



Nursing Home Survey Report
STATE AND CORRESPONDING FEDERAL REQUIREMENTS

1. Page 1 of 2 Pages

2. DATES OF DATA COLLECTION
06/15/16

5. TIME OF SURVEY Day Night
 Weekend Holiday

7. LICENSE NUMBER
1451

3. NAME OF FACILITY
Prestige Care and Rehab Burlington

4. TYPE OF SURVEY
 Full Post Complaint Other: specify _____

6. STREET ADDRESS
1036 Victoria Ave

CITY
Burlington

STATE
WA

ZIP CODE
98233

NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.

8.	9. WASHINGTON ADMINISTRATIVE CODES 388-97	10. CODE OF FEDERAL REGULATION 42 CFR 483.	11. FEDERAL DATA TAG NUMBER	12. REPEAT DEFICIENCY FROM SURVEY DATED	13. NEW CITATION ON POST SURVEY	14. LICENSEE'S PLANNED DATE OF CORRECTION
<input type="checkbox"/> The requirements of the following WAC's and corresponding CFR's were not met. The text of the statements of deficiencies and the licensee's plan of correction may be read on CMS form 2567, dated: <u>04/28/16</u> **Licensee must complete column 14. <input checked="" type="checkbox"/> The following deficiencies were determined to be corrected.	-0280 (3)(c)(i)	.10(b)(8)	F 156		<input type="checkbox"/>	06/08/16
	-640 (2)(a)(b)	.13(e)	F 226		<input type="checkbox"/>	06/08/16
	-0860 (1)(a)	.15(a)	F 241		<input type="checkbox"/>	06/08/16
	-0900 (3)	.15(b)	F 242		<input type="checkbox"/>	06/08/16
	-1000 (1)(b),(2)(l)(o)	.20 (b)(xii)(xv)	F 272		<input type="checkbox"/>	06/08/16
	-1000 (1)(b)(d)	.20(g)	F 278		<input type="checkbox"/>	06/08/16
	-1620(i)(3)	.20(k)(3)(ii)	F282		<input type="checkbox"/>	06/08/16
	-1060 (1)	.25	F 309	02/25/15	<input type="checkbox"/>	06/08/16
	-1060 (2)(b)	.25(a)(2)	F 311	02/25/15	<input type="checkbox"/>	06/08/16
	-1080 (1)	.30	F 353		<input type="checkbox"/>	06/08/16
-1080 (3)(a)*	.30(b)(1)	F 354		<input type="checkbox"/>	06/08/16	
-----	.30(e)	F356		<input type="checkbox"/>	06/08/16	

15. Surveyor's Signature(s)

SIGNATURE <i>Nedra F. Kravish</i>	DATE 06/17/2016	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

16. Licensee or Agent

SIGNATURE OF LICENSEE (OR AGENT)	TITLE	DATE
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AGING AND LONG-TERM SUPPORT ADMINISTRATION
Nursing Home Survey Report
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6. STREET ADDRESS 1036 Victoria Ave	CITY STATE ZIP CODE Burlington WA 98233

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	-2440 (1)	.70(d)(1)(ii)	F 458	02/25/15	<input type="checkbox"/>	06/08/16
	.3220 (1)	.70(h)	F 465		<input type="checkbox"/>	06/08/16
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	

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SIGNATURE <i>Nedra F. Kravits</i>	DATE 06/17/2016	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

16. Licensee or Agent		
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NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.

8. <input type="checkbox"/> The requirements of the following Washington Administrative Code (WAC) were not met: <u>388-97-1380, 388-97-1400, 388-97-1480</u>	9. REPEAT DEFICIENCY FROM SURVEY DATED	11. LICENSEE'S PLAN OF CORRECTION	12. LICENSEE'S PLANNED DATE OF CORRECTION 06/08/2016
<input checked="" type="checkbox"/> The following deficiencies were determined to be corrected.	10. NEW CITATION ON POST SURVEY <input type="checkbox"/> Yes <input type="checkbox"/> No		

DEFICIENCY
WAC 388-97-1380 states: The nursing home must develop and implement a system to ensure that facility personnel and residents have tuberculosis testing within three days of employment or admission.
WAC 388-97-1400 states: The nursing home must ensure that all tuberculosis testing is done...and read within forty-eight to seventy-hours.
WAC 388-97-1480 states: Unless the person mets the requirement for having no skin testing or only one test, the nursing home, choosing to do skin testing, must ensure that each person has the following two-step skin testing: (1)An initial skin test within three days of employment; and (2)A second test done one to three weeks after the first test.

These regulations were not met as evidenced by the following:

13. Surveyor's Signature(s)			
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	10. NEW CITATION ON POST SURVEY <input type="checkbox"/> Yes <input type="checkbox"/> No		
DEFICIENCY Based on record review and interview the facility failed to ensure tuberculosis testing was completed as required placing residents, staff and the public at risk for spread of infection. Findings include: STAFF Staff N, with a hire date of 01/20/16, did not have her first step test initiated until 02/26/16 and there was no second step done. Staff O, with a hire date of 01/22/16, had her first step done and read on the same day, 01/22/16 and there was no second step done. Staff members Q and R had the first step done as required but there was no second step done.			

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DEFICIENCY
RESIDENTS
Resident 63 was admitted [REDACTED] 16. The first step was done [REDACTED] 16 but not read. No results were documented.

Resident 24 was admitted [REDACTED] 16. The first step was done as required but there was no second step completed.

The Director of Nursing was interviewed 04/27/16 at 2:15 PM and further information of testing was requested but no further information was provided on all the above staff and residents.

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8. <input type="checkbox"/> The requirements of the following Washington Administrative Code (WAC) were not met: <u>388-97-1160</u> <input checked="" type="checkbox"/> The following deficiencies were determined to be corrected.	9. REPEAT DEFICIENCY FROM SURVEY DATED	11. LICENSEE'S PLAN OF CORRECTION	12. LICENSEE'S PLANNED DATE OF CORRECTION 06/08/2016
	10. NEW CITATION ON POST SURVEY <input type="checkbox"/> Yes <input type="checkbox"/> No		
DEFICIENCY 388-97-1160 Dietary Personnel (2) If a qualified dietitian is not employed full-time as the food service manager, the nursing home must employ a food service manager to serve as the director of food service. (3) The food service manager means: (a) An individual who is a qualified dietitian; or (b) An individual: (i) Who has completed a dietetic technician or dietetic assistant training program, correspondence or classroom, approved by the American Dietetic Association/Dietary Manager Association.			

13. Surveyor's Signature(s)			
SIGNATURE <i>Nedra J. Vanish</i>	DATE 06/15/2016	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE
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DEFICIENCY

Based on interview and record review the facility failed to provide documentation the food service manager was either a qualified dietitian or was qualified based on completion of other dietetic training. The failed practice placed residents at risk for dietary services that did not meet resident needs and placed them at risk for food-borne illness.

Findings include:

In an interview on 04/27/16 at 1:26 PM, Staff I stated she transitioned into the manager position about 3 months ago and had not completed any dietetic classes. Review of Staff I's personnel record revealed no documentation of formal training.

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

PRINTED: 05/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505378	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/28/2016
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NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - BURLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1036 EAST VICTORIA AVENUE BURLINGTON, WA 98233
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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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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Federal Off-Hours Quality Indicator Survey (QIS) at Prestige Care and Rehabilitation on 04/24/16, 04/25/16, 04/26/16, 04/27/16 and 04/28/16. The survey included data collection on Sunday, 04/24/16 from 08:40 AM to 02:50 PM. A sample of 31 residents was selected from a census of 27. The sample included 25 current residents and the records of 6 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>Nedra Vranish, R.N., B.S.N., M.S.Ed Michelle Scollard, R.N., B.S.N. Cynthia Southerly, MSN./Ed, RN Leslie Watts, R.N.</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Disability Services Aging & Long-Term Support Administration Residential Care Services, Region 2 3906 172nd Street NE, Suite 100 Arlington, WA 98223</p> <p>Telephone: (360) 651-6850 Fax: (360) 651-6940</p> <p><i>Kathy Gold</i> 5-9-16 Residential Care Services Date</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i> Administrator	TITLE	(X6) DATE 5/20/16
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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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NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - BURLINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1036 EAST VICTORIA AVENUE BURLINGTON, WA 98233		
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F 156 SS=D	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal</p>	F 156	<p>██████████ order for Resident #46 has been discontinued. Resident 46's current consents have been reviewed by resident/POA.</p> <p>Verbal consents will be cross-referenced with the signed consent. All consents for antipsychotics have been reviewed for accuracy.</p> <p>LN staff was in-serviced by Director of Nursing on 5/11/16 on completing consents forms.</p> <p>A random review of 5 resident's consents for psychotropic medications and the current medication orders will be completed quarterly and findings forwarded to the QA committee for review and recommendations as needed.</p> <p>Director of nursing/ Designee will assure compliance.</p>	6/8/16

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F 156	<p>Continued From page 2</p> <p>funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p>	F 156			

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F 156	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to honor a resident's Power of Attorney (POA) decision to not administer a psychotropic medication for 1 of 6 (46) residents reviewed for unnecessary medications. This failure placed Resident 46 at risk of experiencing side effects of a anti-psychotic medication.</p> <p>Findings include:</p> <p>Review of a physician orders revealed an order for [REDACTED] 0.5 milligram (mg) to 2 mg every 2 hours as needed for agitation and/or nausea.</p> <p>Review of the signed "Psychotherapeutic Medications Disclosure and Consent" (PMDC) form dated 02/04/16, revealed the resident's POA did not give consent for Resident 46 to receive [REDACTED]. The POA circled the [REDACTED] on the consent form and wrote "no" indicating she did not give consent.</p> <p>Review of the signed anti-anxiety PMDC form, dated 02/04/16, revealed the POA checked the box stating she declined the use of the medication and wrote the medication [REDACTED]. Again, indicating she did not want Resident 46 receiving the [REDACTED].</p> <p>Review of the Medication Administration Record (MAR) from February to April revealed Resident 46 received the [REDACTED] 7 times in February, 4 times in March and twice in April.</p>	F 156		
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F 156	Continued From page 4 In an interview on 04/27/16 at 1:20 PM, the Director of Nursing Services was not able to provide any further information regarding why Resident 46 received the [REDACTED] when the POA did not give consent.	F 156		
F 226 SS=D	<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 observation, interview and record review the facility failed to implement their abuse and/or neglect policy and procedure for 1 of 4 residents (9) reviewed for an bruises of unknown origin on the resident's thigh. This failure placed the resident at risk of abuse/neglect and/or further injury when a resident with bruises of unknown origin were not investigated for the cause.</p> <p>Additionally, the facility failed to ensure new staff members were screened per regulation to prohibit mistreatment, neglect and abuse of residents related to checking criminal background inquiries and Omnibus Reconciliation Act (OBRA) nurse aide registry for 4 of 9 staff members (N, O, P and Q). This failure placed residents at potential risk for receiving care from a staff member with a disqualifying criminal history.</p>	F 226	<p>Staffs N, O, P, and Q, have had an updated background check and OBRA completed. An investigation was completed on resident 9</p> <p>Nursing staff OBRA and background checks were reviewed for accuracy/ completion. BOM was in-serviced by Administrator on background checks and OBRA compliance on 5/25/16. Progress notes reviewed 5/18/16 for current resident skin conditions.</p> <p>New employee audits will be completed by the business office manager within 14 days of hire.</p> <p>New skin conditions will be monitored through the MACC process. Suspicious skin conditions of unknown cause will be investigated to determine cause and/or rule out abuse.</p>	

