

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

1452

PRINTED: 02/20/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505514	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/01/2013
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NAME OF PROVIDER OR SUPPLIER RICHLAND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1745 PIKE AVENUE RICHLAND, WA 99352
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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 INITIAL COMMENTS

F 000

This report is the result of an unannounced Off-Hours Standard and Extended Quality Indicator Survey conducted at Richland Rehabilitation Center on 10/20/13, 10/21/13, 10/22/13, 10/23/13, 10/24/13, 10/25/13, 10/26/13, 10/27/13, 10/28/13, 10/29/13, 10/30/2013, 10/31/2013 and 11/1/13. A sample of 53 residents was selected from a census of 69. The sample included 46 current residents and the records of 7 former and/or discharged residents. On 10/21/13 an immediate jeopardy was identified related to F323 Accidents and Supervision. The facility abated the immediate jeopardy before the completion of Extended Survey on 11/01/13.

The survey was conducted by:

- ██████████, RN, MSN
- ██████████, MA
- ██████████, RN, BSN
- ██████████, LICSW
- ██████████, BS

The survey team is from:
Department of Social and Health Services
Aging and Long Term Services Administration
Residential Care Services
3611 River Road STE #200
Yakima WA 98902
Telephone (509) 225-2823
Fax: (509) 329-3993

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[Handwritten Signature]
Residential Care Services
Date *2/25/14*

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

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F 154 483.10(b)(3), 483.10(d)(2) INFORMED OF SS=D HEALTH STATUS, CARE, & TREATMENTS

F 154

The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.

The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined the facility failed to fully inform residents of the risks and benefits of psychotropic medications prior to administration for 1 of 6 current sampled residents (#127) reviewed for unnecessary medications. This failure prevented the residents from making informed decisions regarding care and treatment related to the use of psychotropic medications.

Findings include:
Review of the facility policy regarding psychotropic medications showed informed consent must be given prior to the use of any psychotropic medication.
Resident #127

Resident #127 was admitted to the facility on [REDACTED]/13 with multiple medical diagnoses to include [REDACTED].

The resident's Minimum Data Set (MDS), an

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F 154	Continued From page 2 assessment tool, dated 10/6/13, indicated the resident was able to make needs known, was cognitively intact, received psychotropic medications and participated in the MDS assessment process. Record review revealed the resident had been prescribed [REDACTED], a medication for depression. No signed consent was in the resident's record to indicate the resident was informed of the risks and benefits of taking this medication. The Medication Administration Record (MAR) documentation revealed the resident had received the prescribed dose daily since ordered. On 10/26/13 at 10:28a.m., Resident Care Manager (RCM) A verified a consent for the [REDACTED] was not completed. RCM A stated, "the RCM or the admitting nurse is to obtain the consent on admit, if an order changed to a different medication a new consent should be obtained...the review of risks versus benefits is included with the consent." At 11:38a.m., Resident #127 was unable to recall being educated on the use of and/or risks and benefits of taking this antidepressant.	F 154		
F 225 SS=G	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment	F 225		

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F 225	<p>Continued From page 3</p> <p>of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility failed to thoroughly investigate incidents to rule out abuse and/or neglect, protect residents and prevent incidents in accordance with state law and 42 CFR 483.13 (c)(3) for 2 of 2 current sampled residents (#65 & 214) and 2 of 5</p>	F 225		

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F 225	Continued From page 4 discharged/former residents (#263 & 204) reviewed for incidents and investigations. The failure placed the residents at risk for abuse and/or neglect due to lack of thorough investigations. This caused harm to Resident's (#214 & 263). Findings include: Resident #214	F 225		
	Resident #214 was admitted on [REDACTED]/13 with diagnoses to include a [REDACTED] fracture and altered [REDACTED] status. According to the record and the daughter, the resident had a history of falls at home and fractured her [REDACTED] in the last fall at home. Between August 13th and October 31st, the resident had 14 falls, including 2 falls on the same day. A review of the resident record and incident reports revealed the following: On 8/17/13 the resident was found sitting on her floor next to her bed. On 8/19/13 the resident was found sitting on the right side of her bed on the floor. On 8/29/13 two witness reports indicated the resident was found with a bruises on her [REDACTED] and [REDACTED] foot. No documentation was found to indicate the facility completed an investigation to rule out abuse and/or neglect. On 9/2/13, The resident attempted to self transfer from her bed and slid to the floor on the floor mat.			

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F 225	<p>Continued From page 5</p> <p>On 9/5/13 at 5:45 am the resident was found with a scratch to her hip region. The incident report did not document an analysis to rule out abuse and/or neglect. As of 10/31/13 the incident report indicated the DNS and ADM did not completed the investigation.</p> <p>On 9/5/13 at 9:15 p.m. the resident attempted to transfer from her bed to the wheelchair.</p> <p>On 9/7/13 a witness report indicated the resident was found with her thumb nail bleeding. No incident report was found to indicate the facility completed an investigation to rule out abuse and/or neglect.</p> <p>On 9/10/13 the resident was found lying on the floor mat next to her bed.</p> <p>On 9/15/13 the resident was found on the floor mat.</p> <p>On 9/18/13 at 7:00 a.m., the resident was found lying on the mat next to her bed. She sustained a skin tear to her forearm. There was no analysis to rule out abuse and/or neglect. The DNS and ADM completion date was 10/24/13, over a month after the incident.</p> <p>On 9/18/13 at 3:39 p.m., the resident was found a second time on the floor lying next to her bed, this time with a skin tear to her arm. There was no analysis to rule out abuse and/or neglect. The DNS and ADM completion date was 10/24/13, over a month after the incident.</p> <p>On 9/20/13 the resident fell out of her wheelchair. This fall resulted in a skin tear to her elbow.</p>	F 225		

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F 225	<p>Continued From page 6</p> <p>There was no analysis to rule out abuse and/or neglect. As of 10/31/13 the incident report indicated the DNS and ADM had not completed the investigation.</p> <p>On 9/23/13 the resident fell out of her chair.</p> <p>On 9/27/13 the resident was found on the floor next to her bed.</p> <p>On 9/29/13 the resident fell when attempting to transfer herself into the wheelchair from the bed.</p> <p>On 10/1/13 the resident was found on the floor in her room. She complained of [redacted] shoulder pain. There was no analysis to rule out abuse and/or neglect. The DNS completion date was 10/22/13 and the ADM completion date was 10/23/13, three weeks after the incident.</p> <p>On 10/6/13 the resident attempted to self-transfer and received two scrapes to her [redacted] shin. In the incident report, there was no analysis to rule out abuse and/or neglect. The DNS completion date was 10/22/13 and the ADM completion date was 10/23/13, almost three weeks after the incident.</p> <p>On 10/9/13 a witness report indicated the resident was found to be bleeding near her [redacted] eye. No incident report was found to indicate the facility completed an investigation to rule out abuse and/or neglect.</p> <p>Record review showed on 10/2/13 a Computed Tomography (CT) scan (a scan that uses X-rays to make detailed pictures of structures inside of the body) of the resident sacral area revealed the resident had new fractures of the [redacted] (lower part of the [redacted]). The order for the CT scan was</p>	F 225		
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F 225 Continued From page 7
obtained after the resident had fallen 9 times.

In an interview on 10/29/13 the Resident Care Manager (RCM) A indicated if a resident was found with a new fracture and the facility was unsure which fall it may be related to, a new incident report should be started and the state hotline called.

In an interview with the DNS on 10/29/13, she indicated if a resident had numerous falls with no documentation of a fracture(s), a new incident report should be filed if a fracture is later discovered and it is unclear when the fracture occurred. She further indicated the state hotline should also be called.

A review of the incident report log and the incident reports for Resident #214 showed no report was started when the CT scan revealed sacral fractures and the state hotline was never called regarding the fractures.

Resident #263

Resident #263 was admitted to the facility on [REDACTED]/13 with diagnoses to include a [REDACTED] and [REDACTED]. Resident #263 resided in the facility for 6 days before she was transferred to the hospital after a fall with a [REDACTED] fracture.

A review of the accident/incident reports for Resident #263 revealed:

On 9/29/13, Resident #263 fell in the bathroom while attempting to transfer self. There was no analysis to rule out abuse and/or neglect. As of 10/31/13, the incident report indicated the DNS

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F 225	<p>Continued From page 8 and ADM had not completed the investigation.</p> <p>On 10/2/13 the resident was found to have a skin tear to the top of her forearm. There was no analysis to rule out abuse and/or neglect. As of 10/31/13 the incident report indicated the DNS and ADM had not completed the investigation.</p> <p>On 10/3/13, Resident 263 fell twice within an hour period. Both times the resident was found alone in her room. According to the witness statement, the instructions given after the first fall indicated the resident was not to be left alone. In the incident report, the alleged abuse and neglect area was documented as "no." There was no analysis to rule out abuse and/or neglect. As of 10/31/13 the incident report indicated the DNS and ADM had not completed the investigation.</p> <p>Resident #204</p> <p>Resident #204 was admitted on [redacted]/13 with diagnoses of multiple [redacted] from a [redacted] accident to include [redacted] surgery, [redacted] and [redacted].</p> <p>Resident #204 had eight falls within 14 days to include four on one day. Four of these eight falls were non-witnessed with injury.</p> <p>1) The facility's investigative report dated 8/22/13 at 3:15 a.m., documented the licensed nurse found the resident lying on the floor next to her bed. The resident had an injury with complaints of hitting her head. The investigation did not have an analysis to rule out abuse and/or neglect.</p> <p>2) The facility's investigative report dated 8/22/13 at 7:00 a.m., documented the staff found the</p>	F 225		

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F 225	Continued From page 9 resident on the floor with complaints of hitting her head on the floor. The investigation was incomplete with no analysis to rule out abuse and/or neglect. 3) The facility's investigative report dated 8/22/13 at 8:16 p.m., documented the staff found the resident beside her wheelchair with complaints of pain from hitting her head on the floor. "Family took resident outside for a walk ..." The investigation was incomplete with no analysis to rule out abuse and/or neglect.	F 225		
	4) The facility's investigative report dated 9/2/13 at 6:00 p.m., documented the staff found the resident on the floor, near her bed "with fecal matter around herself" with complaints of hurting her wrist. The investigation was incomplete with no analysis to rule out abuse and/or neglect. The completions dates for the ADM and DNS were blank for all of the investigations on 8/22/13 and 9/2/13. On 10/29/13 at 11:29 a.m., the DNS explained the facility's incident process was the licensed nurse initiated the form which automatically distributed to the Resident Care Manager (RCM) and herself (DNS). The DNS stated the RCM should investigate it further. Once the RCM was finished, the incident was discussed with her (DNS) and at the stand up meeting. The DNS stated the process to rule out abuse and neglect was not documented on Resident #204's investigations. The DNS said "we have revamped our process recently the computer system is new to us... we should have completed a good overall picture that abuse did not occur,			

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what happened what could it be related to, look at environmental factors or is it medically related, then summarize what is going on, who what when and how and get to root cause why it occurred."

RESIDENT #65

Resident #65 was admitted to the facility from the hospital on [REDACTED]/13. Resident #65 diagnoses included [REDACTED] failure and [REDACTED] ([REDACTED]).

Record review revealed the resident had fallen twice since admission to the facility.

On 10/12/13, the facility's fall incident report documented, "(Resident #65) was found on the floor by her bed and sustained a laceration three quarters of an inch long to [REDACTED] hand [REDACTED] finger." There was no investigation of this injury fall.

On 10/31/13 at 1:00 p.m., interview with resident's family member/representative stated he was concerned with the facility's lack of interventions to ensure his mother would be safe. "She fell 15 minutes after I left the building a few days ago and had another fall 2 weeks ago."

On 10/29/13 discussed with DNS the incident reports and the lack of assessment and analysis on the reports and discussed the analysis on the other reports that kept suggesting the same interventions or just say "WCTM" or follow current plan of care. The DNS indicated she recognized the breakdown in investigation and analysis of incidents. She indicated she was unsure why the incident reports showed her completion dates for

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F 225	Continued From page 11 incidents as either incomplete, or done in the last week. Refer to F-323	F 225		
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to promote care for residents in a manner that was respectful and dignified during dining for 7 of 30 current sampled residents (#6, 29, 91, 130, 133, 134 & 216). Additionally, the facility failed to ensure dignity was maintained for one resident (#214) who required assistance with personal care. These failures placed residents at risk for not receiving necessary care and services in a manner to maintain or enhance each resident's dignity and self-esteem.</p> <p>Findings include</p> <p>Resident #214</p> <p>Resident #214 was admitted to the facility on [REDACTED]/13 with diagnoses included [REDACTED] fracture, [REDACTED], and [REDACTED] difficulty.</p> <p>Observations of the resident revealed the following:</p>	F 241		

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F 241 Continued From page 12

F 241

On 10/21/2013 at 9:43 a.m. Resident was sitting in the hall near the nursing station. Resident #214 kept trying to stand setting off her pressure alarm. For approximately two minutes staff did not respond. A nurse standing approximately 30 feet away stated loudly stating "I'm getting it for you." Resident #214 continued to try and stand. The resident behind her started insisting for Resident #214 to sit down, "I'm going to tell on you, sit down" ...you better sit down or I'm going to tell on you." Resident #214 turned around and yelled at the resident behind her. Staff did not come towards the two residents. The staff member loudly stated again, "I'm getting it for you." Resident #214 continued to try and get out of the chair. After approximately three minutes, another staff came out from the back room stating loudly from down the hall "she is getting it for you." Resident #214 sat down.

At no time did a staff member attempt to address the situation between Resident # 214 and the other resident or come to Resident #214 and reassure her.

On 10/23/13 at 4:00 p.m., the esident returned to the facility from a physician's appointment. The resident was at the nurse's station pulling up her skirt, grabbing her crotch, shoving a wad of paper towels between her legs while waving her hands to get assistance from staff. Several staff members were observed nearby. The resident repeatedly stated, "I need to go to the bathroom." The Surveyor approached after approximately 5 minutes as the resident continued to try to get staff's attention unsuccessfully. She told the surveyor "I am urinating" which was told to the staff sitting at the nurse's station.

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F 241 Continued From page 13

F 241

On 10/25/13 at 2:10 p.m. the resident was sitting across from nurse's station repeatedly standing up setting off the pressure alarm; Staff was sitting at the nurse's station. The resident stated "I'm urinating, I'm urinating, help, help." An activity staff member came and asked if she wanted to play games. The resident stated "no, no I'm urinating; I'm urinating, bathroom," as she grabbed her crotch. The activity staff smiled and said "okay, let's go this way." The activity staff took her into her room and walked away.

At 2:24 p.m., the resident was outside her room as the activity person told her there would be music in the Dining Room (DR) and walked away. The resident commented to everyone walking by "there is music in the dining room." One staff responded, "The dining room, no, I think it will be a couple more hours before dinner." Another staff responded, "No, I don't think there are movies today."

At 2:31 p.m., Resident #214 indicated it was frustrating when people couldn't understand her. Further examples of staff not listening or not responding occurred on 10/27/13. The resident asked Licensed Nurse A to lie down who told the resident twice she would get someone, and soon. Moments later a staff person came telling the resident she would take her to watch movies in the lounge and guided her wheelchair. The resident was not laid down as she requested.

A problem initiated on the care plan (instructions for staff) dated 8/23/13 indicated the resident had garbled speech and difficulty making her needs known. The goal was "(Resident 214) will continue to make attempts to communicate with

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F 241 Continued From page 14

staff using verbal communication." Interventions included: do not make resident feel bad for not being able to communicate appropriately with others, allow her time to respond, encourage resident to repeat herself if she is not understood.

A review of the resident's in room care directive (an information sheet with interventions for direct care staff to use when assisting the resident) showed no information regarding the resident's communication difficulties or the interventions to use to allow resident the ability to make her needs known.

The facility was not observed to allow the resident to have her expressed needs met in a dignified manner.

DINING

On 6/20/13 at 5:30 p.m., a sign measuring 8 X 5 inches in a plastic upright holder was in the center of a dining table. In bold letters the sign on the dining room table read, "CUEING AND ASSISTANCE TABLE." Resident #s 133,134, 216, 130 and 91 were seated at the table.

Residents at other tables in the dining room had their meals delivered and had beverages to drink. No assistance or pre meal beverages were observed to be offered to Residents at the "Cue and Assist" table.

At 5:50 p.m., Nursing Assistant (NA) T stated, "The cueing table trays come last all at one time, but, all the other trays come randomly. Meals don't come in any order actually, it is confusing, and the sign helps the staff so we know where people should sit."

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F 241 Continued From page 15

At 6:15 p.m., (NA) R stated, "I think I would feel labeled if there was a sign like that on a table for me."

At 6:25p.m., NA S stated, "...we don't have enough staff in the dining room to assist the residents who need assistance to eat. That is mostly what it is...we don't have the staff so everyone who needs assistance sits together. I think it's very labeling."

F 241

F 242 483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES

The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, it was determined the facility failed to consistently honor resident preferences for frequency and time of showering and roommate preferences for 3 of 4 sampled residents (#s 84, 111 & 257) reviewed for choices. This failure prevented residents from exercising their right to make choices regarding their care and had the potential to decrease their quality of life.

Findings include:

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F 242	<p>Continued From page 16</p> <p>RESIDENT #84</p> <p>Resident #84 was admitted to the facility on [REDACTED]/13 with diagnoses to include [REDACTED] (a [REDACTED] disorder of the [REDACTED] system) and [REDACTED].</p> <p>Resident #84's Minimum Data Set (MDS), an assessment tool, dated 7/01/13, indicated the resident had minimal cognitive impairment, was able to make his needs known, he required extensive assistance of one person with bed mobility, transfers, toileting, dressing and bathing. The MDS further indicated that personal preferences in all areas of activities of daily living, including bathing/showering, were "very important" to Resident #84.</p> <p>On 10/22/13 at 7:30a.m., Resident #84 stated he would like to take a shower 3-4 times per week, however, was only given two. Resident #84 stated he did not choose the time of the shower or the day he was given a shower.</p> <p>RESIDENT #257</p> <p>Resident #257 was admitted to the facility [REDACTED]/13 with diagnoses to include a [REDACTED] replacement. She was alert, oriented and able to make her care needs known. Resident #257 required extensive assistance of one person with bed mobility, transfers, toileting, dressing and bathing.</p> <p>On 10/22/13 at 5:15p.m., Resident #257 stated, "It would be nice to have a shower every day" Resident #257 explained she was only scheduled for 2 showers a week, Monday and Thursday.</p>	F 242		
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F 242	<p>Continued From page 17</p> <p>On 10/25/13 11:50a.m., Nursing Assistant (NA) N stated, "We have 3 bath aides. We work 6am-2pm. We have a shower schedule in the book. The schedule is broken up according to room number ... "</p> <p>On 10/28/13 at 2:00p.m., the Director of Nursing (DNS) stated, "The facility has a schedule. It depends on the room and bed they are in. They (residents) are not offered a choice of when to take a shower or at what time." The DNS provided documentation of the shower schedule by room and bed number. The DNS stated, "The time a shower is given is determined is by the bath aide who basically bases that on the push back from the residents. I would say the time of day is important and the 2 times of week is not ideal, so it would be nice to have them choose. I have to balance staffing and choices."</p> <p>RESIDENT #111</p> <p>On 10/25/13 at 11:00a.m., Resident #111 stated, "I asked for a room change six weeks ago because my roommate is up all night talking, flops herself out of bed, and they put an alarm on her that goes off all the time... They took me to one room on a different hall and that's the only one they offered. They fill um up (the rooms) as soon as they are empty, it is a fast turnover. I don't get any sleep that is my problem because all night long she is up (pointing to her roommate's bed) and I get no sleep."</p> <p>Resident #111 stated she had continued to request a room change after she refused the one room change offer the facility made.</p>	F 242		

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F 242 Continued From page 18
On 10/25/13 at 11:52a.m., The Social Service Director (SSD) stated, "Our policy is a resident cannot kick out a roommate if they complain they are the ones who have to move." The SSD was aware Resident #111 had wanted a new roommate. When asked to see interventions documented addressing the roommate concerns expressed by Resident #111 there was none. The SSD verified no attempts were made from the time she declined one room change over six weeks ago.

