED], [REDACTED], [REDACTED], [REDACTED] and [REDACTED]. On the MDS dated 12/18/12, the CAA triggered that a care plan should be developed to address potential nutrition risk. No comprehensive care plan was developed for Resident #40.</p> <p>Resident #163 Resident #163 was admitted January 2013 with [REDACTED] and [REDACTED] (a ulcer that is covered by [REDACTED] or [REDACTED] and the [REDACTED] is not visible) on the [REDACTED]. The MDS dated 02/03/13 identified the resident is able to feed self with set up and supervision assist.</p> <p>The Registered Dietician (RD) assessment dated 01/30/13, identified her as having poor nutritional intake of food and the need for healing her</p>	F 279		
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significant skin breakdown. The RD directed staff to offer frequent small meals, provide snacks between meals and to follow a specific fluid restriction of 1200 cubic centimeters (cc) of fluid in a 24-hour period.

An interview on 02/19/13 at 5:15 p.m., with the RD the care plan for nutrition was reviewed. There was no care plan in place to address her needs. This place Resident#163 at risk for potential weight loss, decreased healing and receiving more fluids then the physician ordered.

Resident #94
Resident #94 was admitted January 2013 with [REDACTED] (including [REDACTED]) and [REDACTED] and [REDACTED]. The MDS dated 01/30/13 indicated the resident required supervision with set up assistance with meals.

A review the CAA for nutrition directed staff to refer to the nutritional assessment and care plan for his nutritional needs. There was no nutritional care plan. The nutritional assessment dated 01/31/13 indicated he required a high protein renal diet with double protein portions to meet his [REDACTED] and healing requirements.

Interviews with Resident #94 on 02/12/2013 10:27 a.m., 02/13/13 at 3:30 p.m., and 02/19/13 at 3:38 p.m. confirmed that he was not receiving double portions of protein.

In an interview on 02/19/13 at 5:15 p.m. with the RD, she was aware that the resident does not receive his double protein portions on a

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F 279	<p>Continued From page 27</p> <p>consistent basis and the facility is "working on it."</p> <p>The facility failed to develop a nutritional care plan to adequately identify his nutritional needs which placed him at risk for delayed healing.</p> <p>Resident #20 Resident #20 was admitted in September 2012 with [REDACTED], and risk for [REDACTED]. The MDS dated 09/29/12 identified the resident had [REDACTED] and was on a mechanically altered diet.</p> <p>The chart was reviewed. The RD identified the resident had swallowing issues and a fluid restrictions of 1000 cc per day. The CAA dated 10/02/12 directed staff to view his care plan dated 09/26/12 for nutritional needs. There was no care plan addressing Resident #20's nutritional requirements and fluid restriction.</p> <p>The facility failed to develop a care plan to adequately reflect the care needs required to safely maintain him at his highest practical level.</p> <p>Resident #146 Resident #146 was admitted in December 2012 with a [REDACTED], [REDACTED], and [REDACTED]. The MDS dated 12/27/12 identified a BIMS of 15, the resident exhibited daily signs of disorganized thinking, inability to stay focused, feeling tired, and being restless. The resident also exhibited signs of [REDACTED] and [REDACTED].</p>	F 279		

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The MDS dated 12/27/12 indicated a care plan would be developed related to the resident receiving daily multiple [REDACTED] medications for the diagnoses of [REDACTED], [REDACTED] and [REDACTED].

On 02/19/13 at 4:33 p.m., Staff C stated the staff were responsible reviewing each residents care plans regarding managing [REDACTED] and [REDACTED]. Resident's #146 care plan was reviewed with Staff C, and there were no specific goals, interventions, and approaches for his [REDACTED] [REDACTED] s or [REDACTED].

The facility failed to implement a care plan directing staff on interventions to manage his [REDACTED] and [REDACTED].

Interviews:

On 02/15/13 at 2:26 p.m. Staff M, Director of Care Delivery (DCD), was interviewed regarding the care plan process. The admitting nurse was responsible to place a few "standard approaches" on the care plan upon admission. The DCD was responsible to "individualize" the care plan. The goal was for the DCD to participate in the care planning conference within the first two weeks of admission to discuss the resident's concerns and goals. Staff M said the facility was "working on" this care plan process.

On 02/16/13 11:20 a.m. Staff E, a DCD, was interviewed regarding the care planning process. The License Nurse on the floor was responsible to initiate the care plan and "obtain the generics." The DCD would "personalize" the care plan within two days. The facility was "working on" this process.

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F 279	Continued From page 29 On 02/20/13 at 1:30 p.m., Staff G, Social Service Director, said she was responsible to care plan resident's cognitive, mood, behavior, psychosocial well-being and discharge planning. Staff G stated the care plan was an interdisciplinary approach.	F 279	280 Manor Care of Lacey strives to provide care and services that include the resident and family involvement in care planning and the periodic review and revision of care plan by a team of qualified persons after each assessment.	
F 280 SS=G	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 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to review, revise, and correctly implement plan of care for 3 of 36 #'s	F 280	Resident #41 no longer resides at the facility. Care plans were reviewed and modified for residents # 48 and 63. Care plans have been reviewed and revised for residents who have experienced changes in care needs Care plans are revised when a change in condition or a change in care needs is noted. ADNS or designee will complete audits of care plans for revisions based on changes in resident needs weekly for four weeks. Audit findings will be forwarded to the QAPI committee for review and recommendations. On-going compliance will be ensured by administrator or designee Date of compliance April 8, 2013	

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F 280	<p>Continued From page 30 41, 48 and 63) residents reviewed in Stage 2 of survey.</p> <p>Findings include:</p> <p>Resident #41 Resident #41 was admitted on [REDACTED]/12 with a diagnosis of [REDACTED], [REDACTED] and [REDACTED]. The primary reason for his admission was for rehabilitation services to [REDACTED]. His BIMS (Brief Interview of Mental Status) score was 14 on his MDS (Minimum Data Set) dated 09/19/12. Resident #41 expired on 02/22/13.</p> <p>Pressure Ulcers On the initial Minimum Data Set (MDS) completed on 9/19/12, Resident #41 was assessed to be at risk for pressure sores, but having no pressure sores at that time.</p> <p>On 09/12/12 a care plan was developed to address the risk of skin breakdown. The care plan was updated on 10/22/12. The care plan stated that Resident #41 was "At risk for alteration in skin integrity related to non-compliance with preventative measures, impaired mobility, [REDACTED], declines incontinent care, poor nutrition." The interventions identified included floating heels as able and to observe skin condition with ADL care daily; report abnormalities.</p> <p>His condition generally declined after admission and on [REDACTED] 12 hospice care was initiated related to a diagnosis of [REDACTED]</p>	F 280		
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F 280	<p>Continued From page 31</p> <p>On 12/12/12 the hospice "start of care clinical note" documents "[REDACTED]", likely from pressure of blanket." Per record review, on 01/10/13, a "dime sized open area" was noted on Resident #41's [REDACTED]. It was classified as a pressure ulcer on 01/17/13. On 02/07/13 a second pressure ulcer was noted, also located on his [REDACTED]. By 02/13/13, the two ulcers had enlarged and merged into one pressure ulcer.</p> <p>On 02/11/13 Resident #41's care plan was updated to include care related to skin breakdown, nearly 1 month after the first pressure wounds were identified. Failure to update the care plan as Resident #41's skin condition changed delayed treatment and might have caused him unnecessary pain. (See related F 314 Pressure Sores)</p> <p>Pain Recognition and Management Per the initial Minimum Data Set (MDS) completed on 09/19/12, Resident #41 was assessed to have pain (intensity 5/10, frequency: rarely). He was taking no scheduled pain medication, but was using prn (as needed) pain medication. The MDS stated that no non-medication interventions were being used. He did not trigger for pain on the Care Area Assessment (CAA).</p> <p>On 09/12/12 a care plan was developed to address Resident #41's pain. The goal was to reduce the incidence of breakthrough pain by 1) adjusting times of ADL (activities of daily living) and treatment activities so they occur after [REDACTED] (reduce/eliminate pain) benefits have been achieved, and 2) Report any non-verbal</p>	F 280		

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F 280	<p>Continued From page 32</p> <p>expressions of pain (ie moaning, grimacing.....).</p> <p>On 09/18/12 a Physical Therapy Summary note by Staff GG, Physical Therapist it stated Resident #41's ambulation is limited by "fatigue and residual pain R (right) front abdomen. The abdominal pain is long standing according to patient and is 9/10 to paipation (touching the body part to assess it) and 10/10 pain with gait/transfers and increased activity level. Pain etiology (cause) is unknown. Nursing aware of R quadrant pain." The care plan for pain was not updated.</p> <p>On 09/28/13 a Social Service progress note by Staff G, Social Services Director stated that Resident #41's abdominal pain is historical for resident. Further, a Physical Therapy Summary note by Staff GG relates Resident #41 is spending 90% of the day in bed and the resident stated that he stays in bed because of his abdominal pain. Further, the note stated "Rehab team has discussed all of this with nursing but no change." The care plan for pain was not updated.</p> <p>On 01/07/13, three months after the documentation of ongoing significant pain, Resident #41's care plan was updated to include pain related to [REDACTED]. On 02/11/13 it was updated to include pain related to skin breakdown. It was never updated to address abdominal pain. Failure to re-assess and revise his care plan caused Resident #41 unnecessary pain.</p> <p>Unnecessary Medications On 09/19/12 the admission MDS, Resident #41 was assessed to have no psychosis, no behaviors, and no rejection of care. He was not</p>	F 280		