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F 226	<p>Continued From page 5</p> <p>Findings include:</p> <p>RESIDENT 9 The facility's "Accident/Incident" policy stated an incident investigation was done when an injury of unknown origin was found (which included bruises). The incident report was to be completed by the charge nurse at the time of the incident.</p> <p>According to the Minimum Data Set assessment dated 03/01/16, Resident 9 was a long term care resident with no cognitive impairment.</p> <p>Review of a nursing progress note, dated 03/09/16, revealed two bruises were found on the top of the resident's [redacted] thigh. One bruise measured 7 centimeter (cm) by 3 cm and the second bruise was 3 cm by 1.5 cm. Resident 9 did not know how the bruises occurred.</p> <p>Review of the state reporting log revealed the bruises were not investigated or logged.</p> <p>In an interview on 04/27/16 at 12:40 PM, Staff E, Licensed Nurse (LN), stated when a bruise was found and the resident was not able to state how it happened, the LN initiated an investigation.</p> <p>The facility policy for: EMPLOYMENT OF NEW STAFF MEMBERS It is the responsibility of the nursing home to: Check the (OBRA) Nurse Aide Registry to ensure OBRA certification, prior to the employment of a nursing assistant.</p> <p>Conduct criminal history background checks on</p>	F 226	<p>LN's re in-serviced regarding the Abuse/ Neglect Policy on 5/11/16 by Director of Nursing.</p> <p>Business office compliance audits and a review of suspicious skin conditions and their follow-up investigations will be summarized and reviewed by the QA committee for further recommendations.</p> <p>DNS and Administrator/ designee will assure compliance.</p>	6/8/16

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F 226	Continued From page 6 all staff, volunteers, and students who have unsupervised access to vulnerable adults, within 72 hours of hire date. Ensure all staff, including agency-contracted personnel, are free of any disqualifying criminal history. On 04/27/16 employee records were reviewed and revealed the following: Staff N, with a hire date of 01/20/16 did not have a background inquiry completed until 04/01/16. Staff O, with a hire date of 01/22/16 had an original background inquiry sent 01/14/16 but a report was never received and there had been no follow-up. Staff P, with a hire date of 03/14/16, had no verification of nurse aide registry completed. Staff Q, with a hire date of 03/28/16, had no verification of nurse aide registry completed.	F 226			
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide a dignified and homelike meal	F 241			

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F 241	<p>Continued From page 7</p> <p>service to residents in 2 of 2 dining observations in the main dining area of the facility. Failure to provide meal service that was organized and was conducted with respect of individual needs and wishes placed all residents who received their meals in the main dining area at risk for lowered self-esteem, psychosocial harm and potential decline in nutritional status.</p> <p>Findings include:</p> <p>INITIAL DINING OBSERVATION FOR THE LUNCH MEAL ON SUNDAY, 04/24/16 According to the meal service schedule provided by the facility, lunch was to be served at noon.</p> <p>During the lunch time meal observation on 04/24/16 beginning at 11:52 AM the following was observed: a large dining room with 8 tables. Two of the tables were just outside the main dining room going down a hallway. Residents who required assistance dined at these two tables.</p> <p>At 12:08 PM, the kitchen staff started to pass out beverages.</p> <p>The first lunch tray was delivered to a table 1 with two residents. Resident 19 received her meal at 12:15 PM and Resident 8 received her meal at 12:17 PM. Resident 8's wheelchair was positioned approximately 2 feet away from the table. Staff did not reposition the resident closer to the table after the lunch tray was served.</p> <p>The last tray was served at 12:27 PM to table 7.</p> <p>At 12:32 PM, Staff S delivered Resident 14's meal to her room. Staff S asked Staff G, cook, if</p>	F 241	<p>Resident 8, 29, 19, 15, 3, 20, 26, 13, 14, 4, 6, 63, 25, 65 were reviewed for seating preferences and meal service. Staffs G, D, J, T, C, K, and F have been re in-serviced regarding dining dignity</p> <p>New serving guide with resident identifiers and seating preferences was completed for kitchen and nursing staff on 5/11/16 by Director of Nursing.</p> <p>In-service on dining dignity will be completed at staff meeting 5/25/16 by Director of Nursing.</p> <p>Manager Dining Room Review will be conducted weekly for the next 90 days.</p> <p>Review of the dining experience will be discussed at the next quarterly QA meeting.</p> <p>Administrator/ designee will assure compliance.</p>	6/8/16

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F 241	<p>Continued From page 8</p> <p>there were any other resident's that had not received their meal. Staff G stated Resident 14 was the last resident to be served.</p> <p>In a continuous observation of table 1 beginning at 12:33 PM, Resident 8 had not consumed any of the meal. Staff had not cued her or offered her assistance.</p> <p>At 12:39 PM, staff G approached Resident 8 but did not offer her any assistance or replacement.</p> <p>At 12:43 PM, Staff D asked Resident 8 what she wanted for dinner, but did not offer her any assistance with the meal.</p> <p>At 1:00 PM Staff J, Nursing Assistant (NA), recorded the Resident 8's food intake. The resident had not consumed any of her food and staff did not cue her to eat or offer her another food choice.</p> <p>In a continuous observation of table 7, where three residents were seated (Resident's 4, 6, 63) and Resident 25, who was seated between table 7 and 8 in his wheelchair, with a bedside table in front of him, the following was observed:</p> <p>Resident 4 received her meal at 12:22 PM. The meal was left with the cover in place.</p> <p>Resident 25 received his meal at 12:26 PM. Staff set his tray up by preparing the burger and cutting up food.</p> <p>At 12:27 PM Resident 6 was served her meal. uncovered and Resident 63 was served his meal with the cover left in place.</p> <p>At 12:30 PM, Staff T, Licensed Nurse (LN), sat down at table 7 and began to assist Resident 4 and 63 with their meal.</p>	F 241		

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F 241	<p>Continued From page 9</p> <p>At 12:33 PM, Staff J, NA, came over to help Resident 25 with his meal. Prior to Staff J assisting the resident with his meal he was observed having difficulty manipulating the utensils. Resident 25's fluids had straws. Resident 25 was able to lean forward and take a sip of fluids using the straws.</p> <p>At 12:35 PM, Resident 63 needed to use the bathroom. Staff T and J assisted the resident to the bathroom leaving the three residents, who required assistance, with no one to assist them.</p> <p>At 12:44 PM, nine minutes later, Staff K, NA, came over to assist Resident 4 with her meal.</p> <p>At 12:44 PM, Resident 25 had picked up a bowl and was trying to bring food up to his mouth using a fork. The resident was not able to lift the fork to his mouth without dropping the food on the table. Resident 25 continued to feed himself by leaning forward as he brought the fork up to his mouth, and the food continued to fall off the fork and onto the table.</p> <p>At 12:47 PM, Resident 63 was brought back to the table. Staff K sat down to help Resident 63 at 12:50 PM.</p> <p>At 12:48 PM, Staff K sat down next to Resident 25 and assisted him with his meal.</p> <p>At 12:50 PM, Staff K moved over to Resident 63 and helped him with his meal, leaving Resident 25 with no assistance.</p> <p>The observation concluded at 1:00 PM.</p>	F 241		

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F 241	<p>Continued From page 10</p> <p>SECOND MEAL OBSERVATION FOR THE BREAKFAST MEAL ON TUESDAY, 04/26/16 The observation began at 7:30 AM. There were 5 residents in the dining area. Meal trays were scheduled to be served at 8:00 AM. The television was on and a Lucille Ball sitcom was playing.</p> <p>At 8:00 AM Resident 29 stated, "You know what I don't like about this place?" They tell you breakfast is at 8 but you sit and sit and sometimes it doesn't come until 9:30."</p> <p>By 8:09 AM there were 12 residents present in the dining area.</p> <p>At 8:10 AM Staff F, Licensed Nurse (LN), approached Resident 15 with yogurt and told her her blood sugar was a little low and proceeded to feed her bites of yogurt, standing slightly behind and to the resident's right side.</p> <p>At 8:13 AM a small cart of breakfast trays passed through the dining room to be delivered to residents eating in their rooms.</p> <p>At 8:15 AM Residents 15, 3, 26 and 20, seated at tables in the dining room were observed dozing.</p> <p>At 8:16 AM the first two trays were delivered to Residents 3 and 13, seated at different tables.</p> <p>At 8:18 AM, Resident 14 was sitting at table 5 by herself. Staff delivered a covered plate of food to an empty spot next to the resident.</p> <p>At 8:22 AM, Resident 26 was taken to the bathroom.</p>	F 241		