F 242

F 247 SS=E 483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE

A resident has the right to receive notice before the resident's room or roommate in the facility is changed.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, it was determined that the facility failed to give advance notice to 3of 4 current sampled residents (#s 84, 96 & 219) reviewed for roommate and/or room changes. This failure placed residents at potential risk for diminished quality of life.

Findings include:

The facilities policy regarding notification of room change/new roommate stated, "It is this center's policy to notify each resident in advance of room changes and new roommates."

F 247

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F 247	Continued From page 19 The facilities procedure stated, "1... will notify residents of upcoming room changes or new roommates with advanced notice. 2... use the notification room change/new roommate notification form prior to the occurrence. 3... the form should be completed in its entirety with resident signature present on the form and placed in the resident's physical chart. 4... Should the resident refuse to allow a new roommate or room change; alternate arrangements should be attempted ..."	F 247		
	<p>RESIDENT #84</p> <p>On 10/22/13 at 9:15a.m., Resident #84 stated, "I have had so many roommates, I think at least 6 or 8. I had a couple roommates who yelled all night and I didn't get much sleep, this is the 8th roommate I've had (pointing to the bed on the other side of the room) in the past four months. I try to introduce myself...A lot of times it didn't even seem like the staff knew they (a new resident) was coming, they would come in at 8:00 or 9:00p.m...Resident #84 stated, no one had ever notified him when getting a new roommate.</p> <p>RESIDENT #96</p> <p>On 10/23/13 at 10:30a.m., Resident #96 stated, "I've had two roommates in the past month and will most likely get another one soon." When asked what notification of roommate changes she received Resident #96 stated, "There was a new name on the door, that's how I know I am getting a new roommate."</p> <p>RESIDENT #219</p> <p>On 10/23/13 at 6:15pm, Resident #219 stated,</p>			

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F 247	Continued From page 20 she had at least three new roommates over the past month and a half. Resident #219 stated she was not notified in advance of any roommate changes. Review of Resident (#s 84, 96 & 219) records noted no documentation the residents were given notice before receiving a new roommate. On 10/25/13 at 11.30a.m., the SSD stated, "My understanding was the Admissions Coordinator (AD) was to notify residents currently in the building of new roommates because they are the ones that know what rooms the new admissions are going into. We get an e-mail... The social service department has never provided information to the roommate of a new person. When the new admits come in we never inform roommates of the new admissions." At 1:00p.m., The Admissions Coordinator who was responsible for giving residents advance notice of roommate changes stated, "When I go in to get a room ready I notify the roommate and if they are out of the building sometimes they don't get notified. It is not our policy to document it so I don't documentI have nothing to show that you that I have it, it's all verbal. When the surveyor showed the Admissoins Coordinator the facilities policy on room changes/transfers she stated, "I am not familiar with the policy."	F 247			
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with	F 248			

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F 248	<p>Continued From page 21</p> <p>the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure an appropriate individualized activity program was implemented for 1 of 3 cognitively impaired residents (214). This failure placed her at risk for a diminished quality of life, as well as diminished sense psychosocial well-being. Findings include:</p> <p>Resident 214 was admitted on [REDACTED]/13 with diagnosis to include [REDACTED] fracture related to a [REDACTED] at home, altered [REDACTED] status, and with [REDACTED] difficulties.</p> <p>During an interview on 10/28/13 with the daughter, she indicated prior to the resident's admission she was reading the New Yorker and watching PBS and C Span "the TV was always on those channels." The daughter further indicated the resident liked to be well informed. She was also walking 20-30 minutes a day.</p> <p>On 8/13/13 an activity assessment was completed for resident 214. The assessment checklist indicated the resident liked Bingo, cards, family visits, food preparation, helping others, music, outdoors, puzzles, reading, sports, outings, socialization, watching TV and reminiscing. No specific information was added to the assessment beyond what could be checked off on the checklist. The assessment indicated the in room care plan was updated.</p>	F 248		

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F 248	<p>Continued From page 22</p> <p>A care plan problem for activities was initiated on 8/13/13 with a goal that the "resident will be able to attend activities of interest at ease and as available." The interventions listed included all of the areas of interest from the initial activity assessment, as well as the intervention of "pre-meal social" and "staff will offer 1:1 visits when available." No further updates to the Activity care plan were made after 8/13/13.</p> <p>The information the daughter mentioned in the interview was not found in the activity care plan. A review of the resident's in room care plan showed no activity interventions for the staff to use when working with the resident.</p> <p>An interview was conducted with the Activity Director AD on 10/29/13. When asked about interventions for Resident 214, the AD indicated she will participate in the "pre-meal social " when the activity department is able to offer it in the Progressive Self Feeding Program (PSFP) dining room where Resident 214 eats. She indicated; however, it was difficult to offer this program in the evenings in PSFP as there was only one activity staff during the dinner meal. She also indicated the activity staff will try to visit with Resident 214 on a one to one basis for 15-30 minutes and the resident will sometimes watch television. The AD indicated "When we take her up to the TV and place her in front of TV and try different shows, (Resident 214) will shake her head no over and over until she shakes her head yes then you know you are on the show she wants to watch."</p> <p>When asked if staff outside of the activity department were informed of activities that would</p>	F 248		
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F 248	<p>Continued From page 23</p> <p>be useful and meaningful to the resident when she is in the hall or in her room (such as the information about going through TV channels), the AD stated "No, I haven't really told them. I can do that today and make sure they know. For our long term residents we put a closet sheet on the inside of the closet with all the things they (the resident) likes to do. I in-serviced the staff and told them 'you need to invite them to things and make sure they get there.' We didn't do this for (Resident 214) because she wasn't long term. We can do that today."</p> <p>Observations of the resident during the survey showed:</p> <p>10/21/2013 9:43 a.m. The resident was sitting in the hall. She attempted to stand numerous times. No staff responded. No diversion activities were offered to the resident.</p> <p>10/23/13 10:00 a.m. Resident sitting in her wheelchair(WC) by the nurse's station (NS) with a towel on her head covering eyes.</p> <p>10/23/13 11:05 a.m. The resident was in the dining room with a staff person waiting for lunch. No conversation occurred.</p> <p>10/23/13 11:30 a.m. Resident was sitting behind the NS with the Resident Care Manager (RCM) who was completing paperwork. No conversation occurred with the resident.</p> <p>10/23/13 4:00 p.m. Resident returned to the facility from a physician's appointment and dropped off by the nursing station. Waving arms attempting to get staff attention. No staff responded.</p>	F 248		

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F 248	Continued From page 24 10/25/13 8:55 a.m. Resident sitting in hall by NS in her WC. A staff person was sitting with her. No conversation occurred. 10/25/13 9:20 a.m. Resident sitting in hall by NS. Resident was by herself. 10/25/13 12:39 p.m. resident was brought back to the NS to sit. The resident was by herself.	F 248		
	10/25/13 2:10 p.m. Resident sitting in the hall across from the NS. Kept trying to stand up. Licensed Nurse (LN) A was trying to give report to the next shift but Resident 214 kept trying to get out of chair and setting off the alarm. The resident was softly saying "help, help." 10/25/13 2:24 p.m. Resident 214 was back in the hall outside her room. A staff member pushing the activity cart stopped and gave her a "cloth block" and told her there would be music in the DR. The staff then walked away. Resident throws the block behind her on the floor. 10/26/13 9:00 a.m. Resident in WC by NS. No staff or residents with her. 10/26/13 10:30 a.m. Resident in WC by NS asleep. 10/26/13 11:00 a.m. Resident in WC by NS asleep, head drooped to one side, mouth open, tongue hanging slightly out of mouth. 10/27/13 9:30 a.m. Resident sitting in WC by NS sleeping. 10/28 10:05 a.m. resident was sitting in front of			

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F 248	Continued From page 25 the NS by self. Asked staff to go with her for walk. LN stating "hold on (Resident 214)." A review of the activity calendar showed morning and evening activities on all days of the survey. The resident was observed in only one activity although her assessment indicates the resident enjoys socialization, bingo, music, food preparation, outings and helping others. The resident was observed numerous times in the hallway or at the nurses's station sitting in her chair. Although the resident's assessment and the daughter indicated the resident enjoyed puzzles, reading the New Yorker, playing cards, monitoring current events and socializing, the resident was only offered these options during 3-4 observations. Often she was observed by herself with no activity or socialization. The resident indicated she liked music and she was not observed listening to music outside of 1 hour long activity. When she did attempt to socialize or verbally make her needs known, she was misunderstood. She indicated to the surveyor this was frustrating for her.	F 248		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the	F 278		

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F 278	<p>Continued From page 26 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 review, the facility failed to accurately assess 1 of 3 sampled residents (#34) reviewed for pressure ulcers; 1 of 1 sampled residents (#160) reviewed for hospice, 2 of 2 sampled residents (#84, 133) reviewed for dental, 1 of 2 sampled residents (#182) reviewed for accidents/injury related to seizures, 1 of 6 sampled residents (#82) reviewed for nutrition/weight loss. Failure to accurately assess residents for hospice, dental, pressure ulcers and nutritional care and services placed all residents at risk for unmet care needs.</p> <p>Findings include: Resident 160</p>	F 278		
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F 278	<p>Continued From page 27</p> <p>Resident #160 was admitted to the facility on [REDACTED]/13 with diagnoses to include altered [REDACTED] status and [REDACTED] disease.</p> <p>A physician's order dated, 6/12/13 documented the resident was [REDACTED] due to [REDACTED] disease and [REDACTED] failure. The order indicated to admit the resident to hospice services.</p> <p>The resident's record included a hospice care referral dated 6/14/13. The resident was admitted to hospice on [REDACTED]/13.</p> <p>The Minimum Data Set (MDS), an assessment tool, dated 6/21/13 coded the resident as not having a life expectancy of less than [REDACTED] months.</p> <p>On 10/26/13 at 10:25 a.m., when the surveyor reviewed the MDS and the physician's order with MDS Staff B, she stated, the resident should have been coded as having less than [REDACTED] months.</p> <p>At 10:33 a.m., MDS Staff A stated selecting prognosis less than [REDACTED] months must have been missed. She conveyed the resident had a 9/13 MDS completed for improvement.</p> <p>MDS Staff A and B reviewed Resident #160's 6/21/13 and 9/26/13 MDSs with the surveyor. The MDS for 6/13 was not coded for having a life expectancy of less than [REDACTED] months and the 9/13, which was completed for improvement, was coded as life expectancy less than [REDACTED] months.</p> <p>At 10:43 a.m., MDS Staff A stated, both MDSs were coded incorrectly, "should have been marked the other way around."</p>	F 278	

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F 278 Continued From page 28
Resident #182

F 278

Resident #182 was admitted to the facility on [redacted]/13 to included a diagnosis of [redacted].

The resident's preliminary care plan, dated 8/1/13, indicated the resident received a daily scheduled anti-seizure medication.

The resident's MDS, dated 8/8/13, was not coded for seizures in the section for active diagnoses.

On 10/31/13 at 9:47 a.m., reviewed the resident's MDS with MDS Staff A. She said the resident received medication for seizures showing the surveyor her paper of notes about the resident. MDS Staff A said she must have missed coding seizures in the active diagnosis section.

Resident 82

Resident #82 was admitted to the facility on [redacted]/13 for r [redacted] after a [redacted] and [redacted].

Records showed the resident's admission weight on [redacted]/13 was [redacted] pounds. On 10/15/13 the resident's weight had dropped to [redacted] pounds. This was an [redacted] pound (7.9 percent) drop in weight over an 11 day period.

The Minimum Data Set (MDS) was completed on 10/17. The MDS indicated the resident's weight was [redacted] pounds. The MDS was coded to indicate the resident did not have a weight loss of 5 percent or more in the last month.

RESIDENT #84

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F 278	<p>Continued From page 29</p> <p>Resident #84 was admitted to the facility on [REDACTED]/13 with diagnoses to include [REDACTED] disease and [REDACTED].</p> <p>Resident #84's MDS dated 7/01/13, documented the resident had minimal cognitive impairment, was able to make his needs known, and required extensive assistance of one person with brushing his teeth.</p> <p>Documented in the MDS assessment was resident #84 had no natural teeth, no broken teeth and his mouth was able to be examined.</p> <p>On 10/22/13 at 10:00a.m., Resident #84 was observed to have several broken teeth upper and lower. Resident #84 stated he did his oral care independently. Resident #84 stated he did not wear dentures.</p> <p>On 10/28/13 at 1:00p.m., MDS staff B stated when she completed an examination of the resident's mouth, "I observe, look in the chart and the care directives in the closet ..." The MDS staff B further stated, "I haven't actually done an examination of a resident's mouth honestly. I don't have the time, I have so many MDS assessments to complete and I rely on someone elses opinion ... I don't have the time We can have up to 6 admits per day."</p> <p>Resident #133</p> <p>Resident was admitted [REDACTED]/13 with multiple medical diagnoses to include [REDACTED] with [REDACTED] sided [REDACTED] and [REDACTED].</p> <p>The resident's admission MDS, dated [REDACTED]/13,</p>	F 278		
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F 278	<p>Continued From page 30</p> <p>indicated the resident had "no natural teeth or tooth fragment(s)." The resident required an extensive assist to complete activities of daily living.</p> <p>Observation of Resident #133 during the survey was teeth were present. The resident stated they were her natural teeth and not dentures.</p> <p>On 10/28/13 at 3:30p.m., MDS A said the process to complete the dental section of the MDS was "I look at the closet sheet and admission records." MDS Staff A stated, "I looked and thought they were dentures." MDS Staff A verified that resident did not have dentures and indicated the MDS was coded incorrectly.</p> <p>Resident #34</p> <p>Resident was admitted [REDACTED]/13 with multiple medical diagnoses to include right [REDACTED] with [REDACTED] repair and [REDACTED].</p> <p>The resident's admission MDS dated [REDACTED]/13, indicated the resident had an unstageable deep tissue pressure ulcer and was at risk of pressure ulcer development. The resident required an extensive assist of two persons for repositioning and transfers from bed to wheelchair.</p> <p>The pressure ulcer information from the MDS was not carried forward to the Care Area Assessment (CAA) dated 10/9/13. The CAA indicated the resident "is at risk for developing pressure ulcers. No pressure ulcers present."</p> <p>On 10/30/13 at 3:49p.m., MDS Staff A indicated Licensed Nurse (LN) D completed the skin section of the MDS and the CAA was completed</p>	F 278		

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F 278	Continued From page 31 by MDS Staff. "We write the CAAs, but don't do all the care plans. LN D does (care plans) if actual skin problems and we do if skin at risk." MDS Staff A verified the MDS information was not included in the CAA, "I missed it." The inaccurate assessment resulted in the information of on unstageable pressure ulcer to the resident's heel not being carried forward to the care plan.	F 278		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280		

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F 280	<p>Continued From page 32</p> <p>by: Based on observation, interview and record review the facility failed to review and/or revise a plan of care for 4 current sampled residents (#65, 128, 131 & 214) and 2 discharged/former resident (#222, 263) of 31 residents reviewed for care planning. The facility failed to offer the opportunity for residents to be involved in their daily care for 1 of 24 current sampled residents (#250) reviewed for participation in comprehensive care planning. The failure to develop a comprehensive care plan placed residents at risk for receiving inappropriate and inadequate care to meet their individual needs.</p> <p>Findings include:</p> <p>Resident #214</p> <p>Resident #214 was admitted on [REDACTED]/13 with diagnosis to include a [REDACTED], altered [REDACTED] status ([REDACTED]), and onset of difficulty with [REDACTED] and [REDACTED]. According to the record and the daughter, the resident had a history of falls and [REDACTED] her [REDACTED] at home in the last fall.</p> <p><Falls></p> <p>The fall assessment done on admission indicated the resident was at high risk for falls and the Minimum Data Set (MDS), an assessment tool, dated 8/20/13 also indicated the resident was at risk for falls.</p> <p>A review of the resident's care plan showed a goal minimize the risk to the resident while maintaining maximum independence. The initial interventions on 8/23/13 included:</p>	F 280		
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F 280	<p>Continued From page 33</p> <ol style="list-style-type: none"> 1) Assess for assistive devices, fall mat next to the bed, bed against the wall, bed in low position, perimeter mattress to find boundaries of bed, tilt W/C (wheelchair) to assist with positioning/comfort, Pressure alarms to W/C and bed with reminding resident to wait for assistance with transfers. 2) Assess risk factors 3) OT eval (evaluation) and treatment 4) PT eval and treatment 5) See in room plan of care (an overview of interventions for staff working with the resident on a daily basis) <p>No further interventions were added to the fall care plan and the interventions in place were not reviewed and revised after 8/23/13 although the resident fell 12 times after this date. On the incident report dated 9/2/13 a recommendation was made to keep the resident near the nursing station. This intervention was not added to the care plan. On 10/10/13, over a month after the recommendation, a similar intervention was added to the care plan under behavioral symptoms indicating "seat resident where constant or near constant observation is possible." This intervention was not found on the in room care directive.</p> <p><Activities></p> <p>A review of the Activities care plan for Resident 214 showed a problem of potential for low participation in group activities related to [REDACTED], [REDACTED] and [REDACTED] disease. This problem was</p>	F 280		

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F 280	<p>Continued From page 34</p> <p>initiated on 8/13/13 and interventions were added at that time. No further activity interventions were added to the activity care plan.</p> <p>During an interview with the daughter on 10/28/13, she indicated prior to admission her mother was reading the New Yorker, watching PBS and C Span on TV. She indicated resident #214 liked to be well informed. She further indicated her mother was walking 20-30 minutes a day on her own.</p> <p>A review of the care plan showed no information regarding resident's preference for PBS and C Span. There were no interventions regarding current events and nothing indicating the resident liked to go for walks.</p> <p>In an interview on 10/29/13 the Activity Director (AD) indicated, "When we take her up to the TV and place her in front of TV and try different TV shows, (the resident) will shake her head no over and over. When she shakes her head yes you know you are on the show she wants to watch." When asked if any of the staff have this information, the AD stated, "No, I really haven't told them."</p> <p>The AD further stated "for our long term residents we put an activity sheet on the inside of the closet with all the things they like to do. I in-serviced the staff on these sheets. I told the staff you need to invite them to things and make sure they get there." When asked if (the resident) had a sheet in her closet with this information (she had been there for over 2 months), the AD indicated "We didn't do this because she wasn't going to be long term."</p>	F 280		

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F 280	<p>Continued From page 35</p> <p>A review of the in room plan of care, updated on 10/24/13, showed no information regarding ways to distract or redirect the resident including her likes, her previous activities, her preference for old movies, C Span, PBS, and current events.</p> <p>Resident #128</p> <p>Resident #128 was admitted to the facility with a diagnosis of [REDACTED] with [REDACTED] lesions. During her stay in the facility she had been sent to the hospital for a period of 12 days and returned with further diagnoses to include: [REDACTED] (an [REDACTED] condition) and [REDACTED] (formation of a [REDACTED] inside a [REDACTED]).</p> <p>A review of the record showed, prior to her [REDACTED]/13 hospitalization the resident had occasional complaints of pain, especially related to therapy, and the pain was controlled with the use of [REDACTED]. At that time the resident had no order for an opiate pain medication. Upon return to the facility on 10/16/13, the resident was noted with increased complaints of pain and required the use of [REDACTED] (an opiate pain medication) almost daily to control the pain. Nursing notes indicated the resident was "moaning...Not eating" and "having pain not well controlled by the [REDACTED]."</p> <p>A review of the care plan for Resident 128 showed a problem for pain with interventions related to pain control was initiated prior to the resident's hospitalization on [REDACTED]/13. No further updates or changes were made to the care plan for pain after that date although the resident was showing signs of increased pain and required increased interventions to control the pain upon</p>	F 280		

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F 280	<p>Continued From page 36 her return from the hospital.</p> <p>Resident #263</p> <p>Resident #263 was admitted to the facility with diagnosis to include [redacted] sided [redacted] Accident ([redacted]) (Acute [redacted]) and [redacted]. Resident 263 resided in the facility for 6 days before she was transferred to the hospital after a fall with a [redacted] fracture.</p> <p>Review of the record showed resident #263 was assessed on 9/28/13 as a high risk for falls due to her [redacted], [redacted] sided [redacted] and [redacted]. The OT notes and PT evaluation for 9/28/13 indicated the resident was a one person assist with transfers.</p> <p>During an interview with RCM A on 10/31/13, he indicated if a resident is admitted with a history of falls certain interventions would be utilized right away, such as leaving the bed in the low position.</p> <p>A preliminary care plan was initiated on 9/28/13 with a problem related to the resident's high risk for falls. The goal was "Rs (resident) to have no falls/injury." The only intervention on the preliminary plan was "see in room care plan." The in room care directive indicated the resident was 1 person assist for ambulation and transfers. No specific interventions were noted to mitigate the resident's risk for falls.</p> <p>According to the nursing notes on 10/3/13, a pressure alarm was added to her wheelchair and the recommendation was made to keep resident near staff. Neither of these interventions had been added to the residents preliminary care plan or to her in room care plan.</p> <p>Resident 131</p>	F 280		

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The facility's Dialysis (a process to filter blood for removal of waste and extra fluid) Care Policy and Procedures (P&P), last date of review 2/13, indicated care plan interventions should be individualized to the resident, but also include the following: a) no blood draws on access arm, b) no blood pressure readings on access arm and d) routine weight per MD (medical doctor) order.