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F 280	<p>Continued From page 33</p> <p>using any [REDACTED] medication. Severity score for mood was zero (no issues with mood).</p> <p>On 10/05/12 [REDACTED], an [REDACTED] was ordered and started for loss of appetite and [REDACTED]</p> <p>On 10/25/13, [REDACTED] an [REDACTED] was ordered and started for [REDACTED].</p> <p>On 11/06/12 a care plan was developed by Staff C for "indicators of depression/sadness." One of the interventions of that plan was to "Evaluate effectiveness and side effects of medications for possible decrease/ use of [REDACTED] in the past but stops taking them." There was no documentation this intervention was ever done after the care plan was developed.</p> <p>On 12/15/12 [REDACTED] an [REDACTED] was started on an as needed basis. None was given until 02/04/13. Per the physician, the indicator for use was "[REDACTED]" On the pharmacy review, the pharmacist indicated that the indicator for use was "psychosis." Per interview of Staff G on 02/20/13 at approximately 1:30 p.m. and Staff C at approximately 8:30 p.m. the indication for use of [REDACTED] was "refusal of care." The care plan was not updated at that time nor was implementation of the existing care plan to monitor for side effects and effectiveness done.</p> <p>Per Staff C on 02/20/13 at approximately 8:30 p.m. Resident #41 had requested to discontinue his [REDACTED] medications in December and that this was done on 12/28/12. The care plan was not adjusted to reflect the changing medications.</p>	F 280			

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F 280	<p>Continued From page 34</p> <p>Resident #48 Resident #48 was admitted September 2012 with [REDACTED]s and [REDACTED]. The MDS dated 12/29/2012 identified Resident #48 required extensive assistance of two people for transfers, toileting and bed mobility.</p> <p>During an interview on 2/12/13 at 11:31 a.m., Resident #48 was observed to have several dark to light purple discoloration covering the back of both hands and approximately 2 inches of his wrists. When asked how he obtained the discoloration, he replied the "bruises are from when they (the staff) transfer me; they (the staff) grab my hands." Resident 48 had told the staff not to transfer him by grabbing his hands. "(I) bruise easily and they hurt."</p> <p>A review of a facility investigation regarding a hand bruise found 11/22/12 indicated the bruising was caused from how the staff was transferring him. The result of the investigation was to remind staff not to pull on the resident's arms and allow him to push off the bed himself or to use the caregivers arm for support. The care plan or Kardex was not revised to reflect this information to prevent reoccurrence.</p> <p>On 02/22/13 at 2:45 p.m., an interview with Staff C, Director of Nurses (DNS), was conducted. The DNS verified the transfer care plan was not updated for Resident #48. The staff had no direction on how to properly transfer Resident #48 and prevented further injury and pain.</p> <p>Resident # 63</p>	F 280		
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F 280 Continued From page 35
Resident # 63 was admitted [REDACTED] 13 with diagnosis including [REDACTED] and MDS stated refused cares 1-3 days.
Per record review care plan in place on 02/07/13 for At risk behavior symptoms including declining care. The goals for the resident were to accept care and medications as prescribed with interventions as follows. Engaging the resident in conversation about previous occupation, California, or other topics, Offer to call resident's sister or brother-in-law, Offer resident papers to fill out or write on, provide resident with newspaper, and Use consistent approach when giving cares.
On 02/16/13 at 9:50 a.m. observed resident refusing medication from Staff FF, LN. When asked Staff FF stated there was no behavior monitoring because that was not normal behavior for resident.
Per record review of Nursing Progress notes and MAR resident had refused care and or medication 18 times since admit. Per record of the Nursing Progress Notes not one of the care planned interventions were attempted during or after the refusals.

F 280

F 281 SS=D 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, facility staff failed to meet professional standards of practice for 4 Licensed Nurses (Staff H, KK, K,

F 281

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F 281

Continued From page 36 and F). Failure of these staff to provide care using accepted standards of clinical practice for 4 of 4 residents (# 40, 76, 146, 176) resulted in delays in treatment for an infection and in medication administration.

Definitions:

The Center for Medicare and Medicaid Services State Operating Manual, dated January 2011, defines "professional standards of quality" as services provided according to accepted standards of clinical practice. Recommended practices to achieve desired resident outcomes may be found in clinical literature, current manuals or textbooks, or published by a professional organization.

According to Fundamentals of Nursing, 7th Edition, 2011, page 738 states, "the rights of medication administration can help ensure accuracy when administering medications. Ensure that the (1) right medication is given to the (2) right patient in the (3) right dosage through (4) right route at the (5) right time. Additional rights have been suggested to include ensuring (6) the right reason and (7) the right documentation (Bales et al., 2004; Page, 2003).

Findings include:

Resident #40
Resident #40 was admitted on [REDACTED] 12 with multiple diagnoses, including several that placed her at nutrition risk: history of [REDACTED]

F 281

281
Manor Care of Lacey strives to provide and arrange care and services that meet professional standards of quality.

Resident #40 and #76 have been treated for and recovered from conditions requiring antibiotic treatment. Resident #176 continues to receive ordered medication to treat anxiety.

Residents requiring treatment for acute conditions or increased symptoms of chronic conditions have the potential to be affected.

Nursing staff notify physician when changes in condition are noted and utilize EKIT for medications when needed.

Monitoring for changes in condition is completed weekly and as needed. Audit tools are utilized to ensure changes are monitored and appropriate clinical follow up occurs. Audit tools are submitted to the QAPI committee weekly for review and recommendations.

On-going compliance will be ensured by ADNS or designee

Compliance date is April 8, 2013.

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

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F 281	<p>Continued From page 37</p> <p>██████████, ██████████ ██████████ pressure ulcers and ██████████</p> <p>Per record review, on 02/07/13 at 10:31 a.m. a "STAT" (to be done and reported immediately) order was obtained for a stool sample to rule out an infection.</p> <p>On 02/08/13 at 12:07 p.m., Staff H, a License Nurse (LN) was notified by a fax of a positive stool culture for C. diff.</p> <p>On 02/10/13 at 2:23 p.m., two days later, the physician was notified of the positive stool culture and an antibiotic was initiated.</p> <p>A progress noted dated 02/12/13 identified a 10 x 10 cm "red, inflamed, rash" on the residents ██████████.</p> <p>The failure of the facility not initiated an antibiotic for the C.diff placed her at risk for skin breakdown (due to the diarrhea) and worsening of the infection.</p> <p>Resident #76 Resident #76 was admitted November 2012 with ██████████ and ██████████.</p> <p>A review of the chart was done on 02/20/13. The facility was aware of a positive urinalysis on 02/19/13.</p> <p>Staff KK, a LN, obtained an order for an antibiotic at 8:30 p.m. The resident did not receive her first dose of antibiotic until 8:30 a.m. on 02/20/13. A delay in treatment for twelve hours.</p>	F 281		

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F 281	<p>Continued From page 38</p> <p>An interview with the DNS on 02/20/13 at 9:22 a.m. stated the expectation of the LN was to remove the antibiotic (if available) from the emergency kit and administer. A review of the facilities emergency kit revealed the antibiotic was available to remove. This was not done. (Refer to F157 CRF483.10(b)(11)(i) for further information regarding Notification of Changes for resident #76).</p> <p>Resident #176 Resident 176 was admitted in February 2013 with diagnosis which includes: [REDACTED] and [REDACTED]. The resident admitted at 6:00 p.m.</p> <p>In an interview with Resident #176, indicated she did not receive her routine bedtime medications from Staff K, a LN, when they (the medications) arrived from the pharmacy. The resident experienced [REDACTED] due to not receiving her medications. The resident prior history was if she "did not take her [REDACTED] medication as scheduled, she would experience a panic attack."</p> <p>An interview was conducted with Staff K on 02/15/13 at 11:36 p.m. regarding when medications were delivered from the pharmacy. Medications usually arrive between midnight and 2 o'clock in the morning. If a resident would like their medication prior to the delivery, she was able to access a limited variety from the facilities house supply and emergency kit (e-kit). Residents who receive a controlled medication (which is defined as a scheduled II - V medication) the doctor must authorize the medication prior to removing it from the e-kit. When asked what she would do if a resident was adamant about receiving their controlled</p>	F 281		

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F 281	<p>Continued From page 39</p> <p>medications, she stated she would contact the doctor to obtain the proper authorization. Staff K was asked how many times resident 176 inquired about her medications, including her [REDACTED] Resident #176 asked for them twice.</p> <p>A review of the facilities e-kit revealed the [REDACTED] [REDACTED] was available to be removed. This was not done. Per resident #176, she experienced signs of [REDACTED] that could have been prevented. (Refer to F241 CRF 483.15(a) Dignity for further information regarding Resident #176).</p> <p>Resident #146 On 2/16/13 at 1045 a.m., Staff F, a LN, was observed to administer medications to resident # 146 at the wrong time. Two medications were due at 6:30 a. m. and nine medications due at 830 a.m. Staff F acknowledged the medications were late.</p> <p>The administrator and DNS were both interviewed on 2/16/13. Medications were to be administered an hour before or after the scheduled time.</p>	F 281		
F 309 SS=G	<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 accordance with the comprehensive assessment and plan of care.</p>	F 309		

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F 309

Continued From page 40

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to ensure 4 out of 15 (#'s 41, 48, 20,63) sample residents were provided necessary care and services to maintain highest practicable level of well-being. The failed practice resulted in actual harm to resident # 41 and #48.

Findings include:

Resident # 41
Resident #41 was admitted on [REDACTED] 12 with multiple diagnoses, including [REDACTED] and [REDACTED]. His primary reason for admission was for rehabilitation therapy and strengthening.

Per the initial MDS completed on 09/19/12, Resident #41 was assessed to have pain (intensity 5/10, frequency: rarely). He was taking no scheduled pain medication, but was using PRN (as needed) pain medication. The MDS stated that no non-medication interventions were being used. The pain did not interfere with daily activities and sleep. He did not trigger for pain on the Care Area Assessment (CAA).

On 09/12/12 a care plan was developed to address Resident #41's pain. The goal was to reduce the incidence of breakthrough pain by 1) adjusting times of ADL (activities of daily living) and treatment activities so they occur after analgesia (reduce/eliminate pain) benefits have been achieved, and 2) Report any non-verbal

F 309

309
Manor Care of Lacey strives to provide care and services to residents that attain and maintain the highest practicable physical, mental, and psychosocial wellbeing in accordance with the comprehensive assessment and plan of care.

Residents #41, #63 and #20 no longer resides at the facility. Resident #48 was assessed for pain and care plan and task list updated to reflect current transfer status.