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F 241	Continued From page 11 At 8:22 AM Resident 29 stated, "See what I mean, (as staff member was observed setting-up another resident's meal), we wait for them to put jelly on toast while we wait for a warm breakfast." At table 7, three residents (4 ,6, 63) were seated together. At 8:22 AM, Resident 4 was served. At 8:25 AM, Resident 6 was served her meal. At 8:32 AM, Resident 63 was finally served his meal. At 8:25 AM the breakfast tray was delivered to Resident 15, the tablemate of Resident 29. Staff E, LN, assisted Resident 15 with set-up of her meal, picking up her toast with her bare left hand to put jelly on the toast. At 8:30 AM Staff E wheeled a male resident, who had finished his breakfast, out of the dining area. At 8:30 AM, Staff M, NA, sat down and assisted Resident 4 with her meal. At 8:35 AM Residents 15 and 29 were having a conversation about breakfast being served late. Resident 29 had not yet received her meal. There were no staff members in the main dining area at this time. Resident 15 pushed her plate over to Resident 29. Resident 29 proceeded to finish the partially eaten egg from the plate of Resident 15. At 8:34 AM, Staff J sat down and began to assist Resident 6 with her meal. One minute later, Staff J got up to answer a call light, leaving the resident unassisted. At 8:36 AM, 18 minutes after the tray was delivered to the empty spot, Resident 14 was	F 241			

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F 241	<p>Continued From page 12 trying to reach for the plate of food.</p> <p>At 8:38 AM meals were delivered to Residents 29 and 5, seated at the same table as Resident 15, almost 15 minutes after Resident 15 had been served.</p> <p>At 8:39 AM, Resident 14 called out to Staff G and asked her if that was her food sitting at the table. Staff G stated it was not and obtained the resident's tray off of a cart.</p> <p>At 8:40 AM Resident 26, who had been wheeled out of the dining room at 8:20 AM, was returned to her place in the dining room. She declined her plate of food so staff removed it and left her cold cereal at her request.</p> <p>At 8:43 AM, Staff G delivered a hall tray to Resident 65.</p> <p>Resident 14 was observed trying to take a bite of her ham, but was not able to because it was not cut up. At 8:44 AM, Staff E assisted the resident with her ham.</p> <p>The observation concluded at 8:50 AM</p> <p>In an interview at 9:08 AM, Resident 65 stated her breakfast was late. She stated she kept looking at the clock and wondered what had happened.</p> <p>At 9:13 AM, Staff J stated the timing of the breakfast meal could have been better.</p> <p>At 9:43 AM, Staff C, NA, stated the breakfast meal could have been a little late as "they were cooking eggs," but other than that the meal</p>	F 241		

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F 241	Continued From page 13 service was fine.	F 241		
F 242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to address resident's "customary routine" in a manner accessible to staff caring for residents for 3 of 3 sampled resident's (14, 34, 47). This placed residents at risk for diminished quality of life.</p> <p>Findings include:</p> <p>RESIDENT 14 Resident 14 was admitted to the facility in 2011. According to the resident's Minimum Data Set (MDS) assessment, dated 03/28/16, she required 1 person staff assist with bathing. The MDS also indicated she occasionally had both urinary and bowel incontinence.</p> <p>In an interview on 04/25/16 at 2:58 PM, Resident 14 stated she was not getting to bathe as frequently as she preferred. She said when she</p>	F 242	<p>Residents 14, 34, and 47 were re-interviewed for bathing preferences. Schedules for current preferences were updated accordingly.</p> <p>Residents have been re-interviewed to obtain bathing preferences.</p> <p>New admissions will be interviewed by the Social Services Director on bathing preferences at the 72 hour care conference.</p> <p>Social Services Director will review quarterly during care plan review and make updates accordingly.</p> <p>DNS will review bathing schedules weekly for 4 weeks and compare to resident preferences and report trends at the next QA meeting.</p> <p>Director of Nursing/ designee will be assure compliance.</p>	6/8/16

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F 242	<p>Continued From page 14 lived at home she used to bathe daily.</p> <p>Review of Resident 14's Bath Sheets revealed she had 1 bath weekly from 12/01/15 through 04/27/16.</p> <p>RESIDENT 34 Resident 34 was admitted to the facility in [REDACTED] 2016. According to the MDS assessment dated 03/30/16, she required a 1 person staff assist with bathing. The MDS indicated she was frequently [REDACTED]</p> <p>In an interview with her responsible party on 04/25/16 at 12:22 PM, it was revealed no aspects of her routine for bathing, rising, going to bed are the same as her life prior to admission. He was unable to provide any additional information.</p> <p>Review of Resident 34's Bath Flow Sheets revealed she had 1 bath weekly since admit.</p> <p>RESIDENT 47 Resident 47 admitted to the facility in [REDACTED] 2015. According to the resident's MDS assessment dated 03/23/16, she required a 1 person assist for bathing. The MDS also indicated she was frequently [REDACTED]</p> <p>In an interview with Resident 47 on 04/25/16 at 11:35 AM, she stated she was used to daily baths. She indicated she would like more baths. The resident stated that she got one bath a week on a day the facility chooses.</p> <p>Review of Resident 47's Bath Flow Sheets revealed she had 1 bath weekly since admit.</p> <p>In an interview on 04/27/16 at 4:06 PM, Staff A,</p>	F 242		
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F 242	<p>Continued From page 15</p> <p>Social Services Director, indicated she assessed resident bathing and wake/sleep preferences during the 72 hour care conference. She indicated they were filed in her office, not accessible to staff.</p> <p>In interviews on 04/28/16 at 10:21 AM, Staff B and at 10:25 AM with Staff C, Nursing Assistant Certified (NAC), both stated all residents got 1 bath weekly. They indicated that there was no documented area to identify resident preferences.</p> <p>In an interview on 04/28/16 at 10:25 AM, Staff D, NAC, said the facility arranged the shower schedule and would change the day of shower if the resident requested. She indicated there was no resident option to have the choice for bedtime or weekend bathing.</p> <p>During record review, it was revealed baths or showers were offered Monday through Friday on day shift (hours of 6:00 AM to 2:00 PM). There was no care plan development to alert staff of resident's preferences for bathing.</p>	F 242			
F 272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified</p>	F 272			

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F 272	<p>Continued From page 16 by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to comprehensively assess and follow their Skin at Risk policy for 3 of 3 resident's (9, 46 and 17) reviewed for bruises.</p> <p>Additionally, the facility failed to perform comprehensive assessments to evaluate bilateral</p>	F 272	<p>Comprehensive assessments for residents 9, 46, 17 and 14 have been updated to reflect current skin conditions and care needs.</p> <p>Comprehensive assessments for residents monitored on the TAR for skin conditions have been reviewed by Director of Nursing.</p> <p>LN in-service completed by Director of Nursing reviewing policy and procedure on skin.</p> <p>Compressive assessments for resident with braces have been reviewed and updated by Director of Nursing.</p> <p>Director of Nursing will audit TAR vs. Care Plan monthly for 3 months. Results will be reviewed at the next QA meeting.</p> <p>Director of Nursing will assure compliance.</p>	6/8/16
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F 272	<p>Continued From page 17</p> <p>foot braces for 1 of 1 sampled resident's (14) reviewed for braces. The failure to ensure accurate assessment placed the resident at risk for unidentified or unmet care needs, potential identification of injuries of unknown origin and deterioration in range of motion.</p> <p>Findings include:</p> <p>BRUISES The facility's policy "Skin at Risk/Skin Breakdown" stated a full body audit would be completed weekly by the Licensed Nurse (LN). The weekly skin audit was documented on the Treatment Administration Record (TAR) with either a minus sign (indicating no new skin impairment) or a plus sign (indicating a new skin impairment). New skin impairments were measured and documented on the proper tracking form.</p> <p>In an interview on 04/26/16 at 1:17 PM, the Director of Nursing Services (DNS) stated when a resident was admitted to the facility or when directed by the DNS, the LN was expected to perform daily skin assessments. The skin assessments were to be done daily until further direction by the facility's nurse management team. For example, bruises and skin tears would be tracked weekly on the Skin Grid for Non-Pressure Related Skin Impairment form.</p> <p>RESIDENT 9 Resident 9 was a long term care resident with a diagnosis to include mild [redacted] sided weakness. According to the Minimum Data Set (MDS) assessment, dated 03/01/16, the resident had no cognitive impairment.</p> <p>In an observation on 04/24/16 at 11:10 AM, a</p>	F 272		

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F 272	<p>Continued From page 18</p> <p>bruise was noted on the back of Resident 9's [REDACTED] hand.</p> <p>Review of the April TAR directed the LN to assess the resident's skin daily. The LN documented a "-" (minus sign) sign daily indicating the resident had no new skin issues.</p> <p>There was no documentation indicating the bruise had been assessed.</p> <p>In an interview on 04/25/16 at 8:55 AM, Resident 9 stated she obtained the bruise because staff used her [REDACTED] hand to turn her onto her [REDACTED] side.</p> <p>In an interview on 04/27/16 at 12:40 PM, Staff E, an LN, was not aware of the bruise to the resident's [REDACTED] hand.</p> <p>RESIDENT 46 Resident 46 was admitted [REDACTED] 2015 with a diagnosis to include [REDACTED] Resident 46 was not interviewable.</p> <p>In an observation on 04/26/16 at 1:50 PM, a bruise was found on the [REDACTED] side of the resident's neck.</p> <p>Review of the April TAR directed the LN to perform a skin assessment daily. The LN documented a plus sign daily indicating the resident had a new skin impairment. There was no documentation regarding the neck bruise on a Skin Grid for Non-Pressure Related Skin Impairment.</p> <p>There was no documentation the bruise had been assessed.</p>	F 272		

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F 272	<p>Continued From page 19</p> <p>In an interview on 04/27/16 at 12:45 PM, Staff E, an LN, observed the bruise on the [REDACTED] side of the resident's neck. Staff E was not aware of the bruise or how it occurred.</p> <p>Review of the April TAR on 04/27/16 revealed the bruise measured 3 cm (centimeter) x 2 cm.</p> <p>RESIDENT 17 Resident 17 was admitted [REDACTED] 2013.</p> <p>In an observation on 04/25/16 at 09:45 AM, a dark purple bruise to the resident's left elbow was observed.</p> <p>Review of the Medication Administration Record (MAR) for April 2016 indicated the resident was to receive a daily skin assessment, to identify any skin issues. There was no documentation on the MAR to indicate Resident 17 had a bruise to her elbow.</p> <p>Record review done on 04/27/16 revealed no documentation of a bruise in the progress notes, care plan, and skin assessment form.</p> <p>In an interview on 04/27/16 at 10:58 AM Staff F, an LN stated she was unaware of the bruise to the residents [REDACTED] elbow. She reviewed the chart and acknowledged there was no documentation in the record.</p> <p>BRACES/SPLINTS Resident 14 admitted to the facility [REDACTED] 2011 with diagnoses to include [REDACTED] and [REDACTED].</p> <p>[REDACTED]. The care plan directed staff to re-approach Resident 14 for braces or alternative positioning devices. The failure to reapproach the brace</p>	F 272		