Resident #131 was admitted to the facility on [REDACTED]/13 with diagnoses to include [REDACTED] disease requiring [REDACTED].

On 10/26/13 at 8:13 a.m., the resident stated she went to dialysis three times a week for the past year. The resident was observed to have a shunt (a surgical access site for dialysis) in her [REDACTED] arm. She said, "The facility does not do anything to or for the shunt or dressing."

A review of the resident's dialysis care plan, dated 10/7/13 showed there was no documentation of the interventions in accordance with the policy. The intervention dated 10/7/13 for the shunt location was blank.

On 10/29/13 at 11:28 a.m. the Director of Nursing Services (DNS) stated the Resident Care Manager (RCM)s were responsible for updating the care plans. She said we should be following our dialysis policy.

Resident #250

Resident #250 was admitted to the facility on [REDACTED]/13 with diagnoses to include [REDACTED] and [REDACTED] problems.

The resident's MDS dated 10/15/13 indicated the

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F 280	<p>Continued From page 38</p> <p>resident was able to make her own daily decisions.</p> <p>The resident's Care Area Assessment (CAA) dated 10/18/13 for Activities of Daily Living documented resident evaluated by Physical Therapy (PT) and Occupational Therapy (OT) for decreased strength, mobility, transfers, and safe ambulation.</p> <p>Record review revealed a Daily Therapy Schedule dated 10/24/13 documenting the resident's PT was scheduled for 2:00 p.m.</p> <p>On 10/22/13 at 9:32 a.m., when asked Resident #250 if she was involved in decisions about her daily care, the resident replied, "No, whatever they say goes, PT in the afternoon--no set time."</p> <p>On 10/25/13 at 3:50 p.m., the Director of Rehabilitation (DOR) said she made the resident's daily PT and OT therapy schedules. She stated, "to schedule the resident, the therapist determines what time is most appropriate" for the residents. The schedule was "consistent for most of the residents...not all have set times." The DOR said she provided the daily schedule to nursing who placed the schedule in a book at the nurse's station.</p> <p>On 10/28/13 at 11:58 a.m., the Assistant Director of Nursing Service (ADNS) said she reviewed the therapy schedules. She stated the schedules might be changed on occasion if there was interference with the resident's breakfast or showers. The ADNS conveyed all of the staff worked together if or when there were any issues.</p>	F 280		

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F 280	<p>Continued From page 39</p> <p>Resident 222</p> <p>Resident #222 was admitted on [REDACTED]/13 with diagnoses of multiple [REDACTED] from a [REDACTED] accident to include [REDACTED], [REDACTED] surgery, [REDACTED] and [REDACTED].</p> <p>The resident's preliminary care plan, dated 8/20/13, indicated the resident had confusion and forgetfulness with impaired ADL ability requiring two-person maximum assist, was receiving an anti-anxiety medication as needed and a regularly scheduled blood thinner. This care plan identified the resident at high risk for falls/injury.</p> <p>Resident #222 had eight falls within 14 days to include four on one day.</p> <p>The resident's in-room care directive, dated, 8/20/13, documented rimmed mattress, pressure alarm on wheelchair and bed.</p> <p>The facility's documentation revealed the resident had a non-injury fall on 8/21/13 rolling out of bed at 8:45 p.m. There was no documentation the facility re-evaluated the effectiveness of the rimmed mattress or the functionality of the bed alarm.</p> <p>The resident had four falls on 8/22/13.</p> <p>At 3:15 a.m., the staff found the resident lying on the floor next to her bed with complaints of hitting her head.</p> <p>At 7:00 a.m., the staff found the resident on the floor in her room with complaints of hitting her head. The facility's documentation revealed the resident was agitated, restless, and confused.</p>	F 280		

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F 280	<p>Continued From page 40</p> <p>At 8:16 a.m., the staff found the resident beside her wheelchair with complaints of hitting her head</p> <p>At 5:00 p.m., the staff found the resident with her back on the mat next to her bed.</p> <p>For these four falls in one day, there was no documentation the resident's care plan was updated with new interventions after each fall to prevent further falls for Resident #204 with a TBI receiving a blood thinner medication.</p> <p>There was no documentation the facility re-evaluated the effectiveness of the existing interventions to include the rimmed mattress or the functionality of the bed alarm for these two falls.</p> <p>Progress note dated 8/23/13 documented resident had a bruise to her [redacted] buttock measuring 12.5 centimeters by 12.5 centimeters (4.9 inches by 4.9 inches) as resident has a history of falls on 8/22.</p> <p>After five falls, a falls care plan dated 8/23/13 indicated the resident was at risk for falls due to impaired safety awareness, balance, trunk control, and proprioception (sense of one's body, limb movement, and positioning).</p> <p>Interventions included do not leave alone in the bathroom, low bed with one side along the wall, mattress next to bed as extension of the bed, sensor alarms on bed/wheelchair, physical/occupational therapies and tilt wheelchair to provide resident assist with trunk balance allowing her to be safely up in wheelchair.</p>	F 280		

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F 280	<p>Continued From page 41</p> <p>The next day, 8/24/13 at 4:43 p.m. another fall occurred. The facility's documentation showed, "after this we put a pressure alarm in her chair." According to the care directive, dated 8/20/13 and the fall care plan, the alarm should have been placed in the resident's wheelchair.</p> <p>The resident's MDS dated, 8/27/13, indicated the resident was moderately impaired with daily decision-making skills and required extensive assistance with transferring, walking, and toileting.</p> <p>Resident #222's CAA for ADLs and falls dated 8/27/13. The CAAs documented the resident had multiple falls since admit and was recovering from a [REDACTED]. The resident had cognitive deficits, was impulsive, does not like to wait, and displayed poor safety awareness.</p> <p>There was no documentation the fall care plan was revised or evaluated to address the resident's care needs to include her poor safety awareness and impulsiveness to prevent further occurrences of falls.</p> <p>On 8/30/13 at 9:00 a.m., the staff found the resident on the floor, near her bed with no injuries.</p> <p>On 9/2/13 at 6:00 p.m., the staff found the resident on the floor, near her bed "with fecal matter around herself" with complaints of hurting her wrist.</p> <p>There was no documentation the facility re-evaluated the effectiveness of the current interventions or implemented new interventions to</p>	F 280		
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F 280	<p>Continued From page 42 mitigate further falls.</p> <p>On 10/29/13 at 11:42 a.m., the DNS said the Resident Care Managers should update the care plans and care directives to indicate the resident's fall risk level and when interventions change. The DNS stated, "...we did not do things we should have done."</p> <p>RESIDENT #224</p> <p>Resident #224 admitted to the facility on [REDACTED]/13. Resident was alert and oriented and able to make her care needs known. Admission diagnosis included [REDACTED], [REDACTED] and frequent [REDACTED]. Resident was admitted for [REDACTED] building and [REDACTED] efforts.</p> <p>Record review showed the preliminary care plan and a fall assessment, both dated, 8/23/13 documented resident #224 was at high risk for falls.</p> <p>A falls care plan dated, 9/11/13, documented, Resident #224 was a high risk for falls. The goals was "minimize risk to resident while maintaining maximum independence." The interventions stated, "assess for assistive devices, assess risk factors, physical and occupational evaluation and treatment, tab alarm on resident while in wheel chair and bed and "see in room plan of care." There was no in room care directive observed for this resident.</p> <p>On 8/26/13 a facility's fall investigation report documented, "Resident found on floor next to wheel chair."</p> <p>On 8/28/13, a facility's fall investigation report</p>	F 280		

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documented "Resident's wheelchair alarm was going off when this nurse entered the room and saw the resident on the floor, with her head against the bed and her drink spilled all over the floor. There were no interventions to mitigate additional falls for Resident #224. No updates were made to the resident care plan.

A nursing progress note dated 8/29/13 revealed Resident #224 had a fall at 3:30p.m., "Pt. found on floor on her knees this evening shift ...no complaints of pain or discomfort."

On 9/4/13, a facility's fall investigation report documented, "At 7:10a.m., ...when entered room found resident sitting down on the floor with feet in front, pressure alarm on and wheelchair by her side without brakes ...no injuries noted."

A nursing progress note dated 9/8/13 stated, "Resident with non-injury fall this evening at 8:15p.m., Resident states she 'hit her hip and head' when she 'rolled over and fell out of bed' ... placed on alert charting." There was no further documentation to support the facility had intervened on behalf of the resident to mitigate any additional falls. There were no assessments completed to rule out injury r/t the resident statement that she had 'hit her head.'

On 9/10/13, Resident #224 fell at 6:00a.m., and 2:00p.m., The facilities fall investigation report at 6:00a.m., stated, "Resident was found on floor by Nursing Assistant (NA). At 2:00p.m., on 9/10/13 documentation of the facilities fall investigation stated, NA on duty notified nurse that resident was found on ground next to bed. No new interventions on the care plan were implemented to reduce resident's risk of falling.

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F 280	<p>Continued From page 44</p> <p>On 9/17/13 "Resident fell in the hallway by her room ... at 6:00p.m., resident was in w/c in hallway by her room and was having increased tremors; she slid out of her chair and was caught and lowered to the floor. She than was assisted back to her wheel chair. At 6:05p.m., the resident slid out of her wheel chair again and was assisted to bed."</p> <p>On [REDACTED]/13, Resident #224 was discharged to the hospital from the nursing facility and did not return to the facility.</p> <p>On 10/31/2013 at 9:15a.m., Resident #224's famiily member reported he asked the resident why she wouldn't wait for help and was told, 'they won't come help me.' He stated, "They would keep her in the hallway to keep an eye on her." He reported the roommate would push her button to get help for his mom when she was almost falling out of bed ...I was unhappy no one was around and she fell many times ..."</p> <p>At 10:00a.m., meeting with the Director of Nursing (DNS), Nurse Consultant (NC) B, Administrator (ADM and Consulting Administrator (CADM) regarding the falls of Resident #224. The DNS and ADM were asked to describe what their expectations of what needed to happen after a resident fell in the in the facility. The DNS stated, "We ensure they are safe, assess for injuries, check vital signs and try to figure out why they have fallen. " The ADM Stated,"Everyone on the team has their own piece of it depending on the resident needs so we may have to talk about it."</p> <p>There were no revisions to the residents care plan to decrease the likelihood of continued falls in all instances above.</p>	F 280		

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F 281 SS=E	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure services provided met professional standards of quality for 2 of 6 residents (#s 260 & 69) when the facility did not follow physician orders to ensure resident's received their prescribed medications. This failure resulted in residents not receiving their medications as ordered and timely and placed the residents at risk for complications.</p> <p>Findings include:</p> <p>According to Fundamentals of Nursing, 3rd Edition, (Taylor, Lillis, & LeMone), Fundamentals of Nursing (Lippincott, 3rd Ed.) states, "Nurses are legally responsible for carrying out the orders of the physician in charge of a client."</p> <p>Resident 260</p> <p>Resident 260 was admitted to the facility on [REDACTED]/13 at with diagnoses to include [REDACTED] pain, [REDACTED] and [REDACTED] [REDACTED] (a [REDACTED] infection of the [REDACTED]).</p> <p>On 10/28/13 Resident 260 received a new Doctor's order for a [REDACTED] patch (pain patch).</p> <p>When interviewed on 10/28/13, LN C indicated</p>	F 281		
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F 281	<p>Continued From page 46</p> <p>the patch was ordered that morning and the first patch was placed on the resident. When LN C was asked to show a copy of the MAR documenting the patch, she stated, "I haven't put it on there yet." When asked for a copy of the Doctor's order, LN C stated, "I haven't written it yet. I do have the order I just haven't had time to write it."</p> <p>A review of the MAR and Doctor orders the following morning (10/29/13) revealed an order for the [REDACTED] patch to be applied in the a.m., left on for 12 hours, then removed for 12 hours. The patch was not entered on the MAR.</p> <p>The resident was interviewed at 10:15 a.m. on 10/29/13 regarding the patch. She stated the patch was not changed. "Those are supposed to be removed after 8 hours I think." The resident then reached down towards her [REDACTED] back area. "Yes, I can feel it still there."</p> <p>On 10/29/13 at 10:20 a.m., LN C indicated she put the order for the patch on the MAR the night before. When asked for a copy of the MAR, LN C was unable to find it and stated she forgot to place the order on the MAR the night before.</p> <p>LN C and the surveyor went to the resident room to check the patch on the resident. LN C said she thought she placed a new patch on the resident that morning. While the LN and the surveyor were standing in her room, the resident stated, "it was never taken off last night." The resident indicated the patch was the same patch that was placed on her the morning before.</p> <p>At 10:23 a.m. on 10/29/13, RCM C was alerted to the patch was left on the resident longer than the</p>	F 281			

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F 281	<p>Continued From page 47</p> <p>doctor order indicated. The RCM got up and indicated she would "fix this ASAP."</p> <p>A few minutes later, RCM C said, "It was left on because there was no entry on the MAR so they didn't know to take it off. LN C said, "The patch should have been put on (the MAR) yesterday. We took that patch off and placed a new one on." When asked about the Doctor order regarding 12 hours on and 12 hours off, the RCM stated "On 12 off 12 is the instructions on the package." She then exclaimed, "Oh my gosh and we just put it on for another 12! (Indicating there was no 12 hour period in which the patch was off) I will talk to her (the resident)."</p> <p>Refer to F309</p> <p>Resident #69</p> <p>Resident #69 was admitted to the facility on [REDACTED]/10 with diagnoses to include a [REDACTED] with [REDACTED] sided [REDACTED] and [REDACTED] problems. The resident was placed on comfort care 10/18/13 for new diagnoses to include a [REDACTED]</p> <p>A physician's order, dated 10/11/13, indicated for the resident to receive a transdermal [REDACTED] patch (a patch placed on the skin behind the ear to decrease secretions, nausea and vomiting) and changed every 72 hours.</p> <p>On 10/22/13 at 10:25 a.m., 10/23/13 at 9:25 a.m. and 10/27/13 at 10:45 a.m., a patch was not observed behind or in the area of the resident's ears.</p> <p>On 10/27/13 at 10:53 a.m., reviewed the resident's MAR with LN B. She stated she applied the [REDACTED] patch on the resident the day</p>	F 281		

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F 281	<p>Continued From page 48</p> <p>before. The surveyor asked LN B to show where she applied the patch. LN B checked both sides of the resident's ear area to locate the patch. There was no patch.</p> <p>LN B stated when she applied the [REDACTED] patch the day before, the resident did not have a patch to remove. LN B said she was uncertain what the policy was for the LNs on subsequent shifts to ensure the resident received his medication patch.</p> <p>There was no documentation on the MAR the subsequent shifts ensured the resident received the [REDACTED] patch as per doctor's orders.</p> <p>On 10/28/13 at 3:45 p.m., RCM C was asked what was the expectation of staff to ensure residents received their medication patches as the doctor ordered, RCM C replied the patch was monitored every shift and documented on the MAR. The surveyor and RCM C reviewed Resident #69's MAR. RCM C commented, "There is no place for the LN to initial every shift for placement." RCM C reviewed another resident's MAR with the surveyor and LN C who worked the 100 hall. RCM C said, There should be a place for the LNs to initial, but there isn't."</p> <p>On 10/29/13 at 11:13 a.m., the DNS was asked what was the expectation of staff to monitor medication patches placed on residents. The DNS replied, "the patches should be monitored on the MAR to ensure the patch is in place." The surveyor and the DNS reviewed the MAR for Resident #69. The DNS stated, "There is usually another order on the MAR to check for placement." There was no order on the MAR to ensure the resident received his medication</p>	F 281		
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F 281	Continued From page 49 patch.	F 281		
F 282	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide care and services in accordance with each resident's written plan of care for 2 of 31 sampled residents (#131 & 204) reviewed for implementation of care plans. This failure placed residents at risk for not receiving the proper care and services to prevent complications related to bowel management and dialysis.</p> <p>Findings include:</p> <p>Resident 204</p> <p>Resident #204 was admitted to the facility on [REDACTED]/13 with diagnoses of [REDACTED] loss and [REDACTED]. The resident received narcotic pain medications, which could cause constipation.</p> <p>The facility's nursing admission observation report completed [REDACTED]/13 documented the resident was confused and dependent on staff for toileting.</p> <p>A review of the bowel record, showed Resident</p>	F 282		

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F 282	<p>Continued From page 50</p> <p>#204 did not have a Bowel Movement (BM) from 8/1/13 until the morning of 8/4/13. The resident did not have a BM from 8/5/13 until the morning of 8/8/13. The resident did not receive the facility's bowel protocol for either of the two sets of dates.</p> <p>The resident's constipation care plan, dated 8/11/13, documented interventions to include "bowel care regimen: follow house bowel program ...encourage fiber intake."</p> <p>Record review showed four diet order/communication forms dated 8/2/13, 8/6/13/, 8/8/13, and one undated. There was no documentation regarding fiber was added to the resident's diet. There was no documentation in the record, the resident was encouraged or received fiber foods.</p> <p>On 10/28/13 at 4:45 p.m., in reviewing the resident's record with the Registered Dietician (RD), she stated there was no food preference sheet to provide the resident with fiber foods. The RD said prune juice could be offered, "according to the resident's diet slips, there isn't anything documented about providing or encouraging fiber food of any sorts, no prune juice." The RD conveyed laxatives should have been used."</p> <p>On 10/29/13 at 2:18 p.m., the Director of Nursing Services (DNS) said, "providing fiber should have been on the resident's dietary slip...could be in a pill form or through food." The DNS reviewed the resident's record stating there was no indication the resident received any fiber as documented in her constipation care plan.</p>	F 282		

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F 282	<p>Continued From page 51 Resident #131</p> <p>Resident #131 was admitted to the facility on [REDACTED]/13 with diagnoses to include [REDACTED] disease requiring [REDACTED] (a process to filter [REDACTED] for removal of [REDACTED] and extra [REDACTED]).</p> <p>The resident's Minimum Data Set (MDS), an assessment tool, dated 10/3/13 documented the resident was cognitively intact for daily decision-making.</p> <p>The resident's dialysis care plan, dated 10/7/13, documented interventions to include, "Monitor shunt (surgical access site for dialysis) site erythema (redness), induration, tenderness, and purulent (pus) drainage. CMS (circulation, movement sensation) changes distal to shunt site."</p> <p>On 10/26/13 at 8:13 a.m., when asked the resident about her shunt in her [REDACTED] arm, she replied the site was used for dialysis. She indicated the staff at the dialysis unit were "the only staff who looks at the dressing" and changed the dressing. When asked if the facility staff listened to the shunt with a stethoscope or felt the site, she replied, "the facility does not do anything to or for the shunt or dressing."</p> <p>A review of the resident's record revealed no documentation of implementation of the interventions indicated on her dialysis care plan.</p> <p>On 10/28/13 at 1:25 pm., Resident Care Manager (RCM) B stated the facility looked at the resident's shunt for any signs of infection and assessed for a thrill documenting in the progress notes daily. She reviewed the resident's progress</p>	F 282		

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F 282 Continued From page 52 notes and verified no documentation in the progress notes. When asked if the documentation was located elsewhere in the resident's records, RCM B replied the documentation should be in the progress notes as a daily Medicare charting note and spelled out in the MACC (facility's alert charting system) charting book.