Residents experiencing pain, taking Coumadin, needing assistance with transfers, or refusing care or services have the potential to be affected. Care plans and assessments for like patients were reviewed and updated when indicated.

Residents are monitored for signs and symptoms of pain. Medications that may affect INR results are listed in medication room. Transfer needs are updated on task list. Skin alterations are reviewed and monitored. Refusals of care are reviewed and approaches modified when indicated.

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Continued From page 41
expressions of pain (ie moaning, grimacing.....). Neither of these interventions was found on the Kardex.

Per review of the Medication Administration Record and physician orders, [REDACTED] 325 milligrams PRN (regular strength [REDACTED], by brand name) was the only pain medication ordered until 09/28/12 when [REDACTED] 5-325 milligrams (mg) was ordered.

On 09/18/12 a Physical Therapy Summary note by Staff GG, Physical Therapist stated Resident #41's ambulation is limited by "fatigue and residual pain R (right) front abdomen. The abdominal pain is long standing according to patient and is 9/10 to palpation (touching the body part to assess it) and 10/10 pain with gait/transfers and increased activity level. Pain etiology (cause) is unknown. Nursing aware of R quadrant pain." The care plan for pain was not updated.

On the MDS completed on 09/24/12, Resident #41 was assessed to have pain (intensity 6/10, frequency: occasionally). He was taking no scheduled pain medication, but was using PRN pain medication on occasion. The MDS stated that non-medication interventions were not being used. The pain did not interfere with sleep but did interfere with daily activities. He did not trigger for pain on the Care Area Assessment (CAA).

On 09/26/12 it was noted in the medical record Resident #41 complained of pain in [REDACTED]. A KUB (an x-ray test that is used to diagnose or investigate conditions in [REDACTED]

F 309

Random audits of pain management, Coumadin management, transfer observations, and skin documentation will be completed by ADNS or designee weekly times four weeks. Findings of audits will be forwarded to QAPI committee for review and recommendations.

ADNS or designee is responsible for ongoing compliance

Compliance date is April 8, 2013

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section of the (b) (6) was done and no significant findings were noted.

On 09/28/13 a Social Service progress note by Staff G, Social Services Director stated that Resident #41's abdominal pain is historical for resident. Further, a Physical Therapy Summary note by Staff GG relates Resident #41 is spending 90% of the day in bed and the resident stated that he stays in bed because of his abdominal pain. Further, the note stated "Rehab team has discussed all of this with nursing but no change."

On the MDS completed on 10/14/12, Resident #41 was assessed to have pain (intensity 4/10, frequency: occasionally). He was taking no scheduled pain medication, but was using PRN pain medication. The MDS stated that non-medication interventions were not being used. The pain did not interfere with sleep or with daily activities. He did not trigger for pain on the Care Area Assessment (CAA).

On 01/07/13 Resident #41's care plan was updated to include pain related to gout and on 02/11/13 it was updated to include pain related to skin breakdown (25 days after the skin breakdown was noted).

On 2/3/13 a staff member noted in the progress notes the resident is less agitated and more willing to accept care when pre-medicated for pain.

The MAR reflects the following pain medication received by Resident #41:
* 10/01/12 - 10/31/12: No doses of Tylenol and 2

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F 309	<p>Continued From page 43</p> <p>doses of [REDACTED]</p> <p>* 11/01/12 - 11/30/12: No doses of either Tylenol or Vicodin</p> <p>* 12/01/12 - 12/31/12: No doses of Tylenol and 3 doses of Vicodin</p> <p>* 01/01/13 - 01/31/13: 10 doses of [REDACTED] (all but 2 given after the pressure ulcer was discovered)</p> <p>* 02/01/13 - 02/22/13: 21 doses of [REDACTED];</p> <p>On 02/20/13 at approximately 8:30 p.m. Staff C, Director of Nursing Services stated the underlying causes of pain were not been established for Resident #41. She speculated that it was possibly [REDACTED] or [REDACTED], but she said she didn't know if he had [REDACTED] or not.</p> <p>Although the care plan focus initiated 09/12/12 contained an intervention to adjust ADL and treatment times to occur after [REDACTED], and a staff member noted at the beginning of February the resident was more willing to allow care after receiving a pain med, the residents pain medications were not ordered to occur prior to care until [REDACTED] 13, 3 days before [REDACTED]</p> <p>The facility failed to effectively manage Resident #41's persistent pain. The abdominal pain was not addressed in the care plan and non-medication interventions were not attempted throughout his stay at the facility. Despite frequent documentation that the abdominal pain was a significant and ongoing deterrent to daily activities, the drug regimen was not re-assessed to possibly include alternative dosing schedules, such as having pain medication on a routine basis or before scheduled activity. Further, the facility did not take note of the resident's increase</p>	F 309		
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in use of his pain med starting in January nor did the facility complete a new assessment of the residents overall pain and attempt alternate interventions when it appeared his pain became more frequent. The facility could have positioned his drug schedule to anticipate his pain instead of waiting for him to ask for it.

Resident #48 -
Resident #48 was admitted September 2012 with [REDACTED], [REDACTED], and [REDACTED]

During an interview on 02/12/13 at 11:31 a.m., Resident #48 was observed to have several dark to light purple discoloration covering the back of [REDACTED] and approximately 2 inches of his wrists. When asked how he obtained the discoloration, he replied the "bruises are from when they (the staff) transfer me; they (the staff) grab my hands." Resident #48 had told the staff not to transfer him by grabbing his hands. "(I) bruise easily and they hurt."

A review of the resident chart was conducted. There was no assessment or care plan that identified the resident's bruises. The transfer care plan dated 09/24/12 documented to transfer the resident with one person guidance and physical assist. The second transfer care plan dated 09/22/12 had an intervention dated 10/09/12 to transfer the resident with two people and have him step pivot with walker from bed to chair.

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F 309	<p>Continued From page 45</p> <p>A review of a facility investigation regarding bruises found 11/22/2012 on Resident #48's hand indicated the bruising was caused from how the staff was transferring him. The result of the investigation was to remind staff not to pull on the resident's arms and allow him to push off the bed himself or to use the caregivers arm for support. The care plan or Kardex was not revised to reflect this information to prevent reoccurrence.</p> <p>On 02/14/13 at 3:19 p.m., Staff T, a License Nurse (LN), was interviewed regarding the facilities skin assessment process. A weekly skin assessment was performed in accordance with each residents individual shower schedule. The Certified Nursing Assistant (CNA) documented on the shower sheet any skin issues identified. The CNA gives this to the LN. The LN reviewed the sheet and if there is a new skin issue the LN will take action. If a bruise was identified, the LN was to fill out an incident report and an investigation is initiated. Other skin issues (excluding pressure ulcers) go on a "body audit sheet" and were tracked weekly.</p> <p>On 02/19/13 at 3:20 p.m., Staff S, a LN, was interviewed regarding the facilities skin assessment process. A skin assessment was done on the residents scheduled shower day. The CNA will place on the "skin worksheet" of what they observed and the LN will follow up. The LN was responsible for updating the Treatment sheet. If a new bruise was identified, a "new skin sheet" and incident report was done.</p> <p>On 02/22/13 at 2:45 p.m., Staff C, the Director of Nurses (DNS) was interviewed regarding the facilities skin assessment process. Residents'</p>	F 309		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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skin was assessed upon admission and weekly. The "skin audit sheets" were used for all skin concerns except pressure ulcers and bruises. New bruises were to have an incident report done and placed on alert for three days. The facilities alert board was reviewed for January and February. Resident #48 was not placed on alert or a progress note documented in his medical record. There was no incident report done.

The facility failed to follow their policy on new bruises identified and to update Resident #48's care plan which resulted in actual harm of new bruises on both of his hands and wrists and pain.

Resident #20
Resident #20 was admitted September 2012 with [REDACTED] and [REDACTED].

A review of the physicians orders revealed the resident received [REDACTED] (a medication to [REDACTED]) daily. [REDACTED] required frequent monitoring of blood levels and adjustment in the medication dosage to achieve a therapeutic International Normalized Ratio (INR). The goal for this resident's INR level was between 2.0-3.0.

On 10/12/12 the INR was 2.4. The physician ordered to continue the same dosage of [REDACTED] and to check the resident's INR on 11/02/12.

On 10/13/12, the resident developed [REDACTED] and was started on an antibiotic.

On 10/22/12 at 2:00 p.m. the resident coughed up some blood in his [REDACTED]. The physician was

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F 309	<p>Continued From page 47</p> <p>notified and ordered a blood test to check resident's INR level.</p> <p>On 10/23/12 at 9:11 a.m. (17 hours after the test was ordered) the physician was notified of the INR level at 8.0. The physician ordered Vitamin K "one time only for PT/INR critical high (Vitamin K is used to reverse the high INR level)."</p> <p>Per record review of the MAR, and the [REDACTED] flow sheet the physician ordered INR test 10/22/12 at 2:00pm, the MAR documentation on 10/22/12 at 8:30 p.m. INR level of 2.4, per [REDACTED] flow sheet 10/22/12 at time "a.m." INR level 8.0. The resident's critical high level was not reported to the physician until 10/23/12.</p> <p>On 02/21/13 at 3:00 p.m., the DNS was interviewed regarding the facilities policy on [REDACTED] therapy. The facility had a machine to check INR levels. The LN was to check the INR level, notify the physician, and obtain orders prior to administrating the next scheduled dose of [REDACTED]. The INR results were to be recorded on the [REDACTED] flow sheet. If the INR level is high, the LN is expected to re-check to ensure accuracy. The LN is responsible to notify the physician when an antibiotic is ordered to check if the INR should be monitored more closely.</p> <p>A review of the resident's chart was done. The physician was not notified of the resident starting an antibiotic on 10/13/12. There was no care plan to identify the risks involved for [REDACTED] therapy.</p> <p>On 02/25/13 at 9:42 a.m., Staff S, a LN, was interviewed regarding the facilities [REDACTED]</p>
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309 Continued From page 48
policy. The LN was responsible to check the INR level when ordered by the physician. When an INR is due to be checked, the computer system will alert the LN. The LN was responsible to notify the physician when an antibiotic is initiated.