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F 272	<p>Continued From page 20</p> <p>placed the resident at risk for pain, decreased mobility and a decline in range of motion.</p> <p>Review of the Minimum Data Set assessment tool, dated 03/28/16 indicated the resident had lower extremity impairment on both sides. The resident required assist of one person for bed mobility, and locomotion and two person assist for transfers and toileting assistance. A wheelchair was utilized for mobility as she was unable to walk.</p> <p>The resident was observed without foot braces on either foot on 04/25/16 at 1:21 PM, 04/26/16 at 8:11 AM, 04/27/16 at 9:10 AM, and 04/28/16 at 8:58 AM.</p> <p>In an interview with the resident on 04/27/16 at 9:28 AM, she stated "I have special shoes but I don't know where they are." When asked about braces she stated "I don't have them."</p> <p>The care plan developed 10/02/12 stated resident refuses to wear bilateral foot braces. Re-approach quarterly. There was no mention of bilateral foot braces on the restorative evaluation dated 01/22/16 or quarterly nursing assessment on 03/28/16. The most recent therapy evaluation on 12/24/15 was for the purpose of evaluating the resident for a custom wheelchair. There was no mention of foot braces.</p> <p>In an interview with the Director of Nursing Services on 04/27/16 at 10:47 AM, she stated braces had been tried but unsuccessful as resident refused to wear them.</p> <p>In an interview on 04/28/16 at 9:01 AM, Staff E, an LN, stated "She will not wear them; she is set</p>	F 272		

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F 272	Continued From page 21 in her ways."	F 272			
F 278 SS=E	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record</p>	F 278	<p>Residents 8, 9, 29, 20 and 22 have been referred to therapy services for assessment.</p> <p>Residents receiving restorative nursing programs, MDS' and care plans have been reviewed and updated.</p> <p>Restorative nursing program and MDS coding educational materials have been provided to and reviewed with the restorative nursing staff and MDS nurse.</p> <p>Restorative nursing programs will be updated quarterly by Restorative nurse and in accordance with individual needs. Trends on participation and staffing will be tracked by QAPI committee.</p> <p>Director of Nursing will assure compliance</p>	6/8/16	

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F 278	<p>Continued From page 22</p> <p>review the facility failed to ensure 5 of 8 sample residents (8, 9, 19, 20 and 22), identified with Restorative Nursing Programs (RNP's), met all Resident Assessment Instrument (RAI) requirements for completion/coding of the Minimum Data Set (MDS) assessments. The failed practice placed residents at risk to receive services that did not meet their needs and decline in condition.</p> <p>Findings include, but may not be limited to:</p> <p>Per the RAI manual, restorative programs include nursing interventions that assist or promote residents' ability to attain their maximum functional potential. Restorative care for residents must include measurable objectives with interventions documented in the care plan and clinical record and periodic evaluations by the licensed nurse. The nursing assistants (NA's) must be trained in the techniques to promote resident involvement, groups can not include more than four residents per supervising helper or caregiver and each separate program must be practiced for at least 15 minutes per 24 hour period.</p> <p>Additionally, the program activities are to be individualized to the resident's needs, planned, monitored, evaluated and documented in the resident's medical record. The activities require physical or verbal cueing, and/or task segmentation provided by a staff member.</p> <p>Restorative Nursing Programs include: Range of motion (passive), Range of motion (active), Splint or brace assistance, bed mobility, transfer, walking, dressing and/or grooming, eating and/or swallowing, amputation/prostheses care and</p>	F 278			

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F 278	<p>Continued From page 23 communication.</p> <p>RESIDENT 22 Resident 22 had resided in the facility since 2009. According to the restorative flowsheet her restorative activities were as follows: AAROM (active assisted range of motion) both upper extremities, reaching up for objects such as cones, peg board once a day, arm bike for 10 minutes 2-3 X's (times) per week, once a day, group exercise 2-3 X's per week once a day and standing frame for 10 minutes 2-3 X's per week once a day.</p> <p>Review of the MDS assessment, dated 12/20/15, indicated a splint or brace assistance program was completed 1 time during the 7-day assessment period.</p> <p>Restorative review documentation, dated 01/08/16, addressed her functional level and revealed she had received physical therapy, ending 12/24/15, for shoulder and foot contracture's and her transfers "appear improved." The goal of her restorative programs stated, "to maintain abilities." There were no changes to the care plan. The care plan listed the activities as above with no documentation related to the use of a splint/brace.</p> <p>The most recent restorative review documentation, dated 02/26/16, listed her restorative activities, addressed her functional level and stated the resident had reset the long term goal to "maintain functional abilities."</p> <p>The care plan included the problem, Impaired physical mobility related to diagnosis of weakness, pain and debility as exhibited by</p>	F 278			

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F 278	<p>Continued From page 24</p> <p>inability to ambulate or stand independently. The goal was for the resident to maintain the ability to use a sit to stand (device) with transfers. The restorative activities were listed approaches.</p> <p>The MDS assessment, dated 03/09/16, indicated AAROM (active ROM) was completed 2 times during the 7-day assessment period.</p> <p>Restorative assessment and re-evaluation data did not indicate what functional deficits exhibited by Resident 22 a RNP would be used to improve or maintain. The change in program coded on MDS assessments was without rationale. The stated goals were not measurable or objective and progress toward a goal was not adequately addressed to ensure the resident's RNP were meeting her individualized needs to achieve and/or maintain function and range of motion.</p> <p>RESIDENT 20 Resident 20 had resided in the facility since 2009. She had no cognitive deficits and was independent in all of her activities of daily living. According to the restorative flowsheet her restorative activities included the following: Resident comes out to main dining room to do exercise video independently 5 times per week and Resident likes to do the NuStep machine independently, just remind her to do (best time is after [REDACTED])</p> <p>Review of the most recent MDS assessment, dated 03/17/16, indicated an AAROM program was completed 2 times during the 7-day assessment period.</p> <p>The most recent restorative review documentation, dated 03/16/16, stated the</p>	F 278		

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F 278	<p>Continued From page 25</p> <p>resident is alert and oriented and in charge of her own restorative program. She is independent in ambulation, transfers and bed mobility. She used the NuStep independently with occasional reminders and was maintaining her functional status.</p> <p>The care plan included the problem, Potential for problems with ambulation and/or mobility related to passive lifestyle. The goal stated, Resident will continue to ride NuStep machine independently. The restorative activities were listed approaches.</p> <p>Restorative assessment and re-evaluation data did not indicate what functional deficits exhibited by Resident 20 a RNP would be used to improve or maintain. There was no indication Resident 20 required a staff member to cue or assist with task segmentation. The stated goal was not measurable or objective.</p> <p>After breakfast, on the morning of 04/25/16, several residents were observed in the main dining room when an exercise video was started by the activity director. Resident 20 was one of the residents actively participating with the video. No verbal cueing was given during the exercises.</p> <p>RESIDENT 9 Resident 9 had resided in the facility since 2012. According to the restorative flowsheet her restorative activities were as follows: Ambulate in parallel bars with gait belt and restorative aide the length of bars, increase to 3 X: 2-3 X's per week once a day, AAROM to right side upper and lower extremities 10 repetitions 2-3 X's per week once a day, NuStep at level 3 X 15 minutes 2-3 X's per week once a day and PROM to [redacted] upper and lower extremities, 10 repetitions 2-3 X's per</p>	F 278		

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F 278	<p>Continued From page 26 week once a day.</p> <p>Review of the 2 most recent MDS assessments, dated 11/30/15 and 03/01/15 indicated the resident had completed AAROM 1 day during the 7-day assessment period.</p> <p>The most recent restorative review documentation, dated 02/19/16, revealed the resident had a diagnosis of stroke with [redacted] sided weakness and [redacted]. She reportedly had done well with a change from ambulation in the hall to ambulation in the parallel bars, having met the goal with level of participation in the activities.</p> <p>The care plan included the problem, Impaired physical mobility related to history of [redacted] as exhibited by [redacted] sided weakness. The goal stated, "will be free from injury." The restorative activities were listed approaches.</p> <p>Restorative assessment and re-evaluation data did not indicate what functional deficits exhibited by Resident 9 a RNP would be used to improve or maintain. The stated goal was not related to self-performance of function, nor achieving or maintaining optimal functional level. There was no documentation restorative nursing programs were meeting her individualized needs to achieve and/or maintain function and range of motion to prevent decline and optimize her quality of life.</p> <p>There were similar findings in review of Residents 8 and 19. Assessment data did not indicate what functional deficits exhibited by the residents were used to develop restorative nursing programs. Goals were not measurable/objective and re-evaluations did not address progress toward the resident's self performance of function or their</p>	F 278		
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F 278	Continued From page 27 achievement or maintenance of function and range of motion to ensure the program met their needs. On 04/26/16 at 9:30 AM Staff L, the MDS coordinator, was interviewed regarding coding of restorative nursing programs for completion of the assessment. She stated she only reviewed the restorative flowsheets. If the 15 minute minimum time of participation was met she counted that day.	F 278			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to consistently implement the care plan for 2 of 20 sampled residents (19 and 46) for whom implementation of care plans were reviewed. Failure to consistently implement planned care placed residents at risk for negative consequences of unmet care needs. Findings include: RESIDENT 46 Resident 46 was admitted [REDACTED] 2015 with a diagnosis to include [REDACTED] Review of the accommodations care plan	F 282			

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F 282	<p>Continued From page 28 indicated the following: -The bed was against the wall for the resident's comfort and safety. The care plan did not direct which side of the bed was to be against the wall -There was a fall mat on the floor. The care plan did not indicate which side of the bed the fall mat was to be placed -Protective boots were to be on both feet -The resident's blood pressure was to be monitored daily on the Medication Administration Record (MAR).</p> <p>Review of the February to April MAR revealed the resident's blood pressure was not assessed twice daily.</p> <p>On 04/24/16 at 10:48 AM, 11:10 AM, 11:40 AM, 1:00 PM and 1:40 PM, the resident was observed lying in bed. The bed was not against the wall, no protective booties were on his feet, and there was no fall mat in place.</p> <p>On 04/25/16 at 8:55 AM, 10:12 AM, 11:00 AM the resident was observed in bed. The bed was not against the wall, no protective booties were on his feet, and there was no fall mat in place. In additional observations made at 11:30 AM, 12:45 PM and 1:40 PM the resident did have a protective bootie on his left side, but it was not properly placed. The other care plan interventions were not observed to have been implemented.</p> <p>On 04/26/16 beginning at 7:30 AM until 3:00 PM, the resident was observed in bed. The only care plan intervention in place was a purple bootie to the left foot. The bootie was improperly placed around his ankle and not his heel.</p>	F 282	<p>Staff E and M have been in-serviced by Director of Nursing regarding care plans directives for residents 19 and 46.</p> <p>In-service completed by Director of Nursing with staff on location of care plans and how to reference.</p> <p>Care plans will be reviewed quarterly and with significant change.</p> <p>Director of Nursing or designee will do weekly rounds/audits for 4 weeks to ensure in room care plans are being followed. The audit results will be forwarded to the QAPI committee for review.</p> <p>Director of Nursing will assure compliance.</p>	6/8/16	