On 10/29/13 at 11:13 a.m., the DNS reviewed Resident #131's record with the surveyor. When asked about the facility's responsibility regarding documentation of the resident's shunt, the DNS stated the staff should be documenting the shunt site in the resident's record. She stated RCMs updated the care plans and the policy and procedures should be followed.

F 282

F 309 483.25 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 accordance with the comprehensive assessment and plan of care.

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 3 of 5 current sampled residents (#s 257, 260 & 128) reviewed for pain, 1 of 1 discharged residents

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F 309	<p>Continued From page 53</p> <p>(#204) and 1 of 1 current sampled resident (#128) reviewed for bowel management, 1 of 1 current sampled resident (# 131) reviewed for dialysis. These failures placed residents at risk for increased pain, constipation and complications related to dialysis.</p> <p>Findings Include: <Pain></p> <p>Resident #257</p> <p>Resident #257 was admitted to the facility on [REDACTED]/13 after s [REDACTED] to replace her [REDACTED] and for monitoring of her surgical site and [REDACTED].</p> <p>During an interview on 10/22/13, the resident was observed rubbing her leg and her hip. The resident said, "They told me it's just a part of the healing process for the hip. Nerves take a while to heal. I get some relief from the medications."</p> <p>On 10/25/13 Resident #257 stated, "I have a lot of breakthrough pain. It is getting better and I did have a little less yesterday. [REDACTED] is not effective alone but I take it in between the other pills because the other pain pill doesn't last. This wheelchair is very uncomfortable and that does not help. They tried to find me a new one but they haven't had any luck." The resident further stated she sometimes had shooting pain in her back. "When I was at home I would use a hot water bottle. I have thought about asking for a cold pack, but I don't know if it would work." When asked if anyone had talked to her about other ways to alleviate pain the resident stated, "No one has talked to me about pain management or other things to help with the pain."</p>	F 309		
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F 309 Continued From page 54

On 10/26/13, the Resident indicated she needed a larger ice pack for her hip. The staff had given her an ice pack to alleviate some of her pain. The resident stated she was having pain around the surgical site and the pack given to her was "too small." She recalled getting a much larger pack from Physical Therapy (PT) before and wanted to know if she could use that. The resident pulled the ice pack out to show the surveyor. The ice pack was approximately 4 inches by 3 inches. The resident indicated her incision site was three times larger than the pack nursing staff had provided. The resident stated, "the area it covers feels great. The rest of the surgical site, not so much"

On 10/26/13, a staff member in the rehab room indicated they do have larger ice packs in the therapy room, "but we don't let residents use them without supervision." When asked if nursing would be able to borrow those for residents, she stated "I suppose they could come and ask for one if they needed it." When the resident was informed of this information by the surveyor, she stated, "oh they won't ask, never mind."

A review of the record showed the initial pain assessment was done on 10/18/13. At that time the resident indicated her pain was 8 (on a scale of 0-10 with 10 indicating severe pain). She further indicated she was taking [REDACTED] (a combination of [REDACTED] and the opiate [REDACTED] used to treat moderate to severe pain) but it did not resolve the pain completely.

A review of the facility's Pain Policy showed, "The in room care plan will include non-pharmacological interventions that the

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F 309	<p>Continued From page 55 resident finds helpful for pain management."</p> <p>The preliminary care plan for Resident #257 directed staff to "see in room care directive" and "See MAR/TAR (medication administration record/treatment administration record) for current medical interventions." A review of the in room care directive showed no interventions for alternate pain relief. A review of the MAR showed pain medications as the only intervention to address the pain.</p> <p>A review of the MAR on 10/25/13 revealed the resident had orders for as needed pain medications to include: [REDACTED] and [REDACTED]. Between 10/18/13 and 10/25/13, the [REDACTED] was given 24 times and the [REDACTED] was given 10 times. Assessment of her pain level was not documented with every administration of the [REDACTED] or [REDACTED]. A doctor's order was noted in the record to complete pain level assessments each shift.</p> <p>In an interview Licensed Nurse (LN) F was asked what alternatives to pain meds could be offered to residents experiencing pain, "I don't know if we have anyone who can assess for other interventions. I might offer to reposition but other than that I'm not sure." LN G stated, "Repositioning maybe. Sometimes a warm moist towel in a bag and pillow case."</p> <p>On 10/27/13, Resident Care Manager (RCM) A was asked about pain assessments. He indicated an initial assessment was done when residents arrived. RCM A indicated CNA's (Certified Nursing Assistant's) report to the LN if a resident is hurting. The LN asks the residents if they are in pain or not. "Something should be</p>	F 309		

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F 309	<p>Continued From page 56</p> <p>documented each shift about pain. We also assess on each administration of a PRN (as needed) medication: A pre and post dosage pain level on a scale of 1-10 should be documented on the back sheet of the MAR with each PRN."</p> <p>RCM A indicated, "When we do the initial pain assessment we ask if they are having any pain. If they say yes we will ask what other things have worked for them in the past." When asked if they explore alternatives if the resident indicates he/she is not having pain at the time of the initial assessment RCM A stated, "No we really don't explore it."</p> <p>When asked if the facility had ice packs available that were bigger than the one resident #257 had been given the day before RCM A said, "No, I think they have them down in therapy, but we don't have anything on the floor." RCM A added they were not able to borrow a bigger ice pack from the therapy department.</p> <p>Resident 260</p> <p>Resident 260 was admitted to the facility on [REDACTED]/13 with diagnoses to include [REDACTED] and [REDACTED] (a [REDACTED] infection of the [REDACTED]).</p> <p>Record review revealed a pain assessment was completed when the resident admitted to the facility. On the pain assessment, the resident indicated her pain was 7 out of 10 on the pain scale and the resident used a [REDACTED] Patch as needed to relieve the pain.</p> <p>On 10/21/13 the resident indicated she had breakthrough pain "almost daily" and [REDACTED]</p>	F 309		

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F 309	<p>Continued From page 57</p> <p>patches helped to alleviate the pain. The resident stated no one had discussed pain relief alternatives for breakthrough pain.</p> <p>A review of the MAR on 10/28/13, showed no entry for the [REDACTED] Patch. The resident had received [REDACTED] 27 times in a 10 day period. The resident's pain was assessed, she rated her pain between 7-9 (on a scale where 10 is equivalent to severe pain).</p> <p>A review of the resident's record showed no order for the [REDACTED] Patch or Doctor's note addressing the use of the patch for pain. The nursing progress did not indicate the [REDACTED] patches were addressed with the doctor.</p> <p>A review of the care plan and in room care directive showed no alternatives to pain meds listed as a way to alleviate the resident's pain.</p> <p>When interviewed on 10/28/13, LN C indicated the patch had been ordered that morning and the first patch was placed on the resident. She indicated she was unsure why it took 7 days to obtain the order for the [REDACTED] patch. When LN C was asked to show a copy of the MAR listing the patch, she stated "I haven't put it on there yet." When asked for a copy of the Doctor order, LN C stated "I haven't written it yet. I will write it when I am done with meds. I do have the order I just haven't had time to write it."</p> <p>When asked about the [REDACTED] Patch, RCM C stated, "We just got the order this morning. I didn't know anything about it until today. It was on the communication board but the ARNP never addressed the issue. I would have called him right away if I had known. It's been on the</p>	F 309		
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F 309	<p>Continued From page 58</p> <p>communication board but it was overlooked. I found out this morning and called him right away to get the order."</p> <p>Resident 128</p> <p>Resident 128 was admitted to the facility with a diagnosis of [REDACTED] with [REDACTED] lesions. During her stay in the facility she had been sent to the hospital for twelve days and returned with new diagnoses including [REDACTED] (an [REDACTED] condition), and [REDACTED] (formation of a [REDACTED] inside a [REDACTED]).</p> <p>On initial interview with the resident 10/23/13, the resident indicated she was in pain and didn't want to interview until pain med was given. After pain med the resident appeared very sleepy. She kept indicating she was willing to participate in the interview, but was so sleepy she couldn't stay awake. The resident was also noted wincing and moving her body slowly in bed trying to find a comfortable position. As the surveyor left the room, the resident could be heard moaning.</p> <p>On 10/26/13 the resident was observed to be more alert and able to remain awake during a visit with the surveyor. She indicated she was overdue for her pain pill. She stated her pain was about an 8. The resident had pain in the legs since surgery.</p> <p>On 10/27 the resident was interviewed with her son. The resident stated her pain was still there. She had breakthrough pain even with the [REDACTED] (a pain medication with a combination of [REDACTED] and an opiate). The resident and the son indicated the pain has been worse since she went out to hospital and came back. The</p>	F 309		

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F 309 Continued From page 59
Resident's son stated she "was requesting [REDACTED] for pain prior to her [REDACTED] hospital admit. Now it seems to be pain that isn't reduced with [REDACTED] and she is using the [REDACTED]" Resident stated she was using the [REDACTED] sometimes to "forget the pain is there" because it "makes her sleepy" and she can "zone out" and forget. The resident stated no one had really talked to her about ways to address the pain other than medications.

A review of the records showed, prior to her hospitalization, the resident was participating in therapy, getting out of bed, and appeared more alert. A review of the MAR confirmed the resident had only received [REDACTED] prior to her hospitalization in [REDACTED]. She had no order for opiate medication until her return after the hospitalization.

A review of the care plan showed a care plan problem for pain had been initiated on 9/9/13. After her return from the hospital, no update was done to the care plan regarding pain although the resident had been complaining more of pain and had been receiving narcotic pain medication almost daily. A review of the in room care directive showed no alternatives for pain relief listed.

A review of the pain assessment showed no new pain assessment had been done when the resident returned from the hospital despite the new diagnosis of the [REDACTED] and [REDACTED].

On 10/24/13, 8 days after her return from the hospital, LN H contacted the ARNP indicating "residents C/O (complaining of) pain not relieved by [REDACTED] 10/325 mg given about an hour ago."

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505514	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/01/2013
NAME OF PROVIDER OR SUPPLIER RICHLAND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1745 PIKE AVENUE RICHLAND, WA 99352		
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F 309	<p>Continued From page 60</p> <p>The ARNP gave new orders for [REDACTED] 20 mg a day for edema to upper and lower extremities and [REDACTED] (starting with 100 mg and titrating up over the next 5 days).</p> <p>A review of the MAR showed although the order was received on 10/24/13, the first dose of [REDACTED] and [REDACTED] were not given until 10/25/13. No order was noted from the ARNP indicating the staff should wait until 10/25/13 to start the first dose and no explanation was given in the record regarding the delay in the start of the medication for her pain. A review of the medication list for the facilities emergency medication kit showed both [REDACTED] 20 mg and [REDACTED] 100 mg was available.</p> <p>On 10/27/13, the Director of Nursing (DNS) indicated when residents are admitted there should be a pain assessment. She stated, "With each PRN the nurse should write out what time it was, the date, where the pain was, then go back in a reasonable amount of time to reassess and make sure it (the medication) was effective. Generally they (the nurses) will write 'effective' or ask them on a pain scale 0-10. Most residents are able to use a word to describe their level of pain. That should be documented on the MAR on the last sheet. They are also to do a pain assessment each shift and document a plus or minus on the MARs."</p> <p>When asked about other methods to alleviate pain the DNS indicated repositioning, decreasing environmental stimulation, splinting if needed, a warm cup of milk, heat or cold could be effective. She also indicated alternative methods should be on the in room care directive.</p>	F 309		

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<Bowel Management>

The facility's bowel protocol included the following treatments:

1. [REDACTED] 30 milliliters oral at night of third day of no BM [bowel movement].
2. [REDACTED] Laxative suppository 10 milligrams rectal if no BM by morning of the fourth day
3. [REDACTED] Enema rectal on afternoon shift of fourth day of no BM

Resident 128

Resident 128 was admitted to the facility with a diagnoses of [REDACTED] with [REDACTED] lesions. During her stay in the facility she had been sent to the hospital for a period of twelve days and returned with new diagnoses which included [REDACTED] (an [REDACTED] condition), and [REDACTED] (formation of a [REDACTED] inside a [REDACTED]).

A review of the record showed a report from the hospital to RCM A when the resident was readmitted on [REDACTED]/13, the resident had not had a bowel movement (BM) for over a week. The note from the RCM further indicated, "will start on facility protocol."

On 10/24/13 RCM A was interviewed regarding the facility bowel protocol. RCM A stated the protocol was to give [REDACTED] on the evening of the third day if the resident had no BM. If the resident still had no BM by the morning of

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F 309	<p>Continued From page 62</p> <p>the fourth day, a [REDACTED] suppository was given. If the resident had no BM by the evening of the fourth day, a [REDACTED] enema was given. If the resident did not have results after the [REDACTED] enema, the Doctor should be called. He indicated the follow up would vary from doctor to doctor but could include use of soap suds or [REDACTED]. He further indicated the BM would need to be at least a medium size for the results to be considered successful.</p> <p>A review of the record showed that the resident was given a bottle of [REDACTED] on the evening of [REDACTED]/13 (the day she returned from the hospital). On 10/17/13 at 3:17 am the progress notes indicated the resident was given a suppository although this was not documented on the MAR. Further documentation indicated the resident only had 2 small BM's on 10/17/13 after the [REDACTED] and the suppository.</p> <p>A call was made to the ARNP on 10/17/13 but there was no indication the residents lack of BM was discussed with the ARNP. Documentation in the record showed the resident did not have a successful BM (by facility standards) until 10/18/13 at 10:19 a.m., a week and a half after the resident's last documented BM.</p> <p>Further review of the record showed, after her BM on 10/18/13, the resident went 4 days without a BM other than a small "dry/hard" BM documented on the morning of 10/19/13 (which was not considered a successful BM according to the RCM A and RCM C). The Bowel Protocol was not initiated.</p> <p>According to the nursing notes, the resident was struggling to have a BM and was given a</p>	F 309		

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██████████ by mouth at 8:10 p.m. on the evening of 10/22/13, although this is not documented on the MAR. On 10/23/13 at 4:30 a.m. (5 days after the last successful BM), the resident was given a ██████████ suppository. At 6:43 a.m. on 10/23/13 documentation showed the resident had a large BM. There was no documentation that the MD or the ARNP were notified the resident had gone 4 days without a BM.

Resident #204

Resident #204 was admitted to the facility on ████████/13 with diagnoses of ██████████ loss and ██████████. The resident received narcotic pain medications, which can cause constipation.

The facility's nursing admission observation report completed 8/1/13 documented the resident was confused and dependent on staff for toileting. The report indicated the resident's abdomen (stomach) assessment was soft with hyperactive bowel sounds.

A review of the bowel record, showed Resident #204 did not have a BM from 8/1/13 until the morning of 8/4/13. The resident did not receive ████████ as per the bowel protocol. The BM was documented as two small size and one medium size on 8/4/13.

The resident did not have a BM from 8/5/13 until the morning of 8/8/13. The facility did not follow their bowel protocol. The BM was documented as four medium size on 8/8/13.

The record revealed the resident vomited on 8/5/13, 8/6/13, 8/8/13 and complained of stomach pain on 8/12/13.

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The medication record for the month of August showed the resident did not receive any of the the bowel protocol medications.

On 10/28/13 at 3:03 p.m. reviewed the resident's bowel record with Resident Care Manager (RCM) C. She stated the resident could have been constipated and described the facility's bowel protocol. RCM C said the resident should have received [REDACTED] on the evening of 8/3/13 and something on the evening of 8/7/13. RCM C stated small BMs do not count.

On 10/29/13 at 11:28 a.m., the DNS stated the night shift Licensed Nurse (LN) printed a report of the residents and their bowel status. The LN communicated this report to the next shift identifying who needed a laxative or who received one. The DNS said the report could be printed at any time for review or update. The DNS conveyed she expected the LNs to review the report and follow the facilities' bowel protocol.

Dialysis

The facility's Dialysis (a process to filter blood for removal of waste and extra fluid) Care Policy and Procedures (DCP&P), last date of review 2/13, indicated to assess bruits (the sound of blood when rushing in the artery) and thrills (vibration felt over the artery as the blood rushes through) of the shunt (a surgical access site for dialysis) site every shift while awake. An assessment was not to be done during hours of sleep. The orders were to be placed on the treatment record listing the location of the site. The nurse's initials signify the presence of the bruit and thrill unless otherwise specified in the medical record.