The facility failed to develop a plan of care for a resident on [REDACTED] to identify the risks involved for medication therapy. The resident had an order to obtain an INR on 10/22/12. There is no documentation that indicates the time it was taken. The physician was not notified until 17 hours after the original order was given. After receiving the INR results of 8 the physician ordered Vitamin K on 10/23/12 at 9:11 a.m. This medication was not given. The resident was unable to swallow the medication. Then resident expired on 10/23/12.

Resident # 63
Resident # 63 was admitted [REDACTED]/13 with diagnosis's including [REDACTED], [REDACTED] and [REDACTED].

Per record review admission MDS stated refused care 1-3 days.

On 2/16/13 at 9:50am Staff FF, LN was observed attempting to give resident morning medication. Resident was lying in bed and stated she didn't want to sit up and didn't want to take the pills. Staff FF tried 3 times to give medication asking the resident if she was sure she didn't want medication, then left room. Staff FF was asked if there were any behavior monitoring for this resident she stated no because this is not her normal behavior.

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F 309	<p>Continued From page 49</p> <p>Per record review of MAR and Nurse Progress notes resident has refused medication and or care 18 times since admission on [REDACTED] 13. Two of residents morning medications are for diagnosis of [REDACTED] after her refusal no Blood Pressures were taken.</p> <p>On 2/21/13 at 3:30 p.m. Interview with Staff M,(Director of Care Delivery) stated after a resident refused any medication for [REDACTED] she would expect vital signs be taken on the resident, but was unable to show any blood pressures had been taken on resident #63 since 01/25/13.</p>	F 309	<p>314 Manor Care of Lacey strives to provide care and services that prevent the development of pressure sores unless the clinical condition demonstrates they are unavoidable and that a resident having a pressure sore receives care and services that promote healing, prevent infection, and prevent new sores from developing.</p>	
F 314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to prevent avoidable skin breakdown and failed to treat pressure sores promptly for 1 of 3 residents (#41) reviewed having a stage III or greater pressure sore. This failure resulted in harm for Resident #41 who developed 3</p>	F 314	<p>Resident #41 is no longer residing at the facility.</p> <p>Residents assessed to be at risk or who have actual skin breakdown have the potential to be affected by this practice</p> <p>Residents were reassessed to establish current skin risk and appropriate interventions were placed for each resident. Care plans were revised when indicated.</p>	

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avoidable pressure sores.

Findings include:

Resident #41 was admitted on [REDACTED]/12 with a diagnosis of [REDACTED] and a history of [REDACTED]. His primary reason for admission was for rehabilitation therapy and strengthening.

On the initial MDS completed on 09/19/12, Resident #41 was assessed to be at risk for pressure sores, but having no pressure sores at that time. The MDS listed that a pressure reducing device was being used for Resident #41's bed and chair.

On 09/12/12 a care plan was developed to address the risk of skin breakdown. The care plan was updated on 10/22/12. The care plan stated that Resident #41 was "At risk for alteration in skin integrity related to non-compliance with preventative measures, impaired mobility, [REDACTED] declines incontinent care, poor nutrition." The interventions identified included floating heels as able and to observe skin condition with ADL care daily; report abnormalities. No interventions regarding ways to address the residents care refusal were noted on the care plan.

His condition generally declined after admission and on [REDACTED]12 hospice care was initiated related to a diagnosis of [REDACTED].

On the MDS completed on 12/20/12 Resident #41 no longer walked and required limited to extensive assistance with most daily activities.

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Wounds are assessed when noted and reassessed weekly. Documentation is completed each week. Medical providers are notified of new wounds and treatment orders are obtained. Medical providers are notified of changes in wound condition.

ADNS or designee will conduct random audits of skin documentation and of skin condition to validate appropriate interventions for residents. Findings of audit tools will be forwarded to QAPI committee for review and recommendation.

ADNS or designee is responsible for ongoing compliance.

Date of compliance is April 8, 2013

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Further, the MDS assessed Resident #41 to be at risk for pressure sores but having no pressure sores at that time. The MDS also noted that a reducing device was in use for his bed, but not his chair.

On 01/10/13, the hospice nurse documented the hospice aide found a "dime sized open area" on the resident's [REDACTED]. The Hospice nurse further documented Staff T, LPN Nurse Supervisor employed by the facility had been informed regarding the open area. No documentation from the facility is found until 01/17/13 when the facility "skin team" (consisting of both facility Direct Care Delivery managers) completed a PUSH (Pressure Ulcer Scale for Healing) form on the resident and noted an area on the [REDACTED]. The PUSH form described the wound as "necrotic tissue measuring 2.1 - 3.0 centimeters squared (cm2)." Interview with Staff E, RN Direct Care Delivery and a member of the skin team, on 2/22/13 revealed the team was not notified about the area on resident #41's [REDACTED] until 01/17/13. When asked about the normal referral process if staff note a suspicious area, Staff E indicated a notice would be sent to the skin team so the team could immediately look at the resident's skin. When further asked if the team had been informed about resident #41's open area before 01/17/13, Staff E said "no." When asked how the team knew to look at the resident's skin on 1/17/13, Staff E stated "I'm not sure. A staff must have told one of us in passing."

A review of the record showed no treatment was started for the pressure area and no documentation indicated the physician was

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F 314	<p>Continued From page 52</p> <p>alerted regarding the pressure ulcer. On 02/22/13, Staff E indicated a decision was made on 01/17/13 to attempt "offloading" (keeping the resident off the pressure area by turning him from side to side) although this resident had a documented history of refusing to stay off his back. Staff were also instructed to keep the resident clean and dry.</p> <p>On 02/06/13, the Hospice nurse documented a discussion with the facility staff regarding the resident's unwillingness to let staff do incontinent care. The nurse also noted the healing challenges for the open area due to the resident's resistance to accept incontinent care. Staff II, NAC (facility staff) indicated to the hospice nurse the resident seemed more open to care with male staff and older staff. The hospice nurse requested this information be placed on the residents care plan. Staff V, LPN Nurse Supervisor agreed. As of 02/22/13, this information could not be found on the care plan.</p> <p>On 02/06/13, the hospice nurse further noted "Patient was in a pool of urine where it took a towel to absorb the excess urine in the bed. Discussed the seriousness of the findings with Staff V who agrees to make sure patient would not be found in the same situation..." The Hospice nurse also documented "Instructed Staff V and Staff II that patient being left in pool of urine can exacerbate decline not related to HS (hospice) diagnosis"</p> <p>Offloading was attempted until 02/12/13 (26 days) although staff continued to document the resident didn't want to lie on his side.</p>	F 314		
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On 02/07/13 a second pressure area was noted on the sacrum. By 02/13/13, the two areas had merged into one pressure area.

On 02/21/13 at approximately 11:00 a.m. Staff E stated he talked with Resident #41 about the importance of taking care of his skin. Staff E stated that offloading had not worked for Resident #41 so on 02/12/13 he talked to the resident and asked him if he would allow treatment. Resident #41 agreed to treatment so the physician was contacted to get an order for treatment of the sore (a medicated dressing was ordered). Staff E acknowledged that there was no documented rationale for trying offloading for a month before choosing another treatment approach when the size and severity of the pressure ulcer was worsening.

On 01/31/13 the hospice nurse noted in progress notes the Resident #41's [REDACTED] was "red, boggy." The hospice nurse instructed Staff D, RN to elevate Resident #41's [REDACTED]. No further documentation was noted in the chart regarding the area on the heel. There is no mention on the Kardex regarding floating the heels.

On 02/21/13 (22 days later) about 11:00 a.m. Staff E, a member of the skin team stated he had just assessed the heel and it had darkened color with intact skin and was "probably a deep tissue injury." He stated that if a facility nurse is notified of a new skin issue, that nurse needs to start a "skin sheet" to document the wound. If they suspect that the wound is pressure related they are supposed to contact a skin team member.

On 02/22/13 at about 10:30 a.m. Staff E stated

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F 314	<p>Continued From page 54</p> <p>that if a nurse observes or is told about a red, [REDACTED], he or the other skin team member should be told. He stated that he had not been informed Resident #41 had a possible pressure area on his [REDACTED] until 2/21/13.</p> <p>On 02/11/13 Resident #41's care plan was updated to include care related to skin breakdown, nearly 1 month after the first pressure wounds were identified. Failure to accurately identify skin breakdown and treat it promptly caused Resident #41 to have further skin breakdown. This caused him increased pain and may have accelerated the decline in his condition.</p>	F 314		
F 323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement planned interventions and adequate supervision for safe transfer techniques for 1 of 7 residents (#48). This failure resulted in harm by causing significant bruising and pain to the back of Resident #48 hands and wrists.</p>	F 323	<p>323</p> <p>Manor Care of Lacey strives to provide an environment that remains as free of accidents and hazards as possible and that each resident adequate supervision and assistive devices to prevent accidents.</p> <p>Resident #48 was assessed, care plan modified and task list updated to reflect transfer status.</p> <p>Residents requiring assistance with transfers were reviewed and care plans and task lists updated when indicated.</p> <p>Education was provided to NAC staff on transfer techniques and injury prevention by HR and Safety.</p>	

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F 323 Continued From page 55
Findings include:

Resident #48 was admitted September 2012 with [REDACTED], [REDACTED] and [REDACTED]

During an interview on 02/12/13 at 11:31 a.m., Resident #48 was observed to have several dark to light purple discoloration covering the back of both hands and approximately 2 inches of his wrists. When asked how he obtained the discoloration, he replied the "bruises are from when they (the staff) transfer me; they (the staff) grab my hands." Resident #48 had told the staff not to transfer him by grabbing his hands. "(I) bruise easily and they hurt."

The MDS dated 12/29/2012 identified Resident #48 required extensive assistance of two people for transfers, toileting and bed mobility.

The resident had two transfer care plans. The transfer care plan dated 09/24/12 documented to transfer the resident with one person guidance and physical assist. The second transfer care plan dated 09/22/12 had an intervention dated 10/09/12 to transfer the resident with two people and have him step pivot with walker from bed to chair.