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F 282	Continued From page 29 At 3:00 PM, a green fall mat was observed on the left side of the resident's bed. Similar observations were made on 04/27/16 and the morning of 04/28/16. In an interview on 04/27/16 at 1:10 PM, Staff E, a Licensed Nurse, stated she was not aware the resident was to have protective boots in place. Staff E was not able to provide any further information regarding why the care plan interventions had not been in place on all days of the survey. In an interview on 04/28/16 at 11:01 AM, Staff M, a Nursing Assistant, was not aware the resident's bed was to be against the wall or where the right protective bootie was. RESIDENT 19 Resident 19 had resided in the facility since 2013. A directive on the MAR indicated vital signs were to be done on a monthly basis. Review of the clinical record for March and April, 2016 revealed no vital signs had been documented on the MAR. On 04/28/16 at 10:30 AM the Director of Nursing Service was interviewed regarding missing vital signs for Resident 19. No further information was provided.	F 282			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309			

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F 309	<p>Continued From page 30 accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents received appropriate care and services for 1 of 3 sampled resident's (46) reviewed for positioning. This failure potentially placed Resident 46 at risk for developing pressure ulcers, experiencing discomfort and unmet care needs related to being left in the same position for extended periods of time.</p> <p>Findings Include:</p> <p>Resident 46 was admitted [REDACTED] 2015 with a diagnosis to include [REDACTED]. According to the Minimum Data Set assessment, dated 02/04/16, Resident 46 required extensive assistance of one person for bed mobility and was totally dependent in transfers and toileting. Resident 46 was not interviewable.</p> <p>Review of the care plan indicated the resident was on a "check and change" program every two hours for incontinence and to have protective booties on both feet when in bed.</p> <p>Review of the April Treatment Administration Record (TAR) indicated the resident was to have a [REDACTED] cushion under his legs to keep pressure off of his heels. The LN had documented the cushion was in place every shift.</p> <p>Review of the daily assignment sheet indicated</p>	F 309	<p>Care plan and assessment have been reviewed and updated for resident #46 In-service completed with staff regarding the plan of care for resident 46.</p> <p>Nursing staff has been in-serviced regarding the "check and change" policy.</p> <p>Residents that require extensive assist with bed mobility will be randomly observed during direct care to assure care plan compliance. This will be done one time a week for 4 weeks.</p> <p>Findings will be reported at the next QA meetings.</p> <p>Director of Nursing will assure compliance.</p>	6/8/16

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F 309	<p>Continued From page 31</p> <p>there were 2 Nursing Assistant's (NA) working the day shift on 04/24/16 and 04/25/16.</p> <p>Resident 46 was on a "check and change" program. The facility posted a "check and change" flow sheet daily on the back of the resident's door. The staff were to fill out the form every two hours when they provided care to the resident and indicated the position of the resident by indicating if the resident was facing the door, window or lying on his back. The resident's door and window were located on the same side of the room.</p> <p>On 04/24/16 at 10:48 AM, 11:10 AM, 11:40 AM and 1:00 PM, the resident was observed lying on his back. The resident was sleeping in the same position with each observation. There was no Keene cushion or protective booties in place.</p> <p>At 1:40 PM, the resident was noted to be sleeping on his back, but had a purple bootie on the left heel and a neutral color foam bootie on the right. The Keene cushion was not in place.</p> <p>On 04/25/16 at 8:55 AM, 10:12 AM, and 11:00 AM the resident was observed lying on his back sleeping in bed. There were no protective booties or Keene cushion in place.</p> <p>At 11:30 AM, the resident was observed in the same position. The resident did have a [REDACTED] bootie on the [REDACTED] foot. The bootie was improperly positioned around his ankle and not the heel.</p> <p>At 12:45 PM, the resident was observed in the same position. The purple boot was improperly positioned around the left ankle.</p>	F 309		
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F 309	<p>Continued From page 32</p> <p>At 1:40 PM, the resident was observed in the same position.</p> <p>Similar observations were noted on April 26th, 27th and 28th. The resident was observed to be lying on his back. With each observation the [REDACTED] cushion was not in place and the protective booties were inconsistently implemented.</p> <p>Review of the "check and change" form on all days of the survey revealed it was not filled out to verify if the resident was checked and changed every two hours.</p> <p>In an interview on 4/27/16 at 1:10 PM, Staff E, LN, stated she was not aware the resident was to have protective booties in place. Staff E was not able to provide any additional information why the resident was observed in the same position on all days of the survey.</p> <p>In an interview on 04/28/16 at 11:01 AM, Staff M, NA, was asked about the Keene cushion. Staff M stated she had just placed the Keene cushion. Staff M was not able to state why the cushion was not in place until 11:01 AM.</p>	F 309		
F 311 SS=E	<p>483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS</p> <p>A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 311		

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F 311	<p>Continued From page 33</p> <p>Based on observation, interview and record review the facility failed to ensure 7 of 8 residents (24, 9, 22, 8, 19, 3 and 14) received a Restorative Nursing Program (RNP) to assist in maintaining their current level of function as directed by the care plan. Failure to ensure resident's received their RNP placed the residents at risk for a decline in their current level of functioning.</p> <p>Findings include:</p> <p>The facility's "Restorative Nursing" policy stated residents who were assessed to have a deficit in communication, mobility, range of motion (ROM), performance of activities of daily living, eating or toileting would receive the necessary care and series to attain and maintain their highest practicable physical, mental and psychosocial well-being.</p> <p>RESIDENT 24 A review of the Minimum Data Set assessment, dated 02/29/16, revealed Resident 24 required extensive assistance of two staff members for bed mobility and transfers and was dependent with toileting and dressing.</p> <p>A review of the care plan revealed Resident 24 was on a RNP 2 to 3 times a week to maintain his current level of functioning.</p> <p>A review of the April RNP flow sheets revealed Resident 24 was offered the program 4 out of 26 days.</p> <p>RESIDENT 9 A review of the MDS assessment, dated 03/01/16, revealed the resident required extensive assistance of one person for dressing,</p>	F 311	<p>Residents 24, 9, 22, 8, 19, 3, and 14 have been referred to therapy services for re assessment for appropriate Restorative Nursing Program.</p> <p>Residents receiving restorative nursing programs have been reassessed by the Restorative nurse for measureable goals, progress, changes and participation. Care plans updated.</p> <p>New staff has been hired to accommodate current Restorative Nursing Programs.</p> <p>Restorative nursing programs will be updated quarterly by Restorative nurse and in accordance with individual needs. Trends on participation and staffing will be tracked by QAPI committee.</p> <p>Director of Nursing will assure compliance</p>	6/8/16	

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F 311	<p>Continued From page 34 toileting and transfers.</p> <p>A review of the care plan revealed Resident 9 was on a RNP 2-3 times a week to be free from injury related to [redacted] sided weakness</p> <p>A review of the 02/01/16 to 04/26/16 RNP flow sheets revealed Resident 9 was offered the program 5 out of 29 days in February and 3 out of 26 days in April.</p> <p>In an observation and interview on 04/27/16 at 9:11 AM, Staff B, Nursing Assistant (NA), transferred Resident 9 to the NuStep machine. Resident 9 was able to perform the activity with supervision. Staff B stated Resident 9 was able to perform her own range of motion exercises to her upper and lower extremities. Staff B stated Resident 9 had a routine and would self-propel led her wheelchair (w/c) down the end of each hallway and performed the range of motion exercises. Staff B was made aware when the resident did this, this could not be considered a RNP due to the resident was independent. At 9:30 AM, Resident 9 completed the NuStep and was transferred back to her w/c.</p> <p>RESIDENT 22 A review of a MDS assessment, dated 03/09/16, revealed Resident 22 required extensive assistance of 2 staff for transfers.</p> <p>A review of the care plan revealed Resident 22 was on a RNP 2-3 times a week to maintain the ability to use the sit to stand with transfers.</p> <p>A review of the 02/01/16 to 04/26/16 RNP flow sheets revealed Resident 22 received the RNP 6 out of 29 days in February and 6 out of 26 days in</p>	F 311		
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F 311	<p>Continued From page 35 April.</p> <p>RESIDENT 8 A review of a MDS assessment, dated 03/17/16, revealed Resident 8 required limited assist of one for walking.</p> <p>A review of the care plan revealed Resident 8 was on a RNP 2 -3 times a week to maintain the ability to walk from her bedroom to the dining room.</p> <p>A review of the 02/01/16 to 04/26/16 RNP flow sheets revealed Resident 8 received the RNP 6 out of 29 days in February and 6 out of 26 days in April.</p> <p>RESIDENT 19 A review of MDS assessment, dated 03/31/16, revealed Resident 19 required limited assistance of one person for dressing, extensive assist of one for toileting and supervision with set up for transfers.</p> <p>Review of the care plan revealed Resident 19 was on a RNP 2-3 times a week to maintain strength and endurance in upper and lower extremities.</p> <p>A review of the 02/01/16 to 04/26/16 RNP flow sheets revealed Resident 8 received the RNP 6 out of 29 days in February and 6 out of 26 days in April.</p> <p>RESIDENT 3 Resident 3 was admitted in [REDACTED] 2000 with diagnoses to include a [REDACTED] with [REDACTED] sided [REDACTED]. According to the resident's MDS</p>	F 311		