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F 309	<p>Continued From page 65</p> <p>The DCP&P indicated the LN would fill out the Dialysis Center Communication Form (DCCF) prior to the resident leaving for dialysis including pre dialysis weight. Upon return, the LN completed the post dialysis assessment portion attaching the form to the resident's record.</p> <p>Resident #131 was admitted to the facility on [REDACTED]/13 with diagnoses to include [REDACTED] disease requiring [REDACTED].</p> <p>On 10/26/13 at 8:13 a.m., the resident stated she went to dialysis three times a week for the past year. The resident was observed to have a shunt in her [REDACTED] arm. When asked about her shunt, the resident replied the site was used for dialysis. She indicated the staff at the dialysis unit were "the only staff who looks at the dressing" and changed the dressing. When asked if the facility staff listened to the shunt with a stethoscope or felt the site, she replied, "the facility does not do anything to or for the shunt or dressing."</p> <p>A review of the resident's record revealed no documentation on the treatment record for monitoring of the shunt site. There were no DCCFs in the resident record.</p> <p>On 10/28/13 at 1:25 p.m., RCM B stated the facility was not successful at obtaining the DCCFs from the dialysis center (DC). She stated she had to call the DC for the information. "In fact, today is my second request for post dialysis weights. There needs to be a better system to gather the information. Communication could be better ...hard to stay on top of them."</p> <p>RCM B stated the facility looked at the resident's</p>	F 309		
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F 309	Continued From page 66 shunt for any signs of infection and assessed for a thrill documenting in the progress notes daily. She reviewed the resident's progress notes stating there should be documentation of the thrill. None were found. When asked, if the documentation was located elsewhere in the resident's records, RCM B replied the documentation should be in the progress notes as a daily Medicare charting note and spelled out in the MAC (facility's alert charting system) charting book. On 10/29/13 at 11:13 a.m., the DNS reviewed Resident #131's record stating, "I don't see it in her chart." The DNS explained the LN on duty when the resident returned was responsible for obtaining the DCCF from the DC. The DNS stated the LN should call the CD for the form or at a least obtain the resident's post assessment, which included new orders, condition of the shunt and the resident's weights. When asked about the facility's responsibility regarding the resident's shunt, the DNS replied the facility followed their policy. She stated the thrill should be assessed and documented per policy.	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having	F 314		

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F 314	<p>Continued From page 67</p> <p>pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to conduct ongoing assessments, evaluate the resident clinical conditions and pressure ulcer risk factors, define, follow and implement interventions consistent with the resident needs and identified goals, recognized standards of practice; to monitor and evaluate the impact of the interventions; and/or revise the interventions as appropriate for 2 of 3 current sampled residents (#34 and 133) reviewed for pressure sore development. This failure caused harm to resident #133 when the resident developed three pressure sores after admission.</p> <p>Resident #133</p> <p>Resident was admitted [redacted]/13 with multiple medical diagnoses to include [redacted] with [redacted] sided [redacted] and [redacted]</p> <p>The resident's admission Minimum Data Set (MDS), an assessment tool, dated [redacted]/13, indicated the resident had no pressure ulcers and was at risk of pressure ulcer development. The resident required an extensive assist of two persons for repositioning and transfers from bed to wheelchair. Resident was frequently incontinent of bowel and had a Foley catheter for urine collection. Resident did not exhibit rejection of care per admission MDS and most recent MDS dated 10/4/13. The Care Area Assessment</p>	F 314		
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F 314	<p>Continued From page 68 identified risk factors and indicated to proceed to care planning.</p> <p>A Braden score (an assessment to measure risk of skin breakdown) was completed on readmit from a hospitalization on [REDACTED]/13. Resident scored a 14 which equaled moderate risk.</p> <p>The pressure ulcer care plan dated 3/27/13 and in room care directive dated 9/13/13 were not implemented as follows:</p> <p>The in-room care directive did not address the resident ' s skin condition and it indicated the resident was a "priority lay down after meals - notify nurse if refuse to lay down," and the turn schedule indicated "frequently." There was not instructions for pressure reduction when up in wheelchair.</p> <p>Multiple observations during the survey found the resident in bed on her back or in her wheelchair for hours between meals:</p> <p>On 10/22/13 at 10:43a.m., resident was in her room sitting in the wheelchair in the upright position sitting in front of the TV with eyes closed; at 12:00p.m., in the main dining room in her wheelchair in the upright position; at 1:30p.m., in bed on back with pillow under [REDACTED] hip with eyes closed; at 3:00p.m., same position with eyes closed; and at 5:00p.m., upright in wheelchair to main dining room.</p> <p>On 10/23/13 at 7:00a.m., resident was upright in the wheelchair at a table in the main dining room; at 9:38a.m. resident was in her room sitting upright in the wheelchair in front of the TV with eyes closed; at 11:27a.m., in same position in</p>	F 314		
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F 314	<p>Continued From page 69</p> <p>room; at 12:10p.m., upright in the wheelchair at a table in the main dining room; at 3:55p.m., sitting upright in the wheelchair at nurses' station; and at 6:00p.m., resident upright in the wheelchair at a table in the main dining room.</p> <p>On 10/24/13 at 3:15p.m., the resident was in bed on her back with the head of bed (HOB) elevated about 45 degrees; at 3:56p.m., awake in bed watching TV on back with HOB at about 45 degrees; and at 4:50p.m., upright in the wheelchair in the main dining room.</p> <p>On 10/25/13 at 9:19a.m., the resident was sitting upright in the wheelchair in her room in front of the TV with eyes closed and arm on pillow; at 10:16a.m., in same position with eyes closed; at 11:05a.m., remained in same position, but awake; at 11:07a.m., nursing assistant certified (NAC) P wheeled the resident to the main dining room for lunch; at 12:43p.m., the resident remained sitting upright in the wheelchair at a table in the main dining room; and at 2:23p.m., the resident was in bed on her back with a pillow under hip and HOB at about 15 degrees.</p> <p>On 10/26/13 at 4:00a.m., the resident was in bed on back with HOB at about 15 degrees; at 4:26a.m., was in the same position; at 5:06a.m., same position; at 5:43a.m., same position; at 6:45a.m., sitting in the wheelchair at the nurses' station reclined back; at 7:39a.m., in same position with eyes closed; at 7:52a.m., sitting upright in the wheelchair at a table in the main dining room; at 8:42a.m., upright in the wheelchair near the nurses' station with eyes closed; and at 10:40a.m., sitting upright in the wheelchair in exercise group.</p>	F 314		

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F 314	<p>Continued From page 70</p> <p>The facility's policy and procedure for skin at risk/skin breakdown stated, "It is the policy of this facility, that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing."</p> <p>Record review revealed Licensed Nurse (LN) E made a progress note in reference to a discovered "skin tear" to resident's [redacted] buttock during her shift on 10/24/13. The note did not indicate a new treatment was immediately obtained; rather a communication form was left for the Advanced Registered Nurse Practitioner (ARNP) and the wound nurse. According to the facility policy: "4) Upon discovery of newly identified skin impairment, the LN will: notify the physician and obtain a treatment order if needed." The ARNP was not notified for a treatment order until the afternoon of 10/25/13.</p> <p>The last documented skin assessment on the treatment record (TAR) was 10/22/13 on shift 2 and "no skin impairment present" was indicated.</p> <p>On 10/25/13 at 2:24p.m., the area of skin impairment was viewed while LN D and Resident Care Manager (RCM) C assessed the "skin tear." LN D stated, "It is pressure." LN D indicated, the area on the [redacted] buttock was a Stage II (as defined by facility skin grid sheet: partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough) pressure sore measured 2.5 centimeters (cm) by (x) 2cm x 0.1cm depth. LN D added the</p>	F 314		
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F 314	<p>Continued From page 71</p> <p>● buttock had a 2cm x 1.5cm suspected deep tissue injury (SDTI) (as defined by facility skin grid sheet: purple or maroon area of discolored intact skin due to damage of underlying soft tissue damage. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue). LN D stated, "the ARNP ordered a [REDACTED] dressing to be applied and changed every 3 days."</p> <p>On 10/25/13 at 3:16p.m., OT A said, "the cushion (in resident #133) wheelchair was not a Roho cushion." OT A added, "the current wheelchair cushion (Varilite) was a trial that the vendor claims cannot bottom out in it even if sitting all morning. The cushion formed to her buttocks." When asked how inflation level was monitored, OT A stated "it's currently not monitored." OT A also added, "(the resident) is off of therapy, we are waiting for a new wheelchair, then will change the plan of care."</p> <p>At 3:21p.m., when asked how care needs communicated to NACs, RCM C stated, "the information is on the closet sheet (in-room care directive)." RCM C stated, "priority lay down means skin is at risk and lay down after meals." RCM C acknowledged resident #133 is a priority lay down, but "it depends on her mood, frequently doesn't want to lay down, social person who likes to see what is going on and doesn't like to be confined to her room." RCM C indicated the NAC should pass refusals on to the nurse and it should be documented. Review of the progress notes during the survey time period showed one note of refusal made by RCM C on 10/25/13 at 2:42p.m. RCM C verified no other documentation regarding refusals in other sections of medical record.</p>	F 314		

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F 314	<p>Continued From page 72</p> <p>When asked of interventions that were in place prior to the development of new pressure ulcers, RCM C stated, "frequent reposition (which she defined as at least within 2 hours in bed and wheelchair) and [REDACTED] cream to buttocks." RCM C indicated the new plan included: an air mattress, therapy to evaluate wheelchair cushion, a [REDACTED] dressing to the areas, continue frequent repositioning and priority lay down. She added, "if she continues to refuse laying down I will have the son sign an informed consent."</p> <p>At 5:28p.m., the RD made a note regarding consult for new pressure ulcer. The RD note indicated labs were not current, increased protein and energy needs for healing. "Will recommend [REDACTED] Multi-vitamin, large protein portions and [REDACTED] TID (three times daily) with meals." No labs were requested or ordered.</p> <p>On 10/27/13 at 10:39a.m., asked RCM C the process for placing air mattresses. She indicated the facility owned air mattresses and maintenance puts them on. RCM C was unaware the air mattress was not in place as ordered, "I told MA on Friday and he forgot."</p> <p>On 10/28/13 at 11:18a.m., observed LN D complete the dressing change to [REDACTED] and [REDACTED] buttocks. LN D stated, "(the resident) developed a new stage II pressure ulcer on the distal coccyx slit in between the other two pressure ulcers." It measured 3cm x 1.5cm x 0.1cm. LN D indicated she would follow the procedure to notify the physician, family, registered dietician (RD) and complete an incident report. LN D added, "the area will be covered by a [REDACTED] dressing."</p>	F 314		

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F 314	<p>Continued From page 73</p> <p>At 2:22p.m., the director of nursing services (DNS) was asked of the process for follow up on orders related to the development of new pressure ulcers, in specific related to Resident #133, to include an air mattress and RD recommendations for [REDACTED] and a multivitamin which were obtained on 10/25/13. She stated, "there should be no delay with the mattress as they have in house and the RD recommendations should have been forwarded to the physician when received." The DNS verified the orders/recommendations had not been followed up on.</p> <p>At 3:28p.m., RCM C verified the RD recommendations were on the list, but had not been followed up on. She added the air mattress was put in place on Sunday the 27th after she became aware of the delay in placement.</p> <p>At 3:41p.m., OT B indicated a new wheelchair was on order, "the current wheelchair would allow for pressure reduction by utilizing the tilt feature." She stated, "It (the current cushion) has been in place about 2 weeks." OT B was not aware of the resident's newly developed pressure ulcers. "May not be the right cushion, may need to go back to the Roho."</p> <p>At 4:04p.m., RD explained the process of recommendation follow through was for her to complete dietary slips for changes or additions to the meals and the RCMs complete follow up of recommendations for medication and/or lab needs to the physician. When asked how often she would recommend labs she stated, "Labs are utilized and recommended if the resident has a history of abnormal or if albumin is skewed because of fluids will ask for pre albumin, but not</p>	F 314		
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F 314	<p>Continued From page 74 routinely."</p> <p>On 10/30/13 at 11:04a.m., review of the resident's record revealed the last labs obtained were 7/31/13 for a basic metabolic panel. No labs were obtained to identify nutritional needs to promote wound healing. RD assessment dated 9/25/13 indicated most recent labs (7/31/13) within normal limits with no recommendation for follow up labs.</p> <p>Reviewed the incident reported completed on 10/25/13 for the 2 newly developed pressure ulcers. RCM C documented the pressure ulcers were unavoidable related to "resident frequently refuses priority lay down program which includes incontinent care when she allows." Risk factors identified in this assessment included chronic bowel incontinence and poor skin turgor. According to the incident form, "a determination that a pressure ulcer was unavoidable may be made only if routine preventative care is provided. Check if documentation verifies the following: Good skin care (clean, protect from moisture), maintains adequate nutrition and hydration, if possible, and utilizes pressure reduction support surface(s)." All three areas checked even though the resident was not being laid down as a priority and there was not an air mattress on her bed or the cushion in the wheelchair was different than indicated on the care plan.</p> <p>Resident #34</p> <p>Resident was admitted [REDACTED]/13 with multiple medical diagnoses to include [REDACTED] with [REDACTED] repair and [REDACTED].</p> <p>An incident report was completed on 10/1/13 in</p>	F 314			

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F 314	<p>Continued From page 75</p> <p>relation to the resident developed a heel ulcer. "Resident was found by her aide with a pressure blister to her [redacted] heel. The area is purple and measures 2 x 2.5cm." Report indicated an intervention of "blue boots" (pressure reduction devices for feet) are to be used at all times. According to the report the pressure ulcer was "unavoidable" with a root cause "Resident had a fall with fracture to [redacted] hip. She is noncompliant with cares refusing turning, etc. Often refuses to free float heels and refuses abductor wedge."</p> <p>The resident's admission Minimum Data Set (MDS), an assessment tool, dated [redacted]/13, indicated the resident had an unstageable deep tissue ulcer and was at risk of pressure ulcer development. The resident required an extensive assist of two persons for repositioning and transfers from bed to wheelchair. Resident was identified as rejecting care and verbal behaviors 1-3 days.</p> <p>The resident's care plans dated 10/9/13 did not address that resident #34 had developed a pressure ulcer, only addressed skin at risk. The in-room care directive dated 9/27/13 with dated changes to sections of transfer, weight bearing, and incontinent products on 10/9 and 10/10/13, did not indicate a heel ulcer under wounds. "PRD (pressure relieving device) boots when in bed and w/c (wheelchair), off for transfers, standing" was in different writing, but no date to indicate when this was added to the directive. The care plan and MDS identified resident refused blue boots related to [redacted], but no specific interventions were added to the care plan or in-room directive to address refusals aside from reapproach and educate. Unable to locate documentation of other interventions tried to mitigate the risk of</p>	F 314	

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F 314	<p>Continued From page 76 developing pressure ulcers.</p> <p>A RD assessment dated 10/2/13 did not indicate the resident had developed a pressure ulcer since admission; only skin issue indicated on the document was a surgical incision. No nutritional interventions or labs recommended related to a new in-house pressure ulcer.</p> <p>On 10/30/13 at 3:17p.m., the [redacted] heel ulcer was observed with LN D. The area as described by LN D was "deep purple with a black area on the end and drying out with edges lifting, it is doing what it is supposed to do." LN D applied [redacted] and area left open to air.</p> <p>The facility failed to assess reasons for care refusals and implement alternate interventions to mitigate the development of pressure ulcers for Resident #34 and #133.</p>	F 314		
F 323 SS=J	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to thoroughly investigate and take immediate corrective action related to</p>	F 323		

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F 323	Continued From page 77 unsecured oxygen tanks. Failure to recognize and develop an action plan to mitigate the risk of known potential avoidable environmental hazards placed all residents at risk of serious injury. This constituted an immediate jeopardy (IJ) being called on 10/21/13. In addition, facility failed to respond to fluctuations in water temperatures throughout the facility. The facility failed to assess, evaluate and revise the comprehensive plan of care to prevent further occurrences of falls for 1 of 2 current residents (# 214) and 3 of 4 discharged residents (#s 222, 182 and 263) reviewed for accidents/injuries. Failure to evaluate existing interventions and implement new interventions after each fall placed the residents at risk for serious harm or injury. Findings Include: <Oxygen> On 10/21/13 at 9:30 a.m., Resident #253 had a portable oxygen tank secured with one knot to the back of her wheelchair with a standard size pillowcase. At 9:45 a.m., Licensed Nurse (LN) A stated, "oxygen tanks are very dangerous, we could have an explosion if the bag is not secured" LN A added, the Nursing Assistants (NA's) are responsible for making sure the bag was in place. At 9:56 a.m., two, 4 feet high e-cylinder style oxygen tanks were observed unsecured in the oxygen storage room. The oxygen tanks were full. The oxygen storage rack had space available for the tanks to be secured. At 10:00 a.m., NAD verified there were two free	F 323			

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F 323	<p>Continued From page 78</p> <p>standing e-cylinder oxygen tanks 4 feet high in the oxygen storage room. She stated, "The canisters should be secured in the rack. The reason I know the canisters are full is because the sticker is still on it. It could be they delivered extra and that's why they are on the floor."</p> <p>At 11:03 am, NA P and Q assisted Resident #253 to transfer from the wheelchair to the toilet. As the resident stood up and pivoted to the toilet, the wheelchair tipped backwards onto the anti-tip bars. The pillowcase containing the portable oxygen tank swung freely. NA Q stated she always used an oxygen cover as the tank had to be covered for privacy. When asked about using a pillowcase to secure the portable oxygen tank, NA P stated, "My supervisor said it was okay." NA P said the oxygen tanks needed to be covered for privacy. NA P indicated the facility was out of oxygen tank bags and they were on order.</p> <p>At 11:17 a.m., the Central Supply Person (CSP) stated she knew the facility had been out of the oxygen bags and she had ordered them. She had not notified the the ADM or the DNS that the facility was out of xygen bags.</p> <p>At 11:50 a.m., the DNS stated oxygen tanks should be secured to wheelchairs in black bags. She was not aware the facility was out of bags. The DNS stated, "We can call the company we get oxygen from if needed and they can bring bags over to us. The staff should let us know if the supply is out."</p> <p>The DNS was asked about storage of tanks in the storage room, she stated, "The portable tanks in the storage room should be in the metal racks and not free standing as the tank could shoot</p>	F 323		

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F 323	<p>Continued From page 79</p> <p>across the room if bumped." The DNS stated, "Security and safety of oxygen tanks, is everyone's responsibility as all staff go in and out of the rooms or storage room. Not one person is specifically assigned the task."</p> <p>At 12:05 p.m., the DNS observed Resident #253's oxygen tank in a pillowcase on the back of the resident's wheelchair. The DNS shook her head side to side, stating this was not acceptable and would correct the situation.</p> <p>Record review revealed seven in-service training sign-in sheets regarding checking oxygen tanks dated back to 10/11/12.</p> <p>An in-service dated 8/14/12, "Do not leave oxygen tanks sitting (free standing) anywhere. Even empty tanks must be secured as soon as they have been exchanged for a full tank..."</p> <p>An in-service dated 12/28/12, "Oxygen tanks (again) 1) do not leave full or empty O2 [oxygen] tanks free-standing in resident rooms. This seems to be almost a daily issue-Particularly on the 200 hall-This (is) not a safe practice-even an empty tank can become a projectile if it falls over. 2) When taking empty tanks out to the O2 room be sure you place them in the wire rack. Again, No tanks should be free standing!"</p> <p>An in-service dated 4/15/13, "O2 tanks-This is a very serious issue-Every shift is telling me O2 tanks are being left unsecured in resident rooms-Friday there was one a therapist didn't see and knocked it over. The regulator broke and O2 was leaking out. The tank could have become a projectile causing injury to anyone near it. Even an empty tank is dangerous when unsecured..."</p>	F 323		
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F 323	<p>Continued From page 80</p> <p>An undated in-service, "Portable oxygen tanks MUST be secured at ALL TIMES. They may be secured by the bags on the back of a wheelchair or in the oxygen rack. AT NO TIME CAN THEY BE FREE STANDING OR PROPED AGAINST THE WALL. Disciplinary action will be taken immediately if this safety measure is not adhered to."</p> <p>Although, the facility implemented several trainings over the past year, the staff continued to use oxygen tanks in an unsafe manner. The Administration did not evaluate the effectiveness of the trainings or develop additional plans of actions to ensure avoidable environmental hazards placing all residents at risk of serious injury.</p> <p><Water Temperatures></p> <p>On 10/22/13 at 9:00a.m., a surveyor tested the water temperature at the sink in room # [redacted]. She quickly withdrew her hand as it felt hot. Resident #246 stated the water at the sink was "pretty hot and usually you can't put your hand under it."</p> <p>At 9:32 am, the water temperature at the sink in room #s [redacted], [redacted] and [redacted] were checked by the surveyor with her hand. The surveyor quickly withdrew her hand as the water felt hot.</p> <p>At 10:15am, surveyors used a digital thermometer to check various other water temperatures in resident rooms and shower rooms.</p> <p>At 10:22a.m.-11:30a.m., the water temperature in room # [redacted] was 135.6.</p>	F 323		