The Kardex directed caregivers to transfer resident #48 with a gait belt with one person assist, and to use a walker to step pivot from bed to wheelchair.

On 02/20/13 at 4:00 p.m. Staff O, a CNA, was observed transferring Resident #48 in the bathroom. Staff O directed the resident to hold onto the grab bar with his right hand, as she used

F 323 ADNS or designee will conduct audits by observing transfers and validating transfer is completed safely. Findings will be forwarded to the QA&A committee for review and recommendation.

The facility Administrator or designee will be responsible for ensuring ongoing compliance.

Date of compliance is April 8, 2013

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F 323	<p>Continued From page 56</p> <p>her right hand to go under his left arm and grabbed his left wrist/hand and with her left hand she held onto the front of the gait belt and directed him to stand. Resident #48 stood up and Staff O helped him place his left hand onto the grab bar as she proceeded to perform personal care.</p> <p>On 02/20/13 at 4:08 p.m., a follow up interview with Resident #48 was conducted. He remarked that he had to remind staff not to grab his hands when they transfer him. When asked how his hands and wrists felt, he stated "they (indicating his wrists and hands) do hurt at times."</p> <p>A review of a facility investigation regarding bruises found 11/22/2012 on Resident #48's hand indicated the bruising was caused from how the staff was transferring him. The result of the investigation was to remind staff not to pull on the resident 's arms and allow him to push off the bed himself or to use the caregivers arm for support. The care plan or Kardex was not revised to reflect this information to prevent reoccurrence.</p>	F 323	<p>325</p> <p>Manor Care of Lacey strives to provide care and services that maintain nutritional status unless unavoidable.</p> <p>Resident #41 and #20 no longer reside at the facility. Resident #40 has been reassessed and reweighed with no significant weight change noted.</p> <p>Resident weights have been reviewed and modifications to plans of care implemented when indicated.</p>	
F 325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p>	F 325		

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F 325	Continued From page 57 This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure weights were accurately recorded for 3 of 25 residents (#41, 40, 20) in the sample who were reviewed for nutrition. This placed residents at risk of not maintaining acceptable parameters of nutritional status. Findings include: Resident #41 Resident #41 was admitted on [REDACTED] 12 for rehabilitation services to [REDACTED]. On the MDS (Minimum Data Set) dated 09/19/12, he weighed 167 lbs. Between 09/12/12 and 10/30/12, Resident #41's weight was stable. Between 10/30/12 and 11/15/12 Resident #41's weight decreased from 167 lbs. to 142 lbs., a 25 lb. weight loss. From 11/16/12 through 02/12/13, his weight stabilized at the lower weight, ranging from 142 lbs. to 150 lbs. On 02/21/13, when asked about the early November weight loss, Staff C, Director of Nursing Services stated that the facility found that when the scale they are using is moved, it can "mess up the calibration." We stopped using that "sit to stand" scale and now use a different scale. We feel the weight loss was related to the different scale. She said that the scale issue with Resident #41 was not documented.	F 325	A weight team is established. Scales are calibrated. Weights are obtained based on resident assessment and history. Reweighs are completed if a change in weight (gain/loss) of 5 pounds or greater is noted. ADNS or designee will conduct random audits to identify weight loss and validate appropriate assessments and interventions. Findings are forwarded to QAPI Committee for review and recommendations. On-going compliance will be ensured by administrator or designee Date of compliance is April 8, 2013		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505525	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/26/2013
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F 325	<p>Continued From page 58</p> <p>On 02/21/13 at 1:27 p.m. Staff C stated they think the weight loss Resident #41 experienced in early November was due to poor intake, not an improperly calibrated scale. They did not have further explanation of the weight loss.</p> <p>Resident #40 Resident #41 was admitted on [REDACTED]/12 with multiple diagnoses, including several that placed her at nutrition risk: [REDACTED] [REDACTED] [REDACTED] pressure ulcers and [REDACTED]. On the MDS dated 12/18/12, the CAA triggered that a care plan should be developed to address potential nutrition risk.</p> <p>Between 12/13/12 and 02/21/13, there were 10 times when a gain or loss of 5 lbs. or more was recorded in the medical record for Resident #40: 12/18/12 weight: 211 lbs. and 12/25/12 weight: 225 lbs (14 lb gain; no documentation or re-weigh documented) 01/05/13 weight: 226 lbs. and 01/09/13 weight: 266 lbs (40 lb gain; no documentation or re-weigh documented) 01/11/13 weight: 267 lbs. and 01/14/13 weight: 259 lbs (8 lb loss; no documentation or re-weigh documented) 01/15/13 weight: 260 lbs. and 01/17/13 weight: 222 lbs (38 lb loss; no documentation or re-weigh documented) 01/17/13 weight: 222 lbs. and 01/17/13 weight: 123 lbs (99 lb loss; no documentation or re-weigh documented) 01/18/13 weight: 123 lbs. and 01/22/13 weight: 236 lbs (113 lb gain; no documentation or re-weigh documented)</p>	F 325		

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F 325 Continued From page 59
 01/22/13 weight: 236 lbs. and 01/23/13 weight: 220 lbs (16 lb loss; no documentation or re-weigh documented)
 01/19/13 weight: 217 lbs. and 02/01/13 weight: 231 lbs (14 lb gain; no documentation or re-weigh documented)
 02/10/13 weight: 233 lbs and 02/12/13 weight: 224 lbs (9 lb loss; no weight validation documented; loose stools and diarrhea documented)
 02/16/13 weight: 226 lbs. and 02/19/13 weight: 220 lbs. (6 lb loss; no documentation or re-weigh documented)

Resident #20
 Resident #20 was admitted in September 2012 with [REDACTED] and [REDACTED].

The following weights were reviewed:
 * 09/24/12 = 175 pounds
 * 10/01/12 = 175 pounds
 * 10/04/12 = 174 pounds
 * 10/18/12 = 143 pounds

Resident #20 lost 34 pounds or 18.3% of his body weight in one month. He was not reweighed when the weight loss was indicated.

MDS dated 09/29/12 identified no recent history of weight loss or gain. The CAA directed staff to refer to Registered Dietician assessment and Care Plan (CP). There was no CP for nutrition.

Registered Dietician (RD) assessment dated 09/25/12 directed staff to notify the dietician for weight or nutrition changes.

The progress notes did not reveal any evaluation

F 325

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F 325	<p>Continued From page 60</p> <p>or that the physician, family and registered dietician were notified of the significant weight loss.</p> <p>Policy review and Interview: A review of the facilities Policy and Procedure for "Weight Measurement Guided" indicated the following within the policy: A. New admissions are weighed weekly for the first four weeks "consecutive" and then monthly. B. If there is a discrepancy of more than 5 lbs. of the previous weight, notify the nurse and re-weigh the resident as soon as possible or by end of shift to validate weight. C. Notify the physician and responsible party. D. Validated weights are entered into the computerized medical record. E. If a weight value is disputed ("disputed" is defined as weight not consistent with re-weight or usual weight status), the weight error should be further explained and documented in the health record. F. Locate the scale so it does not have to be moved. G. Calibrate the scales on a regular schedule. H. Use the same scale as for previous weights, unless otherwise directed.</p> <p>On 02/19/13 at 5:15 p.m., the Staff L, Registered Dietitian (RD) was interviewed regarding the facilities process of obtaining and reviewing residents weights. The RD comes to the facility three days a week. The RD reviewed all new admission, re-admissions and weights or nutritional concerns. If a resident is identified as a weight or nutritional concern, the RD will discuss this at a weekly meeting. The information from this meeting was documented in</p>	F 325		

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F 325 Continued From page 61
the resident's medical record. Further, Staff L stated she is aware of weight discrepancies in the chart. She stated the aide is supposed to report the weights to the nurse, who is supposed to check previous weight, then ask the aide to re-weigh if needed. Staff L stated the "sit to stand" scale is inaccurate and they do not use that scale for weights any longer. Staff L acknowledged that an accurate nutrition assessment cannot be done with inaccurate weight data.

The facility was not following the "Weight Measurement Guide" protocol that they had in place for weighing residents. They failed to re-weigh residents with weight discrepancies and failed to document a rationale for weight discrepancies that existed. An accurate assessment of Resident's #40, #41 and #20's nutrition status could not be completed because an accurate series of weights was not obtained. Because of the inaccurate weights, the facility did not know if they were maintaining acceptable parameters of nutrition status for these residents.

F 329 SS=E 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS
Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

F 325

329
Manor Care of Lacey strives to provide care and services that is free of unnecessary drugs.

F 329 Resident #41 no longer resides at the facility. Resident #18, #56 and #146 were assessed by their medical providers and modifications to treatment and medication plans were initiated when indicated.