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F 311	<p>Continued From page 36</p> <p>assessment tool, dated 04/18/16, the resident was cognitively intact and required extensive assistance with toileting, transfers and ambulation.</p> <p>Review of Resident 3's restorative therapy care plan, dated 04/21/16, stated the resident required interventions to maintain current level of functioning with transfers and balance abilities (extensive assistance of 2).</p> <p>Review of RNP from January through April 26, 2016 revealed resident 3 did not receive the RNP 2-3 days week as directed in the care plan.</p> <p>RESIDENT 14 Resident 14 admitted to the facility [REDACTED] 2011 with diagnoses to include [REDACTED] and [REDACTED].</p> <p>[REDACTED]. According to the MDS dated 03/28/16, the resident required extensive assist for bed mobility, transfers and toileting. The resident relied on staff to push her while in her wheelchair.</p> <p>Review of Resident 14's RNP care plan, dated, 09/25/15, indicated Resident 14 would maintain range of motion to her joints at the highest level of function.</p> <p>Review of RNP flow sheets from January through April 26, 2016 revealed the resident did not receive RNP as directed on the care plan.</p> <p>In an interview on 04/27/16 at 9:11 AM Staff B stated she was the only restorative NA and worked five days a week. Staff B stated she was pulled from the RNP when there was a call-in</p>	F 311			

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F 311	Continued From page 37 and had to work the floor or had to accompany a resident to an appointment. Staff B acknowledged that February and April the resident's did not receive their RNP as directed. This was due to call-ins. On 04/27/16 at 1:20 PM, the Director of Nursing Services stated she was aware of the recent staffing challenges and the resident showers and restorative programs were not being done consistently. The DNS stated the facility was actively recruiting staff.	F 311			
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of	F 353			

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F 353	<p>Continued From page 38 duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to have sufficient qualified staffing to provide and supervise care for 8 of 27 residents (5, 9, 14, 16, 22, 29, 34, and 47). Failure to ensure residents received assistance with basic activities of daily living including bathing, and requests for assistance were met in a timely manner, as well as failure to ensure staff were supervised in a manner that enabled them to meet resident's needs placed residents at risk for diminished quality of life and unmet care needs.</p> <p>Findings include:</p> <p>During interviews on 04/24/16 and 04/25/16, 7 of 13 sample residents interviewed and 1 of 3 family members interviewed when asked "Do you feel there is enough staff available to make sure you get the care and assistance you need without having to wait a long time" answered "No".</p> <p>For example, on 04/24/16 at 1:40 PM, Resident 29 stated, she can take herself to the bathroom, but has to wait over a half hour for assistance when done.</p> <p>On 04/25/16 at 9:37 AM, Resident 5 stated, "Sometimes you really have to wait and it seems there is not enough staff here on day or evening shift".</p> <p>On 04/25/16 at 2:20 PM, Resident 22 stated, "You have to wait a long time".</p>	F 353	<p>Residents 5, 9, 14, 16, 22, 29, 34 and 47 were interviewed and affirmed current staffing, as of 5/25/16, levels are meeting their current care needs.</p> <p>Residents have been interviewed regarding sufficient staffing. Facility is continuing with recruitment and retention efforts.</p> <p>Random resident interviews will be conducted by the Social Services Director monthly for the next 3 months.</p> <p>Trends will be presented at the next quarterly QA meeting.</p> <p>Director of Nursing/ designee will assure compliance.</p>	6/8/16

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

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F 353	<p>Continued From page 39</p> <p>On 04/25/16 at 3:02 PM, Resident 14 stated, "They make you wait sometimes an hour and a half. I eat dinner in my room or else I don't get helped to bed until almost midnight".</p> <p>On 04/25/16 at 9:45 AM, Resident 16 stated, "In my opinion we have to wait a long time depending on how many patients they have".</p> <p>On 04/25/16 at 11:43 AM, Resident 47 stated, "We wait a while. The staff say they are short staffed, they say this a lot. Sometimes I wait so long I wet myself. It belittles me when I wet my pants".</p> <p>Review of the daily staffing sheets for February, March, and April 2016 revealed the facility had no bath aide on duty for 16 days out of 63 days. The bath aids only works Monday thru Friday.</p> <p>Review of the daily staffing sheets for February, March, and April 2016 revealed the facility had no restorative aide (RA) on duty for 47 days out of 63 days. The RA only work Monday through Friday.</p> <p>In an interview on 04/27/16 at 1:20 PM, the Director of Nursing Service (DNS) stated she was aware of the recent staffing challenges and the resident showers and restorative program were not being done consistently.</p> <p>In an interview on 04/27/16 at 3:58 PM, the DNS stated the normal staffing pattern for the facility was to have 2 Licensed Nurses (LN), and 3 Nursing Assistant Certified (NAC)'s on duty for day shift and evening shifts, and 1 LN and 2 NAC's on duty for night shift. Additionally, on Monday through Friday, day shift was to have 1</p>	F 353			

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F 353	Continued From page 40 restorative aide and 1 bath aide. Review of the daily staffing sheets for the months of February, March, and April 2016 revealed there was only one NAC on 02/14/16 for day shift, with a census of 31 residents. There were only two NAC's on duty for day shift on 03/05/16, 03/06/16 and 04/07/16 with a facility census of 27 residents. Review of the evening shift staffing sheets revealed only two NAC's on duty 38 shifts out of 87 days reviewed. Review of the night shift staffing sheets revealed only one NAC on duty for 16 shifts out of 87 nights reviewed. The facility census was between 25 to 32 residents.	F 353	As a 49 bed facility the DNS is available for direct care supervision and resident assessments 5 days a week.		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure a Registered Nurse (RN) was on duty directly supervising care and services at	F 354	Ongoing recruitment and retention efforts have been continued for Registered Nurses. A sign on bonus is currently being offered for weekend RN coverage. Administrator will audit recruitment practices and applicants through tracking in Vikus every 2 weeks for 3 months. Quantitative data will be reported to the QAPI team for review. Administrator will assure compliance.	6/8/16	

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F 354	Continued From page 41 least 8 consecutive hours a day, 7 days per week, as required. The failed practice placed residents at risk for lack of assessment, care planning, unmet care needs and decline in condition. Findings include: Review of the 24 hour staffing pattern for 15 days, beginning on 04/10/16 and continuing through 04/24/16, revealed 8 consecutive hours of RN coverage was provided on only 1 day of the 15 days reviewed. In an interview on 04/27/16 at 10:00 AM, the Director of Nursing Services stated, they had been unable to hire RN's. She stated she worked Monday through Friday but not as a charge nurse.	F 354			
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning	F 356			

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F 356	<p>Continued From page 42 of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to provide and maintain accurate daily posted staffing to ensure information was available to residents and the general public. The failed practice prevented residents and visitors from being accurately informed of the daily nurse staffing levels.</p> <p>Findings include:</p> <p>Review of the daily staffing posted 04/24/16 through 04/27/16 revealed the form did not contain all of the required information. The form did not contain the nursing credentials to identify Registered Nurses (RN) or Licensed Practical Nurses (LPN). The form did not include the actual hours worked by Licensed Nurses (LN) and unlicensed nursing staff directly responsible for resident care per shift. The form only indicated the predicted staffing hours.</p>	F 356	<p>Nurse Staffing Information Form has been updated.</p> <p>NOC shift LN will be responsible for initiation of the Nurse Staffing Form including nursing staff credentials for the following day.</p> <p>In-service will be done with nursing staff about completing this form daily and updating with actual hours each shift.</p> <p>DNS will audit for accuracy and completion.</p> <p>Director of Nursing/ designee will assure complianc.</p>	6/8/16

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F 371 F 371 SS=E	Continued From page 43 483.35(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 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide a dedicated hand washing sink in the kitchen. Additionally, the facility failed to ensure food was stored, prepared and served under sanitary conditions. These failed practices placed residents at risk for potential cross contamination of foods, foodborne illnesses and diminished quality of life. Findings include: KITCHEN: In an observation on 04/24/16 at 8:47 AM, there was no dedicated hand washing sink available for kitchen staff to wash there hands. In an interview on 04/24/16 at 8:47 AM, Staff G stated the sink containing dishes soaking was the hand washing sink for kitchen staff. She stated she used the hand sanitizer or the restroom sink across the hall from the kitchen, when the sink was in use.	F 371 F 371	Temporary sink with hand washing sign has been designated while the kitchen is re-plumbed. Dish machine chemicals have been removed from the store room. Staffs G, J and K have been re in-serviced by the Dietician regarding infection control. Refrigerator temperature log has been updated/replaced. Kitchen chemical sanitation mixing machine has been calibrated by the service contractor. Dietary staff has been in-serviced by the Dietary Manager re: chemical storage, chemical testing, infection control and refrigerator temperature log.		

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F 371	<p>Continued From page 44</p> <p>In an interview on 04/24/16 at 8:50 AM, Staff H stated she used the sink in the kitchen when she washed her hands. She then pointed to the sink that contained dishes soaking in the sink.</p> <p>In an observation on 04/26/16 at 7:58 to 08:30 AM, Staff H was observed on multiple occasions removing disposable gloves and not performing hand hygiene before donning new gloves.</p> <p>In an observation on 04/26/16 at 07:58 to 08:30 AM, Staff G was observed to adjust her glasses with gloved hands and then continue to serve foods, without changing her gloves. On 3 occasions she changed her disposable gloves and did not perform hand hygiene before donning new gloves.</p> <p>Review of the hand hygiene policy dated 01/16 stated Hand hygiene would be performed before and after eating or handling food (hand hygiene with soap and water) and after removing gloves or aprons.</p> <p>In an interview on 04/25/16 at 3:10 PM, Staff I stated there was no dedicated hand washing sink for kitchen staff use. Staff routinely used the double sink next to the dishwasher for hand washing. The staff also used the hand sanitizer for hand hygiene.</p> <p>DRY FOOD STORAGE: In an observation on 04/24/16 at 8:47 AM, in a kitchen closet a box containing coffee was stored directly on the floor.</p> <p>In an observation on 04/24/16 at 8:47 AM, dishwasher chemicals were observed on a rack, and also next to the freezer in the food storage</p>	F 371	<p>Dietary manager and dietician will audit monthly for 3 months: refrigerator temperature, chemical logs and infection control practices.</p> <p>Trends will be reported at the following QA meeting.</p> <p>Administrator to ensure compliance.</p>	6/8/16