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F 323	<p>Continued From page 81</p> <p>In room # [REDACTED] the water temped at 124.6. In room # [REDACTED] the hot water temped at 122.9.</p> <p>Due to hot water temperature concerns it was determined to have the facilities Maintenance Assistant (MA) accompany the surveyors to take water temperatures concurrently with the surveyors. Temperatures below are from the MA's thermometer.</p> <p>At 1:30p.m. - 2:20p.m., the water temperature in room # [REDACTED] was 130 degrees. In room # [REDACTED] the water temped at 138 degrees. In room # [REDACTED], the water temped at 122degrees. In room # [REDACTED] the water temped at 133.7 degrees.</p> <p>At 2:26p.m, Meeting with the ADM, MA, DNS and the Consulting Director of Nursing (CDNS). The ADM stated, "We called in a plumber, I knew the water temps were fluctuating." The MA called a plumber last week, (Monday 10/14/13) after he notified me...I was not in the building.</p> <p>When asked to see a bill or report from the plumber the facility called to evaluate the hot water concerns none was provided. The MA stated, " He (the plumber) did not leave any information and did not charge for the visit, he said everything was fine and he could find no problems." When asked for the name and telephone number of the plumber none was provided. The MA opened up a phone book to the plumbing section in the yellow pages, however, failed to provide a name, telephone number or date of a plumber's visit prior to 10/22/13.</p> <p>The ADM stated, since the time I was made aware of the hot water temperatures in the building last week (10/14/13), we have been</p>	F 323		

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F 323	<p>Continued From page 82</p> <p>doing constant adjustment and monitoring." When asked to see documentation of water temperatures being monitored none was provided from 10/14/13 - 10/22/13. The MA stated, "I did not write anything down.</p> <p>At 3:55p.m., the beautician stated, "Yeah, the water gets really hot, it never stays one temperature ..."</p> <p>At 9:38a.m..."NA B stated, the water situation had been worse over the past " two weeks, maybe a month."</p> <p>At 12:00p.m., NA C stated, " Yes the water temperatures vary ... Sometimes it is really hot ... too hot for my hands..."</p> <p><Falls></p> <p>Resident 214</p> <p>Resident 214 was admitted on [REDACTED]/13 with diagnosis to include [REDACTED] related to a fall at home, altered [REDACTED] status, and onset of difficulty with [REDACTED] and [REDACTED]. According to the record and the daughter, the resident had a history of falls at home and had fractured her [REDACTED] in the last fall at home.</p> <p>The fall assessment done on admission indicated the resident was at high risk for falls and the Minimum Data Set (MDS), a comprehensive assessment, dated 8/20/13 also indicated the resident was at risk for falls.</p> <p>A review of the record and the accident/incident reports revealed the following:</p>	F 323		

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F 323	<p>Continued From page 83</p> <p>On 8/17/13 the resident was found sitting on her floor next to her bed. The incident report was initiated but never completed for this fall. No assessment or recommendations done.</p> <p>On 8/19/13 the resident was found sitting on the right side of her bed on the floor. The resident had a tab alarm in place but the string was too long and the alarm did not go off. It is unclear from the records when the tab alarm was started. Recommendation was to change the tab alarm to a pressure alarm and place one side of the bed against the wall.</p> <p>On 8/21/13 a progress notes indicated the resident attempted to get out of bed several times on her own.</p> <p>On 8/23/13 a problem was initiated on her care plan indicating she was at risk for falls with a goal to minimize risk to the resident while maintaining maximum independence. The interventions included assess for assistive devices, assess risk factors, Occupational (OT) and Physical Therapy (PT) eval and treatment, and see in room care plan.</p> <p>On 9/2/13 the resident attempted to sit on the edge of her bed and self-transfer. According to the incident report she slid to the floor and landed on the floor mat. It is unclear from the records when the floor mat was placed next to the resident's bed. Interventions initiated included low bed, near nurse station, one side of bed along wall, mat on floor. The directive to keep the resident near the nursing station was not found on the in room care directive and was not added to the care plan.</p>	F 323		
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F 323	<p>Continued From page 84</p> <p>On 9/4/13 an order was received to discontinue the alarms. No indication could be found in the chart indicating the reason for the discontinuation.</p> <p>On 9/5/13 the resident attempted to transfer herself from bed to her wheelchair. The incident report was initiated but never completed for this fall. No assessment or recommendations were done.</p> <p>On 9/10/13 the resident was found lying on the mat on the floor next to her bed. The incident report was initiated but never completed for this fall. No assessment or recommendations were done.</p> <p>On 9/15/13 the resident was found on the floor mat with pillows under her head. The recommendation was WCTM (Will continue to monitor). No new interventions or recommendations were made. No assessment regarding the effectiveness of the current interventions could be found.</p> <p>On 9/18/13 at 7:00 am the resident attempted to self-transfer out of bed. She sustained a skin tear to her [redacted] forearm. The recommendation was for a bolster mattress (a rimmed mattress to prevent a person from rolling out of bed).</p> <p>On 9/18/13 at 3:39 pm the resident was found on the floor lying next to her bed with a skin tear to her [redacted] arm. Recommendation was to place a "rimmed mattress" on the bed. It is unclear in the record if the bolster mattress had been placed on the bed after it was recommended with the first fall earlier in the day on 9/18/13.</p> <p>On 9/20/13 the resident fell out of her wheelchair</p>	F 323		

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F 323	<p>Continued From page 85</p> <p>when she was attempting to pick up a jacket she had thrown on the floor. This fall resulted in a skin tear to her [redacted] elbow. No assessment or recommendations were made.</p> <p>On 9/23/13 the resident fell out of her chair when she attempted to reach for a [redacted] on the dining room table. The daughter had been with the resident and left the dining area to speak with the nurse. Recommendation was to educate the daughter about the importance of leaving the resident in a high visibility area. The intervention for leaving the resident in a high visibility area had not been placed on the care plan as of this date.</p> <p>On 9/27/13 the resident was found on the floor in her room next to her bed. Recommendation was to continue with raised lip mattress and frequent staff checks while resident in bed. No new interventions or recommendations were made. No assessment regarding the effectiveness of the current interventions could be found.</p> <p>On 9/29/13 the resident fell when attempting to transfer herself into the wheelchair from the bed. The recommendation was to Continue with the POC (plan of care). No assessment regarding the effectiveness of the current interventions could be found.</p> <p>On 10/1/13 the resident fell out of bed. She complained of [redacted] shoulder pain and was given [redacted]. Tab alarms were placed on the resident by the floor LN. No assessment regarding the effectiveness of the current interventions could be found.</p> <p>On 10/2/13 a Computed Tomography (CT) scan (a scan that uses X-rays to make detailed</p>	F 323		

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F 323	<p>Continued From page 86</p> <p>pictures of structures inside of the body) of the resident sacral area revealed the resident had new fractures of the [REDACTED]. The CT scan was obtained after the resident had fallen 9 times.</p> <p>On 10/7/13, after a referral to the orthopedic doctor, the doctor called the facility and indicated he did not feel there was anything he could do for the resident. He also indicated resident 214 should be referred to an endocrinologist. Per RCMA, as of 10/29/13 this recommendation had been acted upon.</p> <p>On 10/10/13 an intervention was added to the care plan to seat resident where constant or near constant observation is possible. No further interventions were added to the residents care plan to mitigate the risk of falls although the resident had fallen 13 times as of 10/10/13.</p> <p>A Review of the in room care directive (an information sheet with interventions for direct care staff to use when assisting the resident) dated 10/24/13 showed no information regarding the residents communication difficulties or the interventions to use to allow resident the ability to make her needs known. No intervention was noted regarding keeping the resident near the Nursing station or within line of site of staff.</p> <p>Observations of resident throughout the survey revealed the following:</p> <p>10/21/2013 9:43 AM Resident was sitting in the hall near the nursing station. Her wheelchair was slightly in of another resident's chair. Resident 214 kept trying to stand. Resident 214 had an alarm on the chair to alert staff if he/she was trying to get out of the chair independently. Each</p>	F 323		

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F 323	<p>Continued From page 87</p> <p>time she scooted forward to stand the alarm went off.</p> <p>10/22/2013 5:03PM Resident sitting in the hall by the Nursing station. Often trying to get out of her chair and setting off the chair alarm. Staff not responding.</p> <p>10/23/13 4:00 pm Resident returned to the facility from a physician's appointment and dropped off by the nursing station at 4:00 pm by activity staff. The resident was observed grabbing her peri area, pulling up her skirt and trying to shove a wad of paper towels into her peri area and waving her hands to summon assistance from staff standing by. The resident kept repeating "I need to go to the bathroom" Surveyor approached after approximately 5 minutes as she continued to try get attention unsuccessfully. She told the surveyor "I am urinating."</p> <p>10/25/ 12:53 pm Resident trying to get out of wheelchair over and over. Very anxious. No staff responded for approximately 3 minutes although the chair alarm was going off each time she tried to stand.</p> <p>10/25 2:10 pm Resident sitting in hall across from Nursing Station. She keeps trying to stand up. Staff sitting at the nursing station were trying to give report but resident kept trying to get out of chair and setting off the chair alarm. Softly saying "help, help." The resident began stating "I'm urinating, I'm urinating, help, help." A activity staff member comes and asks if she wants to play games. Resident states "no, no I'm urinating, I'm urinating, bathroom" grabbing at her peri area.</p> <p>10/27 Between 9:43 and 10:00 am the resident</p>	F 323		

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F 323	<p>Continued From page 88</p> <p>requested to lay down three times. 10/27/13 10:00 am The DNS wheeled the resident down hall stating "let's go watch some of your favorite black and white movies on the TV in the lounge." Resident not laid down as she had been requesting.</p> <p>10/28/13 10:05 am Sitting in front of NS by self. Asked staff to take her for walk. Staff stating "hold on (resident 214) I need to finish with this other resident first then I will come with you."</p> <p>On 10/29/13 a review of the record and interview with RCM A revealed the resident fell again on the afternoon 10/28/13. In the fall she suffered a laceration above her eye. At that time a 1:1 was initiated for the resident. A staff person was to be with her at all times.</p> <p>During an interview with the family member on 10/28/13 she indicated she had requested the pressure alarms be placed back on the resident's bed and Wheelchair "at least three times in the week before (resident 214) fell and fractured her sacrum. I think at least one fracture could have been avoided." The family member further indicated "I was disappointed when I didn't see them responding when things would happen and I knew it wasn't normal for my mom. I feel like I have to be on top of things. I wanted and requested the CT scan after she fell."</p> <p>In an interview with the RCM A on 10/29/13 a timeline was presented to the surveyor and reviewed. On the timeline the RCM indicated "alarms were placed on bed and wheelchair 8/17/13. The only place this is indicated is the incident report, it is not indicated anywhere else in the record. I do not know why the alarms were</p>	F 323		

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F 323 Continued From page 89
discontinued on the 4th. I looked and can't find any indication of a reason. The first time I know the alarms were back in place was on 9/24 when the family member requested them and I filled out the consent. On 10/10 we also placed on the Care plan to place her where she can be constantly monitored. I believe the reason we didn't get the order from the MD for the alarms and floor mats is because it fell through the cracks. We didn't know we needed to have the MD order for those."

F 323

In an interview with the DNS on 10/29/13, she indicated "We have tried chair alarms, bed alarms, and the mattress on the floor. We had a regular mattress but there was a concern about infection control so we removed it and placed a perimeter mattress on the floor instead. (Resident 214) is very impulsive. I think sometimes she thinks she can do things she was able to do in her 20's. We tried the alarms but those don't really work for her because they don't remind her to sit back down."

On 10/29/13 discussed with DNS the incident reports and the lack of assessment and analysis on 4 reports and discussed the analysis on the other reports that keep suggesting the same interventions or just say WCTM or follow current POC. Asked DNS if there is anything else they may have that gives more info about each incident or analysis of each incident. She indicated everything they had given to the survey team was all they had available. She further indicated she recognized the breakdown in investigation and analysis of incidents.

Resident 263

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F 323	<p>Continued From page 90</p> <p>Resident 263 was admitted to the facility [REDACTED]/13 with diagnosis to include [REDACTED] sided [REDACTED] (Acute [REDACTED]), [REDACTED] and [REDACTED] (high [REDACTED]). Resident 263 resided in the facility for 6 days before she was transferred to the hospital after a fall with a [REDACTED] fracture.</p> <p>Review of the record showed resident 263 was assessed on 9/28/13 as a high risk for falls due to her [REDACTED] and [REDACTED] sided weakness and [REDACTED]. The occupational therapy notes for 9/28/13 indicated the resident was a one person assist with transfers. A preliminary Care plan was initiated on 9/28/13 with a problem related to the resident's high risk for falls. The goal was "Rs (resident) to have no falls/injury." The only intervention on the preliminary plan was "see in room care plan." The in room care directive indicated the resident was 1 person assist for ambulation and transfers. However no specific interventions were noted to mitigate the resident's risk for falls.</p> <p>On 9/29/13 resident 263 fell in the bathroom while attempting to transfer self. Recommendations at the time of the incident report included "Staff to reinforce need for resident to wait for staff assistance with transfers and toileting," and "find out resident's usual routine and attempt to follow it." A review of the in room care directive showed neither of these interventions was added to the care directive. A review of the resident records showed no indication anyone had attempted to gather information about the resident's usual routine. According to the incident report, the family indicated the resident had a tendency to be impulsive with self-transfers. This information was not placed on the Care plan or the in room</p>	F 323			

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F 323	<p>Continued From page 91 care directive for staff to be aware.</p> <p>On 10/3/13, resident 263 fell twice in her room within an hour period. A review of the incident report showed, after the first fall on 10/3/13 a pressure alarm was added to the wheelchair and a recommendation was made to ensure resident 263 was not left alone in her room. According to the witness statement, the instructions given after the first fall indicated the resident was not to be left alone. Neither of these interventions were added to the in room care directive.</p> <p>During an interview on 10/31/13 with RCM A, he indicated he had placed the resident near the nursing station after the first fall on 10/3/13. While he was on the phone a family member of another resident took resident 263 into her room and left her there. It was just after this the resident fell a second time.</p> <p>On the afternoon of 10/3/13 at 5:18 pm, an order was received to obtain an x-ray of resident's hip as she was complaining of increased pain on her side after the falls.</p> <p>On /13 an xray was obtained and showed a hip fracture. The resident was discharged to the hospital at 5:07 pm that evening.</p> <p>Resident 182</p> <p>Resident #182 was admitted to the facility on /13 with diagnoses of (fluid in the), impairment, (with and), chronic illness, and a personal history of with .</p>	F 323		
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F 323	<p>Continued From page 92</p> <p>The resident's preliminary care plan, dated 8/1/13, indicated the resident received daily scheduled medications of two antipsychotics, an antianxiety, an antidepressant, an anti-seizure and a narcotic for pain. This care plan identified the resident with impaired activities of daily living (ADL) and at low risk for falls/injury.</p> <p>The preliminary care plan did not identify interventions or goals in place for seizure precautions or to prevent incidences of falls/injury for a resident with significant, multiple risk factors to include falls, diagnoses, medications and extensive requirement for assistance.</p> <p>The resident's Minimum Data Set (MDS) an assesemnt tool, dated, 8/8/13, indicated the resident was moderately impaired with daily decision-making skills and required extensive assistance with ADLs.</p> <p>The resident's record dated 8/1/13 to 8/11/13 documented the resident had intermittent episodes of confusion, multiple complaints of pain, and vertigo complaints on 8/5/13 and 8/6/13. There was no additional documentation the facility re-assessed, re-evaluated the resident or identified interventions to develop or revise the plan of care.</p> <p>Record review revealed the resident had an un-witnessed, injury fall while standing at her sink brushing her hair the morning of [REDACTED]/13. The resident sustained bruising with swelling to the face and [REDACTED] shoulder pain. The facility transferred the resident to the emergency room.</p> <p>Resident #182 was re-admitted to the facility on [REDACTED]/13 with a [REDACTED] fracture.</p>	F 323		

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F 323	<p>Continued From page 93</p> <p>Although, the facility's investigation indicated the resident's substantial injury was reasonably related to her seizure disorder, the preliminary care plan did not identify interventions for seizure precautions or for the prevention of falls/injury for a multi-risk resident.</p> <p>The re-admission preliminary care plan dated [REDACTED]/13 identified the resident with impaired ADL mobility, receiving psychiatric medications, and high risk for falls.</p> <p>The Resident's Care Area Assessment (CAA) dated 8/20/13 for falls indicated the resident was at high risk due to impaired balance, multiple medications, seizure disorder, and confusion with impulsivity, poor safety awareness and impaired memory.</p> <p>Resident #182's falls care plan dated 8/22/13, documented interventions not to leave the resident alone in the bathroom, assess for assistive devices, occupational and physical therapies, and see in-room plan of care.</p> <p>The in-room care directive was dated 8/13/13 and "redid closet sheet @ (at) 9/2/13" without specifics as to what was "redid..." The care directive documented mobility as independent with walker and wheelchair for ambulation. The safety device for the resident was a bed alarm and not to be left alone in the bathroom, which contradicted the resident's independent status. There was no documentation of what specific measures were implemented for seizure precautions or to prevent additional falls/injury.</p> <p>According to the resident's clinical record,</p>	F 323		

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F 323	<p>Continued From page 94</p> <p>Resident #182 continued to have two non-injury falls on 8/27 and 8/29. The staff documented the resident was confused and forget to use the call light. In both incidences, the resident attempted to get to the bathroom.</p> <p>There was no documentation what the facility did to mitigate falls or evaluate the effectiveness of the current interventions.</p> <p>Resident 222</p> <p>Resident #222 was admitted on [REDACTED]/13 with diagnoses of multiple [REDACTED] from a [REDACTED] accident to include [REDACTED] surgery, [REDACTED] and [REDACTED].</p> <p>The resident's preliminary care plan, dated 8/20/13, indicated the resident had confusion and forgetfulness with impaired ADL ability requiring two-person maximum assist, was receiving an anti-anxiety medication as needed and a regularly scheduled blood thinner. This care plan identified the resident at high risk for falls/injury.</p> <p>Resident #222 had eight falls within 14 days to include four on one day.</p> <p>The resident's in-room care directive, dated, 8/20/13, documented rimmed mattress, pressure alarm on wheelchair and bed.</p> <p>The facility's documentation revealed the resident had a non-injury fall on 8/21/13 rolling out of bed at 8:45 p.m. There was no documentation the facility re-evaluated the effectiveness of the rimmed mattress or the functionality of the bed alarm.</p>	F 323		