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F 329	<p>Continued From page 62</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: Based on interview and record review, the facility failed to ensure 4 of 10 residents(# 18, 56, 41, 146) reviewed were free from unnecessary medications, including having adequate indication for use and appropriate monitoring.</p> <p>Findings include:</p> <p>The facilities policy for psychotropic medications identified as "MOOD AND BEHAVIOR PRACTICE GUIDE FLOWCHART" was reviewed. If a resident had a history or evidence of mood or behavior symptoms a care plan would be developed and implemented. The flowchart indicated resident's, family and staff should be educated and "ongoing management strategies" are implemented.</p> <p>The facility used the AIMS tool (A test that monitors for abnormal involuntary movements that can be caused from anti-psychotic</p>	F 329	<p>Residents on psychoactive medications were reviewed by the IDT and modifications made to care plans and/or referral to medical providers were made when indicated.</p> <p>Psychoactive medications are care planned. Resident/family education is documented. Diagnoses are reviewed and referrals are made to medical provider for follow up.</p> <p>ADNs or designee will conduct random audits to validate care plan completion and documentation of education and referrals.</p> <p>On-going compliance will be ensured by administrator or designee</p> <p>Date of compliance April 8, 2013</p>	

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F 329	<p>Continued From page 63</p> <p>medications) to monitor residents receiving anti-psychotics medications to assesses for potential side effects.</p> <p>Resident #18 Resident # 18 was admitted on [REDACTED]/12 with diagnosis including [REDACTED]. Per physician order on 2/6/13 Resident received [REDACTED] ([REDACTED]) 0.5 mg every day at bedtime for increasing episodes of [REDACTED]. [REDACTED] is not an approved diagnosis for the use of [REDACTED] according to Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Training Revision (DSM-IV TR).</p> <p>MDS (minimum data set, an assessment tool) dated 12/28/12 identified resident #18 exhibited [REDACTED] and [REDACTED]s and [REDACTED]. The care plan identified behavior symptoms as moaning, yelling out related to [REDACTED]. Goals were to accept medications and reduce risk of behavior symptoms.</p> <p>A review of the medical record indicated the drug was initiated without a qualitative monitoring system to monitor target behaviors, or for side effects of the medications. Furthermore, there was no baseline AIMS.</p> <p>Resident # 56 Resident #56 was admitted [REDACTED]/12 with diagnosis including [REDACTED] and [REDACTED]. Per physician order resident is receiving [REDACTED] ([REDACTED], [REDACTED], [REDACTED]) and [REDACTED] ([REDACTED]t). No diagnosis for use of [REDACTED] found.</p>	F 329		

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F 329	<p>Continued From page 64</p> <p>A review of the medical record indicated the drug was initiated without a qualitative monitoring system to monitor target behaviors, or for side effects of the medications. Furthermore, there was no baseline AIMS.</p> <p>Resident #41 Resident #41 was admitted [REDACTED]/12 with [REDACTED] and [REDACTED]. The MDS dated 12/20/12 identified resident as having no mood, behavior or refusal of care.</p> <p>Per record review, on 02/04/13, the resident was started on [REDACTED] and antipsychotic medication, for [REDACTED] and [REDACTED]. Per the DSM-IV TR [REDACTED] and [REDACTED] are not appropriate diagnoses for the use of an [REDACTED].</p> <p>In review of his medical record, there was no documentation of non-pharmalogical approaches, interventions attempted, ruling out any other potential medical condition or problem or AIMS prior to the initiation of the [REDACTED]. There was no care plan in place to direct the staff on the target behaviors, interventions regarding his [REDACTED] and [REDACTED], or a monitoring system to ensure the effectiveness of the medication.</p> <p>On 02/19/13 at 4:30 p.m., Staff C, the director of nurses (DNS) was asked why [REDACTED] was initiated for Resident #41. Staff C stated it was related to "refusal of care." When asked if this was an appropriate use for [REDACTED], Staff C replied it was not commonly used for that purpose.</p> <p>On a pharmacy report, the diagnoses for [REDACTED] was [REDACTED]. There was no evidence in his medical record to support this diagnoses.</p>	F 329			

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Resident #146
Resident #146 was admitted in December 2012 with diagnoses of a [REDACTED] and [REDACTED].

Per the physician orders, Resident #146 received [REDACTED] for [REDACTED] (an [REDACTED]), [REDACTED] and [REDACTED] for [REDACTED], [REDACTED] for [REDACTED] (an [REDACTED]) and [REDACTED] for [REDACTED] daily.

MDS dated 12/27/12, identified Resident #146 had exhibited some signs of [REDACTED] and [REDACTED]. The mood CAA identified [REDACTED] and recent life changes could contribute to his mood and behavior. The [REDACTED] medication CAA identified the resident was at risk for adverse effects related to the medications used. The goals for Resident #146 were for "symptom management." (which were not defined).

A review of the medical record indicated there was no monitoring system to monitor resident's sleep, mood, behavior, or for side effects of the medications. Furthermore, there was no baseline AIMS test done.

A review of the care plan revealed no goals, interventions or direction to staff to manage his mood and behavior.

Interviews:
In an interview on 02/19/13 at 12:30 p.m., Staff F, a LN, stated the facility has no monitoring system established for assessing side effects or monitoring the use of [REDACTED] medications.

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F 329	<p>Continued From page 66</p> <p>Staff S, a LN, was interviewed on 02/19/13 at 3:13 p.m. regarding the facilities policy on psychotropic medications. If a psychotropic medication is initiated in the facility, it was a nursing judgment to monitor for side effects. This is not documented in the chart.</p> <p>In an interview on 02/19/13 at 3:49 p.m., Staff M, a LN, stated the facility documented by exception and there was no system to monitor residents' behaviors or interventions attempted.</p> <p>The DNS was interviewed on 02/19/13 at 4:33 p.m.. The facility has a daily meeting and any new or changes in behavior was presented. Concerns are documented in the residents chart. Each residents' care plan identified specific behaviors and direct the staff on interventions performed prior to giving an as needed psychotropic medications. The nurse is expected to look at each individual care plan and documents what interventions were done and the outcome. This documentation was performed in the resident's progress notes. AIMS testing was done on all resident's who received antipsychotic medications upon initiation of the medication or admission to the facility and then every six months. The facility conducts a monthly psychotropic meeting.</p> <p>In an interview on 02/20/13 at 1:30 p.m. with G Social Service Director, stated the facility had psychotropic meetings monthly and discussed the following: residents who are exhibiting behaviors, any concerns to be addressed and who required a gradual dose reduction of their medications. The meeting notes are recorded in the resident's</p>	F 329		

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F 329	<p>Continued From page 67</p> <p>medical record. Care plans are developed for residents who had a concern or was exhibiting a "problem." If a resident was "stable," (not exhibiting a behavior) then they do not have a care plan.</p> <p>Failure to consistently identify residents' manifestations of mood and behaviors or consistently monitor resident's response following specific interventions, had the potential for staff to not know if a medication was effective, if or when it should be discontinued or if the medication regimen should be changed. These failures placed the resident's at risk for receipt of unnecessary medication use.</p>	F 329		
F 332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure a medication administration error rate of less than 5%. Failure of two nurses (Staff F and FF) to administer medications correctly to two residents observed resulted in a medication error rate of 11%.</p> <p>Findings include:</p> <p>Staff F On 2/16/13 at 10:45 a.m., Staff F, a Licensed</p>	F 332	<p>F332 Manor Care of Lacey strives to provide timely administration of medication.</p> <p>Resident #63 was not found to have any untoward effects noted from the delay in receiving medication.</p> <p>Residents who receive medications after their scheduled time have the potential to be affected.</p> <p>Medication schedules are reviewed and adjusted.</p>	

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F 332	<p>Continued From page 68</p> <p>Nurse, was observed to administer medications to at the wrong time. The resident was due for medications to be delivered at 6:30 a.m. which included medications for his [REDACTED] and [REDACTED]. Both medications should not be administered with food. The resident received his food through a feeding tube and this delayed the administration of his feeding by sixty minutes. The same resident was scheduled for an [REDACTED], [REDACTED], and an [REDACTED]. The physician ordered the eye drop every two hours while awake, the [REDACTED] [REDACTED] or three times a day (8:30 a.m., 11:30 a.m. and 4:30 p.m.) and the [REDACTED] twice daily (8:30 a.m. and 4:30 p.m.).</p> <p>Staff F acknowledged the medications were given past the time they were due.</p> <p>An interview with the Director of Nurses on 02/16/13 at 11:54 a.m. stated the facilities policy is to administered medications either an hour before or after the scheduled time.</p> <p>On 2/16/13 at 9:50am Observation of Staff FF, LN during medication administration. Staff FF prepared [REDACTED] 5.25mg and attempted to give to resident #63. Per record review medication was ordered at 8am every day, the policy of facility allows one hour before and one hour after to administer medication. Resident #63 refused medication, however the medication was still prepared out of time frame, resulting in a medication administration error.</p>	F 332	<p>Medication audits are in process for licensed nurses. Audits for medication administration timeliness are completed weekly. Audits will continue for four weeks and findings of audits will be forwarded to QAPI committee for review and recommendations.</p> <p>On-going compliance will be ensured by ADNS or designee</p> <p>Date of compliance is April 8, 2013</p>	
F 353 SS=H	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS	F 353		

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The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.

Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and observation, the facility failed to have sufficient numbers of staff to provide and supervise care for residents for 15 of 24 residents (#s 169, 164, 131, 94, 37, 83, 172, 56, 165, 66 176, 166, 18, 40 and 152), and 1 of 3 family members (Resident 9), interviewed during the survey.

The facility did not have sufficient staff that were experienced in providing timely and necessary care to residents. The care provided was not supervised in a manner to provide consistency in

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Manor Care of Lacey strives to ensure staffing is sufficient to provide timely and necessary care.

Residents # 169, 164, 94, 83, 172, 165, 9, and 166 no longer reside in the facility. Residents #176, 131, 37, 152 18, 40 remain in the facility. Resident #66 was not identified on the Sample Resident List provided to the facility so follow-up could not be completed.

Residents requesting assistance and experiencing a change in condition have the potential to be affected. Resident's/families' preference for care have been obtained.

Staffing meetings are held. Unit needs are identified. Schedules are validated

Resident interviews will be conducted to ensure staff is providing timely and necessary care. Any concerns identified from these interviews will be addressed. Findings will be brought to QA&A for review and recommendations.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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therapeutic approaches to avoid actual harm. Staff did not adequately assess, evaluate or document information needed to formulate effective and timely interventions.

The harm resulted from failure to develop strategies to minimize refusals of care, provision of timely pain management, wound care, delayed response to calls for assistance including timely toileting and incontinent care and delivery of basic activities of daily living causing feelings of frustration, and a diminished quality of life.

Findings include:

1) During interviews with residents and a family member, residents complained of problems with receiving care or assistance from staff due to a lack of sufficient staff.

On 02/12/13 at 12:04 p.m. Resident #131 stated there is often, "Only one person on this hall with 18 residents; sometimes I have to wait 35 minutes when I am already wet; usually the evening shift seems short, people call in; if (they are) short, there are no showers; in 28 days (I had) only 5 showers."

At 2:15 p.m., Resident #169 stated the "weekends are bad" and he went without getting his medications and waits were long.