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F 371	<p>Continued From page 45 area.</p> <p>In an interview on 04/24/16 at 8:47 AM, Staff G stated the dishwasher chemicals are always stored in the food storage area.</p> <p>In an interview on 04/25/16 at 12:54 PM, Staff D stated the dishwasher chemicals were placed in the food storage area about 4 months ago due to lack of space in the maintenance department storage area.</p> <p>In an interview on 04/25/16 at 01:01 PM the Director of Nursing Services (DNS) stated she was unaware of where the chemicals were being stored.</p> <p>Review of the facility chemical safety policy dated 06/2014 stated "(2) When storing chemicals, keep them separate from food".</p> <p>FOOD DISTRIBUTION:</p> <p>In an observation on 04/26/16 at 7:58 AM, Staff G was observed carrying 5 food scoops in her arm to the steam table. The food serving area of the scoops were in contact with her uniform, apron and bare arm.</p> <p>In an observation on 04/24/16 at 12:20 PM, Staff J was assisting a resident in the dining room by opening the cloth napkins that contained the residents eating utensils. When she opened the napkin she touched the eating surface of the utensils with her bare hands.</p> <p>In an observation on 04/24/16 at 12:20 PM, Staff K was placing clothing protectors on residents in the dining room. She was holding a stack of clothing protectors in her clinched bare arm, held</p>	F 371		
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F 371	Continued From page 46 against her chest touching her uniform. NOURISHMENT REFRIGERATOR: In an observation on 04/26/16 at 10:00 AM, the nourishment refrigerator log dated April 2016 indicated the temperature reading ranged from 40 to 46 degrees. Review of the refrigerator log policy stated "If the temperatures are not between 35 Fahrenheit (F) and 46 F, notify maintenance". The Washington State Retail Food Code dated May 2013 stated "The food must have an internal temperature of 41 degrees F or less when removed from cold holding temperature control". EQUIPMENT SANITIZATION: In an interview on 04/25/16 at 3:10 PM, Staff I stated the sanitizer solution used for cleaning countertops and equipment was changed every two hours. She then tested the already prepared solution with a test strip. The test strip did not change color, which indicated there was not enough sanitizer present in the solution. She then explained the procedure for washing the counters in the kitchen and explained they reuse the same rag all day.	F 371			
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced	F 458			

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F 458	<p>Continued From page 47</p> <p>by:</p> <p>Based on observation, interview and record review, the facility failed to ensure 5 residents' rooms (102,107,108, 109 and 110) measured at least 80 square feet per resident in multiple-resident rooms, and at least 100 square feet in single-resident rooms. Failure to ensure resident rooms met the regulatory requirements for square footage, placed residents at risk for living in a physical environment too small to meet their needs.</p> <p>Findings Include:</p> <p>Rm 102 177 Sq feet (3 beds) Rm 107 84 Sq feet (1 bed) Rm 108 89 Sq feet (1 bed) Rm 109 89 Sq feet (1 bed) Rm 110 89 Sq feet (1 bed)</p> <p>Observations and interviews with residents residing in the affected rooms determined that neither the health nor the safety of the residents in these rooms was compromised due to the size of their room.</p>	F 458	<p>Resident's health and safety in rooms 102, 107, 108, 109, and 110 have not been adversely affected by the room size.</p> <p>Residents have been notified, offered room moves, and have consented to the current arrangement.</p> <p>Residents in the rooms listed are reviewed quarterly for continued consent and for any negative outcomes through the care planning process.</p> <p>Social Service director or designee will assure compliance.</p>	6/8/16
F 465 SS=D	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 465		

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F 465	<p>Continued From page 48</p> <p>Based on observation and interview the facility failed to maintain a safe and sanitary environment for residents, staff and the public by not storing resident positioning equipment properly and not repairing a broken window.</p> <p>Findings include:</p> <p>In an observation on 04/26/16 at 3:37 PM, a broken window above the kitchen had two holes in the glass.</p> <p>In an observation on 04/26/16 at 9:47 AM, resident positioning equipment was stored on the floor in the clean utility room.</p> <p>In an interview on 04/26/16 at 3:50 PM, the Administrator and Director of Nursing Services (DNS) acknowledged they were unaware of the broken window.</p> <p>In an interview on 04/26/16 at 4:00 PM, the DNS acknowledged clean positioning equipment should not be stored directly on the floor.</p>	F 465	<p>Window was repaired 4/27/16. Equipmet was reorganized in a the clean utility room.</p> <p>Maintenance director in-serviced staff regarding storage of equipment on 05/25/16. Monthly TELS round have been reviewed.</p> <p>Director of maintenance will monitor windows to assure they are in good repair and storage rooms are in order through TELS.</p> <p>Administrator or designee will assure compliance.</p>	6/8/16
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Nursing Home Survey Report
STATE AND CORRESPONDING FEDERAL REQUIREMENTS

1. Page 1 of 2 Pages

2. DATES OF DATA COLLECTION
04/24/16, 04/25/16, 04/26/16, 04/27/16
and 04/28/16

5. TIME OF SURVEY Day Night
 Weekend Holiday

7. LICENSE NUMBER
1451

3. NAME OF FACILITY
Prestige Care and Rehab Burlington

4. TYPE OF SURVEY
 Full Post Complaint Other: specify _____

6. STREET ADDRESS
1036 Victoria Ave

CITY
Burlington

STATE
WA

ZIP CODE
98233

NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.

8.	9. WASHINGTON ADMINISTRATIVE CODES 388-97	10. CODE OF FEDERAL REGULATION 42 CFR 483.	11. FEDERAL DATA TAG NUMBER	12. REPEAT DEFICIENCY FROM SURVEY DATED	13. NEW CITATION ON POST SURVEY	14. LICENSEE'S PLANNED DATE OF CORRECTION
<input checked="" type="checkbox"/> The requirements of the following WAC's and corresponding CFR's were not met. The text of the statements of deficiencies and the licensee's plan of correction may be read on CMS form 2567, dated: <u>04/28/16</u> . **Licensee must complete column 14.	-0280 (3)(c)(i)	.10(b)(8)	F 156		<input type="checkbox"/>	6-8-16
	-640 (2)(a)(b)	.13(c)	F 226		<input type="checkbox"/>	6-8-16
	-0860 (1)(a)	.15(a)	F 241		<input type="checkbox"/>	6-8-16
	-0900 (3)	.15(b)	F 242		<input type="checkbox"/>	6-8-16
	-1000 (1)(b),(2)(l)(o)	.20 (b)(xii)(xv)	F 272		<input type="checkbox"/>	6-8-16
	-1000 (1)(b)(d)	.20(g)	F 278		<input type="checkbox"/>	6-8-16
	-1620(i)(3)	.20(k)(3)(ii)	F282		<input type="checkbox"/>	6-8-16
	-1060 (1)	.25	F 309	02/25/15	<input type="checkbox"/>	6-8-16
	-1060 (2)(b)	.25(a)(2)	F 311	02/25/15	<input type="checkbox"/>	6-8-16
	-1080 (1)	.30	F 353		<input type="checkbox"/>	6-8-16
<input type="checkbox"/> The following deficiencies were determined to be corrected.	-1080 (3)(a)*	.30(b)(1)	F 354		<input type="checkbox"/>	6-8-16
	-----	.30(e)	F356		<input type="checkbox"/>	6-8-16

15. Surveyor's Signature(s)

SIGNATURE <i>Nedra Z. Vranish</i>	DATE 5/6/16	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

16. Licensee or Agent

SIGNATURE OF LICENSEE (OR AGENT) <i>[Signature]</i>	TITLE <i>Administrator</i>	DATE 5/20/16
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AGING AND LONG-TERM SUPPORT ADMINISTRATION
Nursing Home Survey Report
 STATE AND CORRESPONDING FEDERAL REQUIREMENTS

1. Page 2 of 2 Pages

2. DATES OF DATA COLLECTION
 04/24/16, 04/25/16, 04/26/16, 04/27/16
 and 04/28/16

5. TIME OF SURVEY Day Night
 Weekend Holiday

7. LICENSE NUMBER
 1451

3. NAME OF FACILITY
Prestige Care and Rehab Burlington

4. TYPE OF SURVEY
 Full Post Complaint Other: specify _____

6. STREET ADDRESS
1036 Victoria Ave

CITY
Burlington

STATE
WA

ZIP CODE
98233

NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.

8.	9. WASHINGTON ADMINISTRATIVE CODES 388-97	10. CODE OF FEDERAL REGULATION 42 CFR 483.	11. FEDERAL DATA TAG NUMBER	12. REPEAT DEFICIENCY FROM SURVEY DATED	13. NEW CITATION ON POST SURVEY	14. LICENSEE'S PLANNED DATE OF CORRECTION
<input checked="" type="checkbox"/> The requirements of the following WAC's and corresponding CFR's were not met. The text of the statements of deficiencies and the licensee's plan of correction may be read on CMS form 2567, dated: <u>04/28/16</u> . **Licensee must complete column 14. <input type="checkbox"/> The following deficiencies were determined to be corrected.	-1100 (3) & 246-215	.35(i)(2)	F 371		<input type="checkbox"/>	6-8-16
	-2440 (1)	.70(d)(1)(ii)	F 458	02/25/15	<input type="checkbox"/>	6-8-16
	.3220 (1)	.70(h)	F 465		<input type="checkbox"/>	8-8-16
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	

15. Surveyor's Signature(s)

SIGNATURE <i>Nedra Vranich</i>	DATE 5/6/16	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

16. Licensee or Agent

SIGNATURE OF LICENSEE (OR AGENT) <i>W. Muffin</i>	TITLE Administrator	DATE 5/20/16
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Nursing Home Survey Report

STATE REQUIREMENTS

1. Page <u>3</u> of <u>3</u> Pages
2. DATES OF DATA COLLECTION 04/24/16, 04/25/16, 04/26/16, 04/27/16 & 04/28/16
5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input checked="" type="checkbox"/> Weekend <input type="checkbox"/> Holiday
7. LICENSE NUMBER 1451

3. NAME OF FACILITY Prestige Care & Rehabilitation - Burlington	4. TYPE OF SURVEY <input checked="" type="checkbox"/> Full <input type="checkbox"/> Post <input type="checkbox"/> Complaint <input type="checkbox"/> Other: specify
6. STREET ADDRESS 1036 Victoria	CITY Burlington
	STATE WA
	ZIP CODE 98233

NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.