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F 323	<p>Continued From page 95</p> <p>The resident had four falls on 8/22/13, with three of the falls, the resident complained of hitting her head.</p> <p>At 3:15 a.m., the staff found the resident lying on the floor next to her bed with complaints of hitting her head. The witness report documented the resident "moving around a lot in bed ...pillows were put on her side to prevent her from falling off of bed again."</p> <p>At 7:00 a.m., the staff found the resident on the floor in her room with complaints of hitting her head. The facility's incident investigation documented the resident was agitated, restless and confused. No new interventions were put into place to prevent further falls for Resident #204 with a receiving a blood thinner medication.</p> <p>There was no documentation the facility re-evaluated the effectiveness of the rimmed mattress or the functionality of the bed alarm for these two falls.</p> <p>At 8:16 a.m., the staff found the resident beside her wheelchair with complaints of hitting her head. The description on the facility's incident investigation indicated, "The family took resident outside for a walk and was not injured in the fall." There was no documentation the facility communicated with the family regarding precautions to be aware of with the resident to prevent falls.</p> <p>At 5:00 p.m., the staff found the resident with her back on the mat next to her bed. There was no documentation of evaluating the effectiveness of the current interventions or implementing new interventions to prevent further falls.</p>	F 323		
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F 323	<p>Continued From page 96</p> <p>Progress note dated 8/23/13 documented resident had a bruise to her [redacted] buttock measuring 12.5 centimeters by 12.5 centimeters (4.9 inches by 4.9 inches) as resident has a history of falls on 8/22.</p> <p>After five falls, an individualized falls care plan dated 8/23/13 indicated the resident was at risk for falls due to impaired safety awareness, balance, trunk control, and proprioception (sense of one's body, limb movement, and positioning).</p> <p>Interventions included do not leave alone in the bathroom, low bed with one side along the wall, mattress next to bed as extension of the bed, sensor alarms on bed/wheelchair, physical/occupational therapies and tilt wheelchair to provide resident assist with trunk balance allowing her to be safely up in wheelchair.</p> <p>The next day, 8/24/13 at 4:43 p.m. another fall occurred. The facility's incident investigation indicated, "resident stood up from W/C (wheelchair), NIF (non-injury fall), NWF (non-witnessed fall). The witness report documented, "after this we put a pressure alarm in her chair." The care directive dated 8/20/13 identified an alarm should be placed in the resident's wheelchair.</p> <p>The resident's MDS dated, 8/27/13, indicated the resident was moderately impaired with daily decision-making skills and required extensive assistance with ADLs to include transferring, walking, and toileting. The MDS identified the resident had two or more falls since admission.</p>	F 323		
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F 323	<p>Continued From page 97</p> <p>Resident #222's CAA for ADLs and falls dated 8/27/13. The CAAs documented the resident had multiple falls since admit and was recovering from a [REDACTED]. The resident had cognitive deficits, was impulsive, does not like to wait, and displayed poor safety awareness.</p> <p>On 8/30/13 at 9:00 a.m., the staff found the resident on the floor, near her bed with no injuries. There was no documentation the facility re-evaluated the effectiveness of the current interventions or implemented new interventions to mitigate further falls.</p> <p>On 9/2/13 at 6:00 p.m., the staff found the resident on the floor, near her bed "with fecal matter around herself" hurting her wrist.</p> <p>On 10/29/13 at 11:42 a.m., the DNS reviewed the resident's chart and stated the resident was impulsive as she had a [REDACTED] injury due to a [REDACTED] accident. The DNS said the resident was "very challenging in the beginning with poor safety awareness."</p> <p>The DNS reviewed the resident's multiple falls on 8/22/13 to address what the facility did to mitigate future falls. She said a low bed against the wall was probably implemented within the first 24 hours due to the resident's condition. The perimeter mattress came next along the way with the mat, and then alarms fairly close in the beginning.</p> <p>The DNS said the Resident Care Managers should update the care plans and care directives to indicate the resident's fall risk level and when interventions change. The DNS stated, "...we did not do things we should have done."</p>	F 323		
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F 325 SS=G	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review it was determined the facility failed to ensure 3 of 6 Sample Residents (#s 91, 134 & 219) reviewed for nutrition and/or weight loss maintained or attained acceptable nutritional status and/or did not experience significant unintentional body weight loss of the 51 residents who were included in the Stage 2 review. Failure to provide a nutritionally adequate diet for Resident #s 91, 134 & 219 resulted in harm. Findings Include:</p> <p>Resident #134</p> <p>Resident was admitted to facility on [REDACTED]/13 with multiple medical issues to include [REDACTED] fracture with [REDACTED] repair, [REDACTED] and [REDACTED]</p> <p>The resident's admission Minimum Data Set (MDS), an assessment tool, dated 7/31/13, noted mild cognitive impairment, no behaviors or resistance to care, and required set-up for meals</p>	F 325			

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F 325	<p>Continued From page 99</p> <p>but ate independently. The Care Area Assessment (CAA) for nutrition dated 8/4/13 indicated the risk factors for nutritional status were diabetic medications, recent hip fracture, and dementia. The CAA indicated care planning would be initiated "to monitor risk factors for developing poor nutrition."</p> <p>On 10/20/13 at dinner, Resident #134 was sitting at a table with three other residents. The meal began at 5:05p.m. and her tablemates were served at 5:31p.m. She asked, "Where is my food, all I wanted was a salad." At 5:55p.m., the resident's meal tray arrived after her tablemates had finished. The resident said, "I did not order this" and she did not eat. The meal did not include a salad.</p> <p>At 6:00p.m., NA T was asked about Resident #134, she said, "She is at the wrong table, she should be at the cueing table. She needs help, she need to be cued. The group she is sitting with seem to be a little more social and they encourage her to eat. It would be better for us and more fair for her, she is confused, looking around wondering where her food is."</p> <p>On 10/27/13 at breakfast, the resident sat alone at a table and did not eat anything off her plate.</p> <p>At lunch, the resident was served after her tablemates finished. She did not eat and no staff encouraged her to eat.</p> <p>At dinner, the resident ate 1 bite of a bread stick and 1 bite of the entree. No staff encouraged her or offered a substitute.</p> <p>The Resident's documented admission weight of</p>	F 325		

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F 325	<p>Continued From page 100</p> <p>● pounds (lbs) was on the Registered Dietician (RD) admission assessment, the Nutritional Risk Review, and the 14 day MDS. On 10/22/13, the resident's weight was ● lbs, a 27lb or 20.5% weight loss in 13 weeks. A discrepancy of 9lbs was noted as the weight record and further RD assessments had a weight of ● lbs on admission. With that number considered, the weight loss would have been 19lbs or 14.6% in 13 weeks.</p> <p>On 8/7/13, the RD completed the resident's admission assessment for nutrition, no supplements were ordered. The documented admit weight was ● lbs. The resident was identified as "at risk for inadequate nutrition RT (related to) dementia." The intervention was to add HiPro Milk with meals.</p> <p>The RD notes dated 8/23/13 state the resident's weight was ● lbs. "Supplements added last week, will continue with POC (plan of care) and monitor closely until weight stabilizes. Will consider fortifying additional foods and/or adding 2oz (ounces) 2 cal med pass (supplement drink)."</p> <p>On 8/28/13, the RD progress note indicated the weight as ● lbs, "down 5# (pounds) (4.2%) x 6 days." "May need appetite stimulant."</p> <p>On 9/6/13, the RD progress note indicated the resident weighed ● lbs down 2lbs from last weight. The RD indicated intake was down to less than 25% at all meals. ● (an antidepressant) started recently..." The RD recommendation on this date was 2oz 2 cal med pass which was started on 9/8/13.</p> <p>On 10/3/13 a nutritional risk review was</p>	F 325		

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F 325	<p>Continued From page 101</p> <p>completed by the resident care manager (RCM)</p> <p>C. The reason documented for this review was "weight loss of 8lbs since admit", although weights recorded on this form indicated a 23lb loss. The plan indicated, "asked the ARNP (advanced registered nurse practitioner) to increase her [REDACTED] to 15mg (milligrams) from 7.5 to see if this helps with appetite."</p> <p>On 10/16/13, the RD progress note indicated, "Current weight [REDACTED]#, now down 19# (15.4%) since admission and down 5# in past 2 weeks. Resident with an average intake of about 25% at most meals. Difficult to provide nourish if food is rejected. May need additional assistance or texture modification? May need increase in [REDACTED]? Will D/C (discontinue) CCHO diet at this time because foods are fortified and supplements are given. Will also increase medpass to 3oz TID (three times daily) for continued supervised supplementation."</p> <p>On 10/28/13 at 2:22p.m., the Director of Nursing Services (DNS) was asked the process to identify weight loss. She stated, "residents are discussed during the NAR meeting. I write out the forms to communicate weight loss to the doctor. The RD comes in 1-2 days per week, if concerned we will have her see them. The RD does not participate in the NAR meetings, but reads the reports." When asked what interventions were expected with weight loss, the DNS said " labs, talking to the resident about likesdining services interview." The DNS was unable to locate a dining service interview to address the resident's likes/dislikes. "Should be done on every resident, must have been missed." The only lab the DNS located for this resident was a thyroid function test from 8/19/13. The DNS reviewed the</p>	F 325		
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F 325	<p>Continued From page 102</p> <p>recommendations for increased [REDACTED] and med pass or for texture modification, verified these were not followed up on or initiated.</p> <p>On 10/28/13 at 4:03p.m., when asked about Resident #134's weight loss the RD stated, "I don't know what I'm going to do with her. She refuses to eat and we cannot force her to eat." The RD was informed of the multiple observations of the resident being served after the table mates had completed their meal. She shook her head side to side and stated, "I was not aware of this" and acknowledged it could play a role in the resident's intake. When asked what "na" meant for usual weight on the admission assessment, she said, "not available." "We might not be able to figure that out since not in the record, if we have concern I will send the dietary manager in (to find out)." Asked if this was done for Resident #134, she said, "I know she is probably below her usual weight without having that information."</p> <p>On 10/30/13 at 10:05a.m., Resident #134 said, "I weigh about [REDACTED] lbs, always. I've lost weight." When asked what her favorite foods were, Resident #134 added, "I do like ice cream. I don't have a favorite food. I love all food."</p> <p>RESIDENT #91</p> <p>Resident #91 admitted to the facility on [REDACTED]/2013 with diagnoses to include [REDACTED], [REDACTED], [REDACTED] fracture, [REDACTED] and [REDACTED]. The resident was on a regular diet.</p> <p>Resident #91's MDS dated 8/26/13, indicated the resident was not oriented to time or place, but, was able to make simple decisions about his</p>	F 325		

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F 325	<p>Continued From page 103</p> <p>preferences and needs. The resident had a Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment.</p> <p>Resident #91's weight on admission to the facility 8/19/13 was █ lbs. On 9/4/13, his weight was █. On 9/12/13, his weight was █. On 10/15/13, his weight was █ (which is 22 lbs. less than at admission or a 10.0% loss)</p> <p>Review of the medical record revealed Resident #91 was staffed by the Nutrition at Risk Committee on 10/3/13. An intervention added by the Registered Dietician (RD) to mitigate weight loss was "Large protein portions for all meals."</p> <p>Observations at meal times 10/20/13-10/28/13 revealed Resident #91 was ate 100% of his meals at breakfast, lunch and dinner.</p> <p>On 10/26/13 at 8:30a.m., Resident #91's order was taken for breakfast, he stated, he would like to have 2 sausage links and a piece of toast and coffee. After he completed his meal Resident #91 continued to feel for food on the plate in front of him. He poked at the empty plate with his fork several times. When he did find any food with his fork, he placed his fork down at the side of his plate and ran his fingers in a circular motion around the plate, licking bread crumbs from his toast off his fingers. No additional food was observed being offered to resident.</p> <p>A review of the meal monitor filled out for Resident #91 by the Nursing Assistants (NAs) indicated he was eating most all of every meal. Options on the meal monitor to indicate what Resident #91 ate were; 1) less than 25%, 2) 26-50%, 3) 51-75% and 4) 76-100%. Of 171</p>	F 325		
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F 325	<p>Continued From page 104</p> <p>entries made since the time of admission to the facility it was documented Resident #91 ate 76-100% of his meals over 85% of the time.</p> <p>On 10/26/2013 at 10:32a.m., Resident #91 stated, "...I eat what is put in front of me." When asked what his usual weight was Resident #91 stated, "██████ pounds."</p> <p>On 10/27/13 at 12:30p.m., observation of Resident #91 at lunch revealed he ate 100% of his food. The protein on his plate was one chicken leg.</p> <p>At 6:40p.m., observation of Resident #91 at dinner revealed Resident #91 ate 100% his food. Nursing Assistant (NA) G stated, "No that is not a large portion, he got the general portion like everyone else receives." Resident #91 was not offered more food.</p> <p>At 7:05 the Dietary Manager (DM) stated, some meals like the casserole are hard to give large protein portions of, for example, the casserole served at dinner. The DM continued, "For lunch he would have gotten 3 chicken legs."</p> <p>On 10/28/13 at 11:00a.m., Residential Care Manager (RCM) C stated, "I understand he has had weight loss, we are trying to get him to eat more, and he is eating what he wants to eat ... I believe we have added fortified large protein portions." When asked who was monitoring to ensure Resident #91 received large protein portions RCM C stated, "The NA's are monitoring what he eats..." When asked for documentation of any interventions that had been tried to decrease the weight loss of Resident #91 RCM C stated, "I did not document anything."</p>	F 325		

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F 325	<p>Continued From page 105</p> <p>At 4:03p.m., the RD stated, she had completed Resident #91's initial nutrition assessment on 8/28/13. On 9/6/13. The RD stated she did not actually know what Resident #91's usual weight was. On 10/3/13 resident #91 was staffed by the Nutrition at Risk committee. It was identified he had a 22 pound weight loss since admission to the facility on [REDACTED]/13. It was identified he was eating well, 76-100% of all his meals. A plan was put in place to talk to the family about his usual weight and dietary preferences. On 10/10/13 further documentation by the RD and the NAR committee, documented, "May benefit from a snack of a meat sandwich ..." The RD stated, "None of these interventions had been implemented..."</p> <p>Although the resident experienced a 22 pound weight loss, the facility failed to put interventions in place in order to prevent further weight loss.</p> <p>RESIDENT 219</p> <p>Record review revealed Resident #219 admitted to the facility on [REDACTED]/13 with diagnoses to include a [REDACTED] with [REDACTED] ([REDACTED] side) and [REDACTED]. The resident was on a regular diet.</p> <p>Resident #219's the MDS dated, 9/5/13, indicated she required extensive assistance with eating to include; cues, supervision, oversight and encouragement. The resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment.</p> <p>Resident #219's weight on admission to the facility [REDACTED]/13 was documented to be [REDACTED] pounds. On 9/24/13 Resident #219's weight was</p>	F 325		

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F 325	<p>Continued From page 106</p> <p>● pounds. On 10/29/13 Resident #219's weight was ● pounds.</p> <p>On 10/30/13 at 11:00a.m., Resident #219 stated, "I have lost weight my normal weight is 145 pounds... My husband is telling me I am too skinny and need to eat ... Currently I am having trouble eating, things just don't sound good to me."</p> <p>On 10/30/13 and 10/31/13 during at lunch, Resident #219 was offered no cues, encouragement or assistance with eating. Resident #219 ate less than 25% of her meals.</p> <p>10/31/13 at breakfast and lunch, Resident #219 was observed to eat less than 25% of her meal. No alternatives were offered, no assistance with meals was observed.</p> <p>At 12:30p.m., Residential Care Manager (RCM) A stated, "We have NAR (nutrition at risk) meetings that are supposed to happen every week. The last one we had was a couple of weeks ago."</p> <p>Review of the documentation from resident 219's NAR staffing revealed, On 9/10/13 a note from the Registered Dietician, "... Appetite continues to be very poor, rejects facility food..."</p> <p>On 9/19/13, "...Appetite is poor with average of 25% intake of meals and is refusing supplements. Dietary Manager (DM) to follow up with food preferences.</p> <p>On 10/30/13 at 1:30 the RD stated, "When she (Resident #219) first came in she did not eat anything, she admitted on ●/13. She hit my radar fast because she was not eating. A Nutrition</p>	F 325		

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F 325	Continued From page 107 assessment completed on 9/6/13 ... I saw her again on 9/10/13. I have not seen her since. The RD stated "I do not attend NAR meetings it is the facility policy, that is not the best use of my time, they prefer I follow up on my assessments and documentation."	F 325			
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329			

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F 329	<p>Continued From page 108</p> <p>Based on interview and record review, it was determined the facility failed to ensure 4 of 6 residents (#214, 258, 69 & 260) reviewed for unnecessary medications were free of unnecessary medications related to adequate indications for use and consistent monitoring of psychoactive, pain and blood pressure medications. This placed the residents at risk for clinically significant adverse side effects.</p> <p>Findings include:</p> <p>Resident 260</p> <p><Monitoring effectiveness></p> <p>Resident 260 was admitted to the facility with diagnoses to include [REDACTED] pain, [REDACTED] and [REDACTED] (a [REDACTED] infection of the [REDACTED]).</p> <p>A review of the record indicated a pain assessment was completed when the resident admitted to the facility. In the assessment the resident indicated her pain was 7 out of 10 on the pain scale and she also indicated she used a [REDACTED] Patch as needed to assist with the pain.</p> <p>A review of the Pain Management policy for the facility indicated "For residents using PRN (as needed) pain medication, a 0-10 pain scale will be used to document on the MAR (Medication Administration record) levels of pain both before and after receiving pain medication."</p> <p>In an interview with RCMA on 10/27/13, he indicated each PRN pain medication should be assessed before and after each dose on a pain</p>	F 329			

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F 329	<p>Continued From page 109</p> <p>level scale of 1-10. This information should be documented on the back of the MAR.</p> <p>During an interview with the DNS on 10/27/13, she stated "With each PRN they (the nurses) should write out what time it was given, the date, where the pain was, then go back in a reasonable amount of time to reassess and make sure it was effective. Generally they will write 'effective' or ask them on a pain scale 0-10. Most residents are able to use a word to describe the pain. That should be documented on the MAR also."</p> <p>A review of the resident's MAR showed the resident received [REDACTED] (an opiate pain medication) 27 times over a 9 day period (10/18/13-10/27/13). An assessment of the resident's pain level prior to receiving the dose was completed for 7 of the 27 doses. The effectiveness of the medication was evaluated for 13 of the 27 doses.</p> <p>Resident 214</p> <p>A review of the Psychoactive medication Policy for the facility Indicated:</p> <ul style="list-style-type: none"> -Behavior Monitoring will be initiated to identify problem behaviors and specific behavior interventions will be written on the behavior monitoring log for staff to use prior to initiation of PRN psychoactive medications. -Non-pharmacological interventions will be attempted prior to psychoactive medication usage. -Alternatives attempted will be documented on the behavior log and in the progress notes. <p>Resident 214 was admitted on [REDACTED]/13 with diagnoses to include [REDACTED] fracture, altered [REDACTED] status, and onset of difficulty with [REDACTED]</p>	F 329		
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F 329	<p>Continued From page 110</p> <p>and [REDACTED]. According to the record and the daughter, the resident had a history of falls and fractured her [REDACTED] at home in the last fall.</p> <p>A review of the nursing notes showed the resident had periods of anxiety and restlessness. On 8/25/13, a doctor ordered PRN (as needed) [REDACTED] for generalized anxiety disorder.</p> <p>On 9/12/13 a problem was added to the residents care plan for Psychotropic drug use specifically related to the [REDACTED]. An approach on the Care Plan stated "Behavior monitoring, Behavior Flow Sheet Q Shift (every shift)..."</p> <p>Two behavior monitor logs were found in the MARs for Resident #214 for the month of October. The first indicated the behaviors to look for included: Grabbing at others, starting having worried thoughts. The interventions to use included: Redirect, one on one, Take her to the big TV, Medication.</p> <p>The second log indicated the behaviors to look for included: Paranoia, Delusions/Hallucinations, Continuous screaming/yelling, Striking out/hitting/kicking, Biting or spitting, and Danger to self or others. Interventions included: Redirect, one on one, Return to low stimulation environment/room, offer activity, give food or fluids, offer activity, medication.</p> <p>No daily behavior flow sheet was found.</p> <p>Between 10/1/13 and 10/30/13, a review of the Medication Administration Record (MAR) revealed the resident received [REDACTED] 10 times as follows:</p>	F 329		

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F 329	<p>Continued From page 111</p> <p>On 10/3/13, there was no documentation on the behavior log, the PRN medication notes, or the nursing notes why the [REDACTED] was given. There was no documentation as to the interventions used prior to giving the [REDACTED] and the effectiveness of the [REDACTED] for the resident.</p> <p>On 10/5/13, 10/7/13 and 10/11/13, the PRN medication notes indicated "increased anxiety." There were no specific behaviors listed on the MAR or on the behavior log. There was no documentation as to the interventions used prior to giving the [REDACTED] and the effectiveness of the [REDACTED] for the resident.</p> <p>On 10/8/13 the resident received [REDACTED] twice. Only one dose was listed on the PRN medication notes indicating "increased anxiety." No specific behaviors were listed on the MAR notes, on the behavior log or in the nursing notes. There was no documentation as to the interventions used prior to giving the [REDACTED] or the effectiveness of the [REDACTED] for the resident.</p> <p>On 10/15/13, the resident received [REDACTED] twice. The PRN medication note for each dose only indicated "increased anxiety." The effectiveness was documented on the behavior log and in the nursing notes for only one of the doses.</p> <p>On 10/16/13, the PRN medication note only indicated "increased anxiety." No specific behaviors are listed on the PRN MAR notes, on the behavior log or in the nursing notes. There was no documentation as to the interventions used prior to giving the [REDACTED] and the effectiveness of the [REDACTED] for the resident.</p> <p>On 10/29/13, a nursing note indicated the</p>	F 329		

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F 329 Continued From page 112
resident received [REDACTED] at 9:00 a.m. for agitation with "good results." This dose was not listed on the MAR or on the behavior logs.