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On-going compliance will be ensured by administrator or designee

Date of compliance April 8, 2013

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F 353	<p>Continued From page 71</p> <p>On 02/13/13 at 9:52 a.m., Resident #172 stated the facility was short staffed on the weekends. "I usually see two aides for the whole three rows" (the facility has three hallways on the first floor). The resident was admitted on the weekend after [REDACTED]. The resident said the day of her admission, after she waited 20 minutes to be assisted to the bathroom, she walked to the bathroom on her own. The following Monday she told the physical therapist, "I was up walking all weekend because no one was here to help me."</p> <p>At 2:15 p.m., Resident #83 stated (the facility was) "consistently short, the ones (staff) who are here are good." He stated he returned to the facility in the evening after an outing to find a visitor unable to open the entrance door and no staff available to assist her.</p> <p>At 5:30 p.m., Resident #40's spouse stated his wife required extensive assistance with activities of daily living including toileting and transferring. He said he spoke to the Administration about his wife not having her compression stockings on daily, waiting for her call light to be answered and not receiving toileting assistance in a timely manner. The spouse explained a nurse told his wife she would have to wait until the NA returned from dinner to assist her to the bathroom. Resident #40 could not wait and "had a bathroom accident" including bowel and bladder.</p> <p>On 02/14/13, at 1045 a.m. Resident #166 was observed in her room with her bathroom door open. The resident said "I have to poop and if you don't get in here I am going myself." The surveyor asked her if she put her call light on. The resident replied, "Yes, I do but no one is</p>	F 353		

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coming." The call light was observed to be on.

At 4:45 p.m., Resident #166 was observed in her room seated in her wheelchair with the meal tray on her bedside table. She yelled out in a frustrated tone, "Hey! I asked for coffee so long ago and no one is bringing it!" The resident stated she needed coffee with her dessert. No staff were observed in the halls.

On 02/15/13 at 9:30 a.m., Resident #176 stated she was admitted evening prior at 6:00 p.m. She said after her arrival to the facility, she was left alone in her room, not oriented to her room or the use of her call light. She said she was not offered dinner, provided water or her medications that were due. Resident #176 stated she was to receive her scheduled [REDACTED] medication and was concerned about side effects of missed doses to include a panic attack. She said the facility did not provide her with her scheduled medication that evening.

Resident #176 also stated her room had not been cleaned, trash was not emptied or provided with fresh water "all day." Resident #176 stated as a result of the facility's admission process, she felt hopeless and abandoned. Per review of the facility's admission report, 3 additional admissions occurred that afternoon/evening. (additional information about this resident and staffing related dignity issues, see F241)

On 02/15/13 on the evening shift, two NA staff were working on the first floor, not on the "Active Employee List" provided by the facility. Staff Member D, Staff Development Coordinator stated the NAs were from the Gig Harbor Manor Care

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facility assisting the Lacey facility. She stated, "we have access to them because they work at a Manor Care facility. "

Resident #18 was a resident with multiple diagnoses including [REDACTED] and [REDACTED]. She required extensive assistance with activities of daily living.

On 02/16/13 at 12:00 noon, the daughter of Resident #18 stated her mother was last toileted at 6:30 a.m. At 10:45 a.m., she realized her mother urinated and was wet. She asked the facility staff for assistance to clean her mother. Resident #18 waited 25 minutes longer (until about 11:10 a.m.) for assistance from an aide to get her clean and dry. The resident's daughter stated the weekends are "hellish" because there was "no staff available." She said she worried about her mother getting [REDACTED] and high or low blood sugars related to the lack of care.

She stated she never saw her mother given a snack even though Staff Member L, Registered Dietitian approved snacks. She stated staffing was worse on weekends, and "we don't know when meals will be served."

She stated she did her mother's laundry for 2 main reasons. First, she felt the facility had her mother wear her clothes for too long. Second, she was able to monitor how often her mother was soiled from not being provided timely incontinent care. She stated her mother's clothes were so saturated with urine that after laundering the clothes through the wash multiple times, the clothes still smell of urine.

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F 353	Continued From page 74 On 02/21/13, Resident #83 and his significant other stated staffing was the biggest problem on a daily basis. They stated they did not want to ask for help because the Nursing Assistants (NAs) have said they were short staffed. The resident and significant other felt bad asking the NAs for assistance as there were other residents worse off. Residents 169, 164, 94, 37, 56, 165, 66 and 152 also shared comments during Stage 1 interviews about insufficient staffing, including comments such as: the facility was short staffed daily; whenever there was a call in, there were no replacements; needed more NAs as they are very overworked; hardly ever saw the aides; they were understaffed; one NA cared for 18 resident rooms. On 02/26/13 at 5:45 p.m., during the exit conference with the residents, family members and staff, Resident #45 stated the facility opened the second floor (for admissions) before they had enough staff to meet the resident's needs. Resident #45 stated "there is not enough help up here for us" and "they can't open the upstairs dining room because they don't have the staff." She stated the aides frequently had to borrow aides from the first floor to complete the resident care needs making for long wait times. Resident #40's spouse stated his wife was told to wait until a staff member came back from their lunch break before she could use the bathroom. He stated "my wife had to poop on herself, because there is not enough help." Resident #40	F 353			

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F 353	<p>Continued From page 75</p> <p>required assistance with a mechanical lift to meet her transfer needs. Resident 40's spouse stated "they are supposed to use two people to transfer my wife, and there is frequently only one person."</p> <p>On 02/21/13 at 10:55 a.m., Staff Member B, the corporate resource nurse stated their staffing issues were not related to turnover as much as growing the census. She stated they tried to manage the growth in census with hiring and training employees for the increasing patient census. She stated it was a struggle to staff the facility with the increasing census. Staff Member B stated the staffing concern was not a Quality Assurance Committee issue, merely discussed "nearly every day" among Administration staff.</p> <p>During the course of the survey, multiple resident admissions were observed, even though staffing was acknowledged as "a struggle." The "Active Employee List" provided by the facility included 110 staff. Of those 110 employees, 21 (19% of total) were hired since January 1, 2013 and 26 (24% of total) were hired in the past 3 months.</p> <p>2) Refer to 42 CFR 483.10(b)(4), F-155 Right to Refuse: Formulate Advance Directives for failure to assess the reason for resident refusal or offer alternative treatments in 1 of 1 resident (#41) investigated for refusal of care. This failure did not allow him to maintain or attain the highest practicable physical, mental and psychosocial well-being in the context of making the refusals and caused harm through skin breakdown and unnecessary pain.</p>	F 353		

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F 353	Continued From page 76 3) Refer to 42 CFR 483.15(g)(1), F-250 Provision of Medically Related Social Service for the failure to provide medically related social services to attain the highest level of physical, mental and psycho-social well-being for 1 of 1 resident (#41) investigated for social service support. The facility did not provide support for psychological adjustment difficulties related to grief about life changes and did not mitigate the circumstances causing the refusals of care. The failure to address the adjustment difficulties placed Resident #41 at risk for worsening depression and increased the likelihood he would refuse care. Failure to address the reasons for his refusal of care led to weight loss and skin breakdown, which resulted in a serious decline in health, infection and pain. 4) Refer to 42 CFR 483.20(d)(k)(1), F-279 Develop Comprehensive Care Plans. The facility failed to use the results of the assessment to develop the resident's comprehensive plan of care. For 6 of 29 residents (#41, 40, 163, 94, 20, & 146) reviewed in the areas of accidents, nutrition, skin condition, hospice and medication use, and for 4 of 4 units, the facility failed to develop a comprehensive care plan for each resident that includes resident specific interventions to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 353			

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F 353	Continued From page 77 5) Refer to 42 CFR 483.25, F-309 Provide Care/Services for Highest Well Being. The facility failed to review, revise, and correctly implement plan of care for 3 of 36 (#s 41, 48 and 63) residents reviewed in Stage 2 of survey. 6) Refer to 42 CFR 483.25(c), F-314 Treatment/Services to Prevent/Heal Pressure Sores. The facility failed to prevent avoidable skin breakdown and failed to treat pressure sores promptly for 1 of 3 residents (#41) reviewed having a stage III or greater pressure sore. This failure resulted in harm for Resident #41 who developed 3 avoidable pressure sores.	F 353		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F 371 Manor Care of Lacy strives to ensure that food is stored, distributed and served under sanitary conditions No residents were identified as having consumed unlabeled or outdated food items	

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F 371	<p>Continued From page 78</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to store, distribute and serve food under sanitary conditions. For 2 out of 2 nourishment room refrigerators, the facilities failed to label and date food properly, discard food that was past date, and keep the refrigerator in a sanitary condition.</p> <p>Findings include:</p> <p>On 02/19/13 at 4:15p.m. Observation of downstairs refrigerator dirty with sticky substance on shelves and bottom inside. Thickened fruit punch, apple juice and dairy drink opened and dated 02/12 and 02/15. One container of thickened dairy drink was open and not dated, 3 cartons of vanilla shakes were not labeled with thaw dates. The freezer contained a bag of open tortillas with no name or date label, open ice cream with no name or date label and ice packs used on resident bodies that were lying on top of full ice cube trays. The temperature logs were missing dates.</p> <p>On 02/19/13 5:15 p.m. Observation of upstairs refrigerator temperature log was missing Feb. 7, 8, 9, 10 temperatures. Opened thickened orange, and dairy drink dated 02/12, two containers of thickened dairy open with no date. Open</p>	F 371	<p>Residents are at potential risk if food is not stored, distributed and served under sanitary conditions. Nourishment refrigerators were cleaned and unlabeled or outdated items were disposed of.</p> <p>Refrigerator temperatures are monitored. Foods are dated and labeled. Refrigerators are cleaned and foods are checked for expiration dates and disposed of when indicated.</p> <p>Audits of compliance will be done by administrator (or designee) and findings will be forwarded to QAA committee for review and recommendations. On-going compliance will be ensured by administrator or designee</p> <p>Date of compliance is April 8, 2013</p>	