8. <input checked="" type="checkbox"/> The requirements of the following Washington Administrative Code (WAC) were not met: <u>388-97-1380, 388-97-1400, 388-97-1480</u> <input type="checkbox"/> The following deficiencies were determined to be corrected.	9. REPEAT DEFICIENCY FROM SURVEY DATED	11. LICENSEE'S PLAN OF CORRECTION	12. LICENSEE'S PLANNED DATE OF CORRECTION 6-8-16
10. NEW CITATION ON POST SURVEY <input type="checkbox"/> Yes <input type="checkbox"/> No	<div style="border: 1px solid black; padding: 10px;"> <p>Residents 63 and 24 will be re tested with a 2-step PPD process.</p> <p>Staff N, O, Q, R will be re-tested using a 2 step PPD process.</p> <p>The Director of Nursing will review the staff TB book weekly to ensure compliance.</p> <p>Resident TB tests will be initiated by admitting nurse on admit day 1 and tracked by Medical Records during 7 and 14 day chart audits.</p> <p>Staff TB tests will initiated on hire day 1 and audited for compliance within 14 days of hire by the Business Office Manager.</p> </div>		
DEFICIENCY RESIDENTS Resident 63 was admitted [redacted] 16. The first step was done [redacted] 16 but not read. No results were documented. Resident 24 was admitted [redacted] 16. The first step was done as required but there was no second step completed. The Director of Nursing was interviewed 04/27/16 at 2:15 PM and further information of testing was requested but no further information was provided on all the above staff and residents.			

13. Surveyor's Signature(s)			
SIGNATURE <i>Nedra Krawish</i>	DATE 5/6/16	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

14. Licensee or Agent		
SIGNATURE OF LICENSEE (OR AGENT) <i>Melissa Dwyer</i>	TITLE Administrator	DATE 5/20/16



Nursing Home Survey Report
STATE REQUIREMENTS

1. Page <u>2</u> of <u>3</u> Pages
2. DATES OF DATA COLLECTION 04/24/16, 04/25/16, 04/26/16, 04/27/16 & 04/28/16
5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input checked="" type="checkbox"/> Weekend <input type="checkbox"/> Holiday
7. LICENSE NUMBER 1451

3. NAME OF FACILITY Prestige Care & Rehabilitation - Burlington	4. TYPE OF SURVEY <input checked="" type="checkbox"/> Full <input type="checkbox"/> Post <input type="checkbox"/> Complaint <input type="checkbox"/> Other: specify		
6. STREET ADDRESS 1036 Victoria	CITY Burlington	STATE WA	ZIP CODE 98233

NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.

8. <input checked="" type="checkbox"/> The requirements of the following Washington Administrative Code (WAC) were not met: <u>388-97-1380, 388-97-1400, 388-97-1480</u> <input type="checkbox"/> The following deficiencies were determined to be corrected.	9. REPEAT DEFICIENCY FROM SURVEY DATED	11. LICENSEE'S PLAN OF CORRECTION	12. LICENSEE'S PLANNED DATE OF CORRECTION 6-8-16
	10. NEW CITATION ON POST SURVEY <input type="checkbox"/> Yes <input type="checkbox"/> No		

DEFICIENCY
Based on record review and interview the facility failed to ensure tuberculosis testing was completed as required placing residents, staff and the public at risk for spread of infection.

Findings include:
STAFF
Staff N, with a hire date of [REDACTED] 6, did not have her first step test initiated until [REDACTED] 16 and there was no second step done.
Staff O, with a hire date of [REDACTED] 16, had her first step done and read on the same day, [REDACTED] 16 and there was no second step done.
Staff members Q and R had the first step done as required but there was no second step done.

13. Surveyor's Signature(s)			
SIGNATURE <i>Nedra Vranish</i>	DATE 5/6/16	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

14. Licensee or Agent		
SIGNATURE OF LICENSEE (OR AGENT) <i>[Signature]</i>	TITLE Administrator	DATE 5/20/16



Nursing Home Survey Report
STATE REQUIREMENTS

1. Page <u>1</u> of <u>3</u> Pages
2. DATES OF DATA COLLECTION 04/24/16, 04/25/16, 04/26/16, 04/27/16 & 04/28/16
5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input checked="" type="checkbox"/> Weekend <input type="checkbox"/> Holiday
7. LICENSE NUMBER 1451

3. NAME OF FACILITY Prestige Care & Rehabilitation - Burlington	4. TYPE OF SURVEY <input checked="" type="checkbox"/> Full <input type="checkbox"/> Post <input type="checkbox"/> Complaint <input type="checkbox"/> Other: specify
6. STREET ADDRESS 1036 Victoria	CITY STATE ZIP CODE Burlington WA 98233

NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.

8. <input checked="" type="checkbox"/> The requirements of the following Washington Administrative Code (WAC) were not met: <u>388-97-1380, 388-97-1400, 388-97-1480</u> <input type="checkbox"/> The following deficiencies were determined to be corrected.	9. REPEAT DEFICIENCY FROM SURVEY DATED	11. LICENSEE'S PLAN OF CORRECTION	12. LICENSEE'S PLANNED DATE OF CORRECTION 6-8-16
	10. NEW CITATION ON POST SURVEY <input type="checkbox"/> Yes <input type="checkbox"/> No		
DEFICIENCY WAC 388-97-1380 states: The nursing home must develop and implement a system to ensure that facility personnel and residents have tuberculosis testing within three days of employment or admission. WAC 388-97-1400 states: The nursing home must ensure that all tuberculosis testing is done...and read within forty-eight to seventy-hours. WAC 388-97-1480 states: Unless the person meets the requirement for having no skin testing or only one test, the nursing home, choosing to do skin testing, must ensure that each person has the following two-step skin testing: (1)An initial skin test within three days of employment; and (2)A second test done one to three weeks after the first test. These regulations were not met as evidenced by the following:			

13. Surveyor's Signature(s)			
SIGNATURE <i>Nedra Vranich</i>	DATE 5/6/16	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

14. Licensee or Agent		
SIGNATURE OF LICENSEE (OR AGENT)	TITLE	DATE



Nursing Home Survey Report

STATE REQUIREMENTS

1. Page <u>1</u> of <u>2</u> Pages
2. DATES OF DATA COLLECTION 04/24/16, 04/25/16, 04/26/16, 04/27,16 and 04/28/16
5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input checked="" type="checkbox"/> Weekend <input type="checkbox"/> Holiday
7. LICENSE NUMBER 1451

3. NAME OF FACILITY Prestige Care & Rehab	4. TYPE OF SURVEY <input checked="" type="checkbox"/> Full <input type="checkbox"/> Post <input checked="" type="checkbox"/> Complaint <input type="checkbox"/> Other: specify
6. STREET ADDRESS 1036 Victoria Ave	CITY STATE ZIP CODE Burlington WA 98233

NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.

8. <input checked="" type="checkbox"/> The requirements of the following Washington Administrative Code (WAC) were not met: <u>388-97-1160</u> <input type="checkbox"/> The following deficiencies were determined to be corrected.	9. REPEAT DEFICIENCY FROM SURVEY DATED	11. LICENSEE'S PLAN OF CORRECTION	12. LICENSEE'S PLANNED DATE OF CORRECTION <u>6-8-16</u>
	10. NEW CITATION ON POST SURVEY <input type="checkbox"/> Yes <input type="checkbox"/> No		
DEFICIENCY 388-97-1160 Dietary Personnel (2) If a qualified dietitian is not employed full-time as the food service manager, the nursing home must employ a food service manager to serve as the director of food service. (3) The food service manager means: (a) An individual who is a qualified dietitian; or (b) An individual: (i) Who has completed a dietetic technician or dietetic assistant training program, correspondence or classroom, approved by the American Dietetic Association/Dietary Manager Association.			

13. Surveyor's Signature(s)			
SIGNATURE <i>Nedra Vranish</i>	DATE <u>5/6/16</u>	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

14. Licensee or Agent		
SIGNATURE OF LICENSEE (OR AGENT) <i>M. Anderson</i>	TITLE <i>Administrator</i>	DATE <u>5/12/16</u>

Nursing Home Survey Report

STATE REQUIREMENTS

1. Page <u>2</u> of <u>2</u> Pages
2. DATES OF DATA COLLECTION 04/24/16, 04/25/16, 04/26/16, 04/27/16 and 04/28/16
5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input checked="" type="checkbox"/> Weekend <input type="checkbox"/> Holiday
7. LICENSE NUMBER 1451

3. NAME OF FACILITY Prestige Care & Rehab	4. TYPE OF SURVEY <input checked="" type="checkbox"/> Full <input type="checkbox"/> Post <input type="checkbox"/> Complaint <input type="checkbox"/> Other: specify
6. STREET ADDRESS 1036 Victoria Ave	CITY STATE ZIP CODE Burlington WA 98233

NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.

8. <input checked="" type="checkbox"/> The requirements of the following Washington Administrative Code (WAC) were not met: <u>388-97-1160</u> <input type="checkbox"/> The following deficiencies were determined to be corrected.	9. REPEAT DEFICIENCY FROM SURVEY DATED	11. LICENSEE'S PLAN OF CORRECTION	12. LICENSEE'S PLANNED DATE OF CORRECTION <u>6-8-16</u>
10. NEW CITATION ON POST SURVEY <input type="checkbox"/> Yes <input type="checkbox"/> No	<div style="border: 1px solid black; padding: 10px;"> <p>Staff I is enrolling in a Food Service Managers course. The contracted RD has agreed to mentor the Dietary Manager. Estimated completion date is April 2017. Evidence of successful completion of each sub course will be placed in the employees file to track progress.</p> <p>Staff I has completed in-service training from the corporate dietary trainer. This 2 day course was completed May 2nd and 3rd.</p> <p>On-going in-services are scheduled with corporate trainer.</p> </div>		
DEFICIENCY Based on interview and record review the facility failed to provide documentation the food service manager was either a qualified dietitian or was qualified based on completion of other dietetic training. The failed practice placed residents at risk for dietary services that did not meet resident needs and placed them at risk for food-borne illness. Findings include: In an interview on 04/27/16 at 1:26 PM, Staff I stated she transitioned into the manager position about 3 months ago and had not completed any dietetic classes. Review of Staff I's personnel record revealed no documentation of formal training.			

13. Surveyor's Signature(s)			
SIGNATURE <i>Nedra Kraus</i>	DATE <u>5/6/16</u>	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE
14. Licensee or Agent			
SIGNATURE OF LICENSEE (OR AGENT) <i>[Signature]</i>	TITLE <u>Administrator</u>	DATE <u>5/20/16</u>	