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F 371	<p>Continued From page 79</p> <p>container of applesauce no name or date label.</p> <p>On 02/19/13 at 6:00 p.m. Interview with dietary staff in kitchen asked how long they keep thickened liquid containers after opened, they stated 7 days.</p> <p>On 02/20/13 at 10:00 a.m. interview with Staff J, Dietary Manager regarding thickened liquid he stated after it is open it is kept and used for 7 days. When asked to provide manufactures documentation regarding use, Staff J found label that read product should be used within 5 days of opening. Out dated containers were removed.</p> <p>On 02/20/13 at 3:30p.m. Interview with Staff HH ,housekeeping stated the housekeepers clean the nutrition room including wiping down the refrigerator inside and out, asked how often, he stated every day.</p> <p>On 02/20/13 at 4:00p.m. Staff F, LN stated the dietary department is responsible for cleaning the fridge and the nurses are responsible for dating things that they open.</p> <p>On 02/20/13 at 4:15p.m. Interview with Staff J stated the nurses are responsible to clean out the fridge, the dietary staff is responsible to stock it and remove any out dated food or beverages.</p> <p>On 02/21/13 at 9:00a.m. Interview with Staff BB, housekeeping stated they are responsible for the common areas including wiping down the outside of the refrigerator but not the inside.</p> <p>On 02/21/13at 9:30a.m. interview with Staff C DNS stated dietary is responsible to taking old</p>	F 371		

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F 371	<p>Continued From page 80</p> <p>things out of fridge, and if someone spills they should clean it up, if it is really dirty then nursing should alert housekeeping and dietary so it can be cleaned.</p> <p>On 02/21/13 at 11:00a.m. Observation of downstairs refrigerator sticky brown substance on shelves and in both bottom drawers.</p>	F 371	F428	
F 428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that the pharmacist reviewed resident's medication regimen an order to identify irregularities; and to identify clinically significant risks and/or adverse consequences resulting from or associated with medications for 1 of 10 residents (#146) reviewed for unnecessary medications.</p> <p>Findings Include:</p>	F 428	<p>Manor Care of Lacey strives to ensure the drug regimen of each resident is reviewed at least once monthly.</p> <p>Resident #146 has been reviewed and AIMS testing completed.</p> <p>Resident receiving psychotropic medications have the potential to be affected by this practice. Residents receiving psychotropic medications were reviewed and referrals made as indicated.</p> <p>Drug regimens are reviewed monthly. AIMS assessments are completed every six months.</p> <p>ADNS or designee will conduct random audits to validate pharmacist review. Findings will be forwarded to QA&A for review and recommendation.</p>	

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F 428	<p>Continued From page 81</p> <p>Resident #146 Resident #146 was admitted December 2012 with a [REDACTED] and [REDACTED]. The resident was admitted on five different [REDACTED] medications.</p> <p>According to the State Operations Manual Appendix PP - Guidance to Surveyors for Long Term care for Unnecessary Medications, each resident must have a Medication Regimen Review (MMR). An MMR was a "thorough evaluation of the medications regimen by a pharmacist, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication."</p> <p>A review of the facilities monthly medication review from the pharmacy was done on 02/18/13. There was no indication from the pharmacist that Residents #146 medication regimen was reviewed. Resident #146 received an [REDACTED] medication and was to have an AIMS test done by the License nurse. Upon review of other residents who received [REDACTED] medications it was noted the pharmacist indicated when other AIMS testing was done, but not for Resident #146. There were no AIMS in his chart.</p> <p>On 02/21/13 at 9:45 a.m., Staff C, Director of Nurses (DNS), was interviewed. The pharmacy recommendations were reviewed. It is documented that the pharmacist reviewed residents on 01/14/13 and 01/24/13. The pharmacist came into the facility on 01/14/13 and performed a medication review. On 01/24/13, the pharmacist did an additional "satellite review." The pharmacy "Consultation Report" dated</p>	F 428	<p>Administrator or designee will be responsible for ensuring on going compliance.</p> <p>Date of compliance is April 8, 2013</p>	

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F 428	<p>Continued From page 82</p> <p>January 1-31, 2013 listed each resident reviewed and the date it was done. There were no recommendations made for Resident #146 who was reviewed on 01/24/13.</p> <p>On 02/21/13 at 2:06 p.m., Staff C spoke to the consulting pharmacist. Staff C stated the pharmacist reviewed Resident #146 and made a recommendation to check his AIMS on the February 2013 report. Staff C also commented the pharmacist stated he had an appropriate diagnoses for the [REDACTED] which was [REDACTED] and [REDACTED]. A review of the resident's chart indicated the [REDACTED] medication was due to [REDACTED]. The resident does not have a diagnoses of major depression.</p> <p>See F329 CRF 483.25(l) Unnecessary Drugs and F279 CRF 483.20(k) for addition information on Resident #146.</p>	F 428	<p>F 431</p> <p>Manor Care of Lacey Strives to ensure safe and secured storage of medications/biological.</p> <p>Hospice "comfort pack" for resident 156 was secured. There are no medications stored in the refrigerator that require a "double lock" system.</p> <p>Staff K was re-educated on the importance of securing medication cart prior to stepping away.</p> <p>Contracted hospice provider has agreed to no longer send "comfort packs". Medications will be obtained through facility pharmacy provider.</p>	
F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</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</p>	F 431	<p>Medications will be secured upon receipt.</p> <p>ADNS and/or designee will audit to ensure on-going compliance. Findings will be brought to QA&A for further recommendations</p> <p>On-going compliance will be ensured by administrator or designee Compliance date is April 8, 2013</p>	

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F 431	<p>Continued From page 83 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: Based on observation, interview and record review the facility failed to provide a safe and secured storage of scheduled II and IV medications in the first floor medication room and safely store medications in 1 of 5 medication carts.</p> <p>Findings include:</p> <p>Medication Room: On 2/13/13 at 7:00 p.m., a medication storage was conduction in the first floor medication room with Staff T, a License Nurse (LN). There was one cabinet to the far right that was locked; this contained the facility emergency controlled scheduled II-IV medications. Staff T indicated the</p>	F 431		

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F 431	<p>Continued From page 84</p> <p>LN on the 200 hall had the only key to this cabinet. The refrigerator in the medication room was not locked and contained several medications that require refrigeration. Example of some of the medications stored in the refrigerator include: influenza vaccine, injectable insulin, intravenous medications, and as a box with emergency kit medications.</p> <p>There was a "fed ex" bag open with a box inside labeled "comfort pak" (a comfort pak is used for residents on hospice services and contains several different types of medications) for Resident 156. There was a packing slip indicating what medications were in this package that included 15 cc bottle of liquid Morphine Sulfate (a schedule II controlled substance), 10 tablets of 1 mg of Ativan (a scheduled IV controlled substance).</p> <p>At 709 p.m., Staff N, a LN, came into the medication room with Staff T. The "comfort pak" was open. Inside contained Morphine Sulfate and Ativan tablets. The Morphine and Ativan were removed immediately and placed in the medication cart and accounted for in the facilities controlled substance books.</p> <p>On 2/13/13 at 712 p.m. Staff M, Director of Care Deliveries (DCD), was interviewed regarding the process of when a "omfort pak" arrives at the facility. Staff M was not aware of this type of package. Staff M was asked the process for logging in scheduled II-IV medications. The process for these types of medications, that are required to be refrigerated, are accounted for every shift and the refrigerator is locked and the LN on the 200 hall had the only key. She was</p>	F 431		

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

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FORM APPROVED
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F 431	Continued From page 85 informed the refrigerator was not locked. On 2/13/13 at 7:20 p.m. the Director of Nurses (DNS) stated she received the package about a week and half to two weeks ago. The package was addressed to the resident and was opened. The DNS did not recognize the contents of the package, and called the sender. She was told that it had something to do with hospice. The DNS gave the package to the LN on who cared for the resident and was going to follow up with hospice. This was not done. On 2/15/13 at 845 a.m. with Staff S, a LN, entered the medication room on the first floor. The refrigerator was not locked. Medication Cart: On 2/15/13 at 10:40 p.m., Staff K, a LN, walked away from her medication cart and left a drawer slightly ajar. This drawer was easily open. There were no residents around the cart. At 10:43 p.m. Staff K admitted the cart was left unsecured. The DNS was notified of the observation.	F 431	F 520 Manor Care of Lacey strives to maintain a quality assessment and assurance committee that identifies quality care concerns and implements modifications and corrections of facility systems in a timely manner. QA&A committee has met to review quality care concerns and implemented corrections. (see Plan of correction for F 353, F281 and F226. QA&A meetings are held to validate progress of plan of correction. Compliance will be ensured by Administrator or designee		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.	F 520	Date of compliance April 8, 2013.		

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F 520	<p>Continued From page 86</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility's Quality Assessment and Assurance Committee(QA&AQ) failed to identify quality deficiencies, and implement modifications and corrections of facility systems in a timely manner. These failures contributed to residents experiencing delay in care and medication administration, and a diminished quality of life.</p> <p>Findings include:</p> <p>Refer to F353 Sufficient Nursing, F281 Services provided meet professional standards, and F241 Dignity and Respect for individuals and F226 Development of Abuse and Neglect Policies.</p> <p>On 02/21/13 at 10:55a.m. Interview with Staff B, corporate representative regarding staffing</p>	F 520		

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F 520	<p>Continued From page 87</p> <p>issues, stated the issues were related to the growing census. They have tried to manage the growth in census so they can hire new employees. She stated it is a struggle at times to staff the increasing census. The staffing issue had not been brought to the attention of QA&A committee, but it was discussed "nearly every day" among administration staff.</p> <p>On 02/16/13 at 12:15 a.m. during an interview with Staff C, DNS, it was identified the facility had been having trouble obtaining proper authorization for scheduled II-V medications when a resident is admitted. Staff C stated "this has been ongoing since we opened" (seven months ago). Staff C stated "this has been brought up today (02/15/13) in our QA&A meeting with corporate." (refer to F246 CRF 483.15(c) Accommodation of Needs for further information). On 02/25/13 at 11:28 a.m. Staff B was interviewed and stated as a part of QA&A, employee files are audited every 3-6 months for accuracy. Per recorded review of employee files, 2 employees hired in October of 2012 did not have background checks completed (see F226). The facility did not have an effective system to identify quality care concerns to address in the QA&A committee and did not have an effective plan in place to ensure facility protocols were followed which put the residents at risk for decreased quality of care.</p>	F 520		