On 10/30/13, the PRN medication note only indicated "increased anxiety." No specific behaviors are listed on the PRN MAR notes or on the behavior log. Interventions tried prior to use of the [REDACTED] were not found.
Resident 258

Resident #258 was admitted [REDACTED]/13 with multiple medical diagnoses to include [REDACTED], [REDACTED] disease and [REDACTED].

Record review revealed a physician order for [REDACTED], a medication to control high blood pressure. The order included instructions for the licensed nurse to, "hold for HR (heart rate) less than 60, hold for SBP (systolic blood pressure) less than 100." Documentation on the Medication Administration Record (MAR) showed 8 days with an initial and no HR or SBP recorded.

On 10/28/13 at 11:08a.m., Licensed Nurse (LN) H indicated an initial on the MAR meant the nurse gave the medication. LN H indicated the BP and HR for medications would not be documented in the computer. LN H stated, "Usually record on the MAR if (order) asked for it or sometimes on back sheets (of the MAR)." LN H verified the BP and HR were not recorded on the MAR for resident #258, "I checked it, but didn't record it."

At 11:12a.m., LN C stated, "The NACs (nursing aide certified) always take the vitalsI record it on the MAR." LN C verified the BP or HR was not recorded on the MAR and an initial indicated the medication was given. LN C stated, "I may still

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F 329	<p>Continued From page 113</p> <p>have the vitals sheets from those days", but did not provide such documentation during the survey.</p> <p>At 11:59a.m., the Director of Nursing Services (DNS) said, "Nurses should document the BP on the MAR if MD ordered. The Matrix (computer) is used for the NACs to record vitals for Medicare, not for the nurses to use for meds." The DNS reviewed the MAR for resident #258 and stated, "if it's not on here then can't say it was done. "</p> <p>Resident #69 Resident #69 was admitted to the facility on [REDACTED]/10 with diagnoses to include a [REDACTED] with [REDACTED] sided [REDACTED] and [REDACTED] problems resulting in the resident receiving nutrients through a surgically inserted [REDACTED] in the [REDACTED].</p> <p>The resident was placed on comfort care 10/18/13 for new diagnoses to include a [REDACTED] mass.</p> <p>A physician's order, dated 10/11/13, indicated for the resident to receive a transdermal [REDACTED] patch (a patch placed on the skin behind the ear to decrease secretions, nausea and vomiting) and changed every 72 hours.</p> <p>On 10/22/13 at 10:25 a.m., 10/23/13 at 9:25 a.m., and 10/27/13 at 10:45 a.m., a patch was not observed behind or in the area of the resident's ears.</p> <p>At 10:53 a.m., reviewed the resident's Medication Administration Record (MAR) with LN B. She stated she applied the [REDACTED] patch on the resident the day before. The surveyor asked LN B to show where she applied the patch. LN B checked both sides of the resident's ear area to</p>	F 329		

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F 329	<p>Continued From page 114</p> <p>locate the patch. There was no patch.</p> <p>LN B stated she did not have a chance to check for the [REDACTED] patch that day since she started her shift at 7:00 a.m. She stated when she applied the [REDACTED] patch the day before, the resident did not have a patch to remove. LN B said she was uncertain what the policy was for the LNs on subsequent shifts to check for placement of the resident's medication patch.</p> <p>There was no documentation on the MAR the subsequent shifts checked for placement of the [REDACTED] patch.</p> <p>On 10/28/13 at 3:45 p.m., RCM C was asked what was the expectation of staff to monitor medication patches placed on residents. RCM C replied the patch was monitored every shift and documented on the MAR. The surveyor and RCM C reviewed Resident #69's MAR. RCM C commented, "There is no place for the LN to initial every shift for placement." RCM C reviewed another resident's MAR with the surveyor and LN C who worked the 100 hall. RCM C said, There should be a place for the LNs to initial, but there isn't."</p> <p>On 10/29/13 at 11:13 a.m., the DNS was asked what was expectation of staff to monitor medication patches placed on residents. The DNS replied, "the patches should be monitored on the MAR to ensure the patch is in place." The surveyor and the DNS reviewed the MAR for Resident #69. The DNS stated, "There is usually another order on the MAR to check for placement." There was no order on the MAR for monitoring.</p>	F 329			

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F 334	Continued From page 115	F 334		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal	F 334 F 334		

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F 334	<p>Continued From page 116</p> <p>immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to have a system in place to ensure the pneumococcal immunization was offered and/or administered for 5 of 8 residents (#s 202, 264, 48, 54 & 96) reviewed for immunizations. This placed the residents at risk for infections.</p> <p>Findings include:</p>	F 334		

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F 334	<p>Continued From page 117</p> <p>On 10/28/13 at 10:50 a.m., the surveyor reviewed the pneumococcal immunization program with the Infection Control Coordinator (ICC). She said the Licensed Nurse (LN) admitting a resident explained the risks and benefits to the resident/legal representative prior to obtaining the consent. The pneumococcal immunization (PI) was given every five years requiring a consent to be signed. The ICC explained the immunization was ordered through the pharmacy on an individual basis. She stated, "If ordered today and comes in tonight, will give the next day."</p> <p>The ICC said, the LN documented the administration of the PI on the Medication Administration Record (MAR). The ICC stated the floor nurse was responsible to ensure the PI was administered communicating to the next shift during report.</p> <p>The ICC conveyed she did not do oversight to ensure residents were offered or received the PI. She stated the Resident Care Managers were responsible for the oversight of the residents receiving PI.</p> <p>Resident #202 was admitted to the facility on [REDACTED]/13. The resident's record revealed a blank pneumococcal immunization consent form. The ICC stated, "No pneumococcal immunization consent completed ... will need to follow up." There was no evidence showing the facility offered or administered the influenza vaccine to the resident.</p> <p>Resident #264's PI consent was signed. In the space on the MAR where the LN should have placed his/her initials was a large X. The ICC stated, "it looks like it wasn't given ... wonder what</p>	F 334		

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F 334	Continued From page 118 happened ...will need to check on that." Resident #48's PI consent was signed. There was no documentation on the MAR the PI was given. The ICC said, "another to look into." The PI program for Resident #s 54 & 96 were incomplete. The ICC conveyed she would need to follow up to determine what happened. The facility did not provide any follow up information.	F 334		
F 371 SS=F	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 and interview the facility failed to prepare and serve food under sanitary conditions. This failure created the potential for food contamination for all residents receiving food prepared in the facility's kitchen. Findings include: On 10/20/13 at 5:00p.m., the following observations were made of the facility's kitchen	F 371		

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F 371	Continued From page 119 with Dietary Aide (DA) B: a) The facility's stove, top, back and front was covered in grease and dust. b) Two pieces of bread, wet wash towels and several plastic gloves were observed on the floor. The cook was stepping on or over the debris as she was dishing up dinner plates for residents. c) 5 of 11 trays observed, revealed the eight ounce clear plastic drinking cups on the resident trays for dinner were stained, yellow and deeply scratched. d) At 6:23p.m., Two box fans black in color on the blades from the accumulation of dirt and grease were observed on the food preparation counter. DA B stated, "They are dirty it should not be there." e) The floors of the kitchen and dishwashing area were observed to have black residue and grime. The traffic areas of the floor were sticky when walked upon. DA B stated, "Yeah, the floors are dirty." f) The plate warmer used to keep plates warm prior to the meal being served was coated with food particulates on the top, sides, and back. g) The food mixer was dirty with grease and dust, DA B stated, "Yes it needs to be cleaned." h) The can opener was coated with food particulates on the blade. DA B stated, "It needs to be run through the dish- pit (dishwasher)." i) The convection oven was so dirty you could not	F 371			

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F 371	Continued From page 120 see through the glass doors. j) The toaster and waffle iron were full of crumbs and dried matter. k) The microwave oven was coated with food particulates. DA B agreed the oven, toaster waffle maker and microwave all needed to be clean, "Yea they are all dirty." l) The preparation shelf where DA B stated she made sandwiches was dirty and there was a sticky substance visible on the surface. m) There were randomly placed food items, used paper towels, wiping rags, cookbooks and spices observed on the shelves above the prep area. DA B stated, "I don't know what to say, it all needs to be cleaned." n) There were dirty pots and pans, six dirty crock pots, a cookie maker, serving utensils, old vases, plates, knick-knacks, shelves of clutter and disorganization observed where the clean dishes were stored. On 10/22/13 at 2:45 p.m., the Registered Dietician (RD) and Dietary Manager (DM) verified the equipment and flooring in the kitchen was visible with food particulates, debris, dust, grease and grime. All counter tops, shelves, drawers, equipment and prep areas needed to be cleaned. The DM confirmed the dust and grease were older than two months. When asked what the routine cleaning schedule for the kitchen was the DM stated, "We just had a QA (Quality Assurance) report from the (RD) on October 13th, and a cleaning schedule was going to be made and implemented. We are working on it."	F 371		

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F 371	Continued From page 121 The RD stated she had given the QA report to the administrator the previous week, but was not able to talk with her directly about the cleanliness of the kitchen. The RD stated, "A deep cleaning is really what we need." There was no cleaning schedule or maintenacne scheldule for the kitchen appliances, flooring, shelves or misc. equipment. The RD stated, "...We are working on a cleaning schedule." 10/25/13: at 10:30a.m., the Administrator (ADM) and Consulting Administrator (CADM) stated they were aware of the cleanliness issues in the kitchen and were in the process of getting it cleaned up. On 10/26/13 at 4:30a.m., dining room kitchen review with the ADM revealed of the 60 glasses set on the table for residents for breakfast 11 were dirty, stained and unusable for residents to drink from. The ADM agreed and removed the glasses from the table. <INFECTION CONTROL CONCERNS> On 10/20/13 at 5:10 p.m., DA B was observed, going to the walk- in freezer wearing plastic gloves, she opened the freezer door and exited. Without washing her hands or changing her gloves, the cook was observed to go directly back to the oven and flip a Quesadilla (a flat stuffed flour tortilla) with her hands. Utensils were observed to be stored in plastic bins six 12 by 8 inchs high. Forks, knives, spoons, spautulas, tongs, apple peelers, three can openers, 25 measuring cups and two cooking funnels were piled in bins. The DM stated,"The	F 371		

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F 371	Continued From page 122 problem is we don't have them in any order and when 10 different people go in to grab for utensils...it's a problem."	F 371		
F 425 SS=E	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to acquire prescribed medications for 5 of 9 (#s 128,134,214,258 & 260) current sampled residents. Not aquired in a timely manner were; pain, eye mouth, anti-fungal, antidepressant, blood pressure, thyroid, antibiotic and breast cancer treatment medications. These</p>	F 425		

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F 425	<p>Continued From page 123</p> <p>failures placed residents at risk for delayed treatment, adverse side effects or to not receive the intended effects of a medication.</p> <p>Findings include:</p> <p>In an interview with the Director of Nursing (DNS) on 10/27/13, regarding medication availability and delivery from pharmacy she indicated "When we get an order for a medication, we take the order and fax it to the pharmacy. They have two runs a day Monday through Friday. On Saturday there is one delivery. On Sunday there are no deliveries, but there is a pharmacy on-call that can satellite medications 24/7. To satellite we get the order to our pharmacy and they call it in to the local pharmacy and get the order done. Our pharmacy is contracted with several local pharmacies that are open 24/7. If it is a valid script and new order for resident, we will talk to pharmacy and discuss how many we can pull from e-kit. The expectation is that residents should get their medications within few hours of order."</p> <p>In an interview on 10/27/13, Resident Care Manager (RCM) A indicated "If the resident is not going to get it (a medication) right away the nurse should document in the medication notes. A circle on the Medication Administration Record (MAR) means the medication was not given. Any time it is circled they are supposed to be writing a note indicating why it was not given."</p> <p>Interviews with three LNs (J, E, and H) confirmed they were aware of the expected practice for ordering/obtaining medications for the residents.</p> <p>Resident 260</p>	F 425			

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F 425 Continued From page 124
Resident 260 was admitted to the facility on [REDACTED]/13 at 2 p.m. with diagnosis to include [REDACTED] pain, [REDACTED] and [REDACTED] (a [REDACTED] of the [REDACTED]).

A review of the Medication Administration Record (MAR) for Resident 260 showed:

On 10/18/13 the evening doses of [REDACTED] (an anti-depressant), [REDACTED] (a blood pressure medication), [REDACTED] Solution (a Glaucoma medication) and [REDACTED] (a blood pressure medication) were circled.

On 10/19/13 the [REDACTED] and [REDACTED] (a blood pressure medication) were circled in the AM. The morning dose of [REDACTED] (a seizure medication also used to control pain) was circled and the afternoon dose was left blank. The [REDACTED] (an anti-fungal) was left blank for the 2 p.m. dose.

A note on MAR indicated the [REDACTED] and [REDACTED] were "not in Stock" on the 18th. No notes were found on the MAR or in the progress notes indicating why the other meds were circled or left blank on the 18th and 19th.

A note in record on 10/19/13 indicated the resident's medications did not arrive in facility until 8 p.m. on [REDACTED]/13, 30 hours after the resident was admitted to the facility.

No notes were found indicating the doctor was notified the medications were not available or that the satellite pharmacy was called in an attempt to obtain the medications.

A review of the list of medications in the facility

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F 425 Continued From page 125
e-kit revealed the [REDACTED], [REDACTED], and [REDACTED] were available for use.

During an interview with the resident on 10/22/13 she stated "I didn't have any of my medicine. It didn't get here until my daughter got my stuff from home on Saturday night. The nurse said she didn't have orders for the medications and had to wait for the pharmacy to deliver. I took no medicine on Friday."

Resident 128

Resident 128 was admitted to the facility on [REDACTED]/13 with a diagnosis of [REDACTED] with [REDACTED] lesions. During her stay in the facility she had been sent to the hospital for a period of twelve days and returned with further diagnoses of [REDACTED] (an inflammatory condition), [REDACTED] (a decrease of [REDACTED] in the [REDACTED]), [REDACTED] (formation of a [REDACTED] inside a [REDACTED]), and [REDACTED] Pressure.

A review of the records showed:

The MAR for 8/28, 8/29, 8/30, 8/31 and 9/3/13 indicated the resident did not receive her [REDACTED] (a corticosteroid used to relieve inflammation and also used to treat certain types of [REDACTED]) as it was "not available."

On 8/28/13 the resident did not receive her [REDACTED] (an antibiotic) as it was "not available."

On 8/29/13 the resident did not receive her [REDACTED] (a thyroid hormone) as it was "not

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F 425	<p>Continued From page 126 available."</p> <p>On 9/1/13 the resident did not receive her [REDACTED] (a [REDACTED] treatment) as it was "not in stock."</p> <p>On 9/1, 9/2, and 9/4/13 the resident's [REDACTED] was also circled but no explanation was given.</p> <p>On 10/24/13 the resident received an order for [REDACTED] due to increased pain. A review of the MAR showed the medication crossed out through the 24th with the 1st dose being given on the 25th. No note was found indicating why the medication was started 1 day after the order and no doctor's order was found indicating the start date of the medication should be 10/25/13.</p> <p>A review of the e-kit showed [REDACTED], [REDACTED] and [REDACTED] were available.</p> <p>No notes were found indicating the Doctor was notified the medications were not available or the satellite pharmacy was called in an attempt to obtain the medications.</p> <p>In an interview on 10/26/13 RCM A indicated if an order was obtained on day shift, the order would be faxed to the pharmacy and the med should be there on the evening delivery. Even if it isn't available on the evening delivery, [REDACTED] is available in the e-kit and the staff could have given it to her. The same (e-kit availability) would be true if the medication was ordered on swing shift after the last Pharmacy delivery. When shown the MAR with the 24th crossed out and indication the first dose of [REDACTED] was given on the 25th, He stated "There is no reason for</p>	F 425		

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F 425	<p>Continued From page 127 that. She should have got it. It's in the e-kit"</p> <p>Resident 214</p> <p>Resident 214 was admitted on [REDACTED]/13. A review of the nursing notes showed on 8/21/13 the resident had a "darkened, irritated areas and redness to roof of mouth as well as a yellowish film to tongue." A doctor's order was received for [REDACTED] swish and spit three times a day.</p> <p>A review of the MAR for 8/23/13 indicated [REDACTED] swish and spit not given as it was "not available." No notes were found indicating the doctor was notified the medication was unavailable or that the satellite pharmacy was called to obtain the medication.</p> <p>Resident #134</p> <p>Resident #134 was admitted to facility on [REDACTED]/13 with multiple diagnoses including [REDACTED] and [REDACTED].</p> <p>Record review revealed an order for [REDACTED] (a medication for depression) on 9/1/13. The resident received the medication 9/1-9/3/13 as indicated by an initial on the dates. From 9/4-9/8/13 the boxes were initialed and circled for the [REDACTED]. According to RCM C, the circle indicated the medication was not given. The reason documented on the back sheet of the MAR was, "not available" on 9/4-9/8/13 with the pharmacy notified only once on 9/6/13. RCM C stated, "A nurse probably came and told me and I helped out to get it [REDACTED]." A note on the back sheet of the MAR by RCM C dated 9/9/13, "Call placed to (pharmacy) after notification of</p>	F 425		

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F 425 Continued From page 128
med not available, order refax and will be on today's shipment." RCM C said, "The nurses are aware to call the pharmacy, the MD should be notified right away." RCM C verified no documentation in the record to indicate the physician was notified of the resident not receiving the medication as ordered.

Resident #258

Resident #258 was admitted [REDACTED]/13 with multiple medical diagnoses to include [REDACTED].

Record review revealed an admission order for [REDACTED] (a pain medication) to be given three times daily. The medication was circled on 10/10-10/11/13 with only one note on back sheet of MAR dated 10/10/13 which indicated "[REDACTED] not in stock." No documentation of follow up to the pharmacy or physician. RCM C indicated the process for new admission medications was to "fax orders to (pharmacy) and (they) send to us, (we) take what we can from the e-kit, meds are usually on the next delivery, if not can have satellite." RCM C verified [REDACTED] was not available in the e-kit and added, "any nurse can call for a satellite....should have called and told didn't have [REDACTED] so could be satellited." RCM C verified no documentation in the record to indicate the physician or pharmacy was notified of the resident not receiving the medication as ordered.

F 425

F 428 483.60(c) DRUG REGIMEN REVIEW, REPORT SS=D IRREGULAR, ACT ON

The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505514	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/01/2013
NAME OF PROVIDER OR SUPPLIER RICHLAND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1745 PIKE AVENUE RICHLAND, WA 99352		
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F 428	<p>Continued From page 129</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to act upon a pharmacist recommendation indicating a potential medication interaction for 1 of 6 current sampled residents (#127) reviewed for unnecessary medications. This failure placed the resident at risk for adverse effects from a potential drug interaction.</p> <p>Findings include:</p> <p>Resident #127 was admitted to the facility on [REDACTED]/13 with multiple medical diagnoses to include [REDACTED] syndrome and [REDACTED] disease ([REDACTED]).</p> <p>Review of the resident's medication regimen revealed the last pharmacist medication review was on 9/12/13. Irregularities were noted on the pharmacist's worksheet in the record which indicated a possible interaction between [REDACTED] (a medication for [REDACTED]) and [REDACTED] (a medication for [REDACTED] syndrome). The facilities drug book, Mosby's Drug Handbook 2013, located at the nurse's station noted a potential decreased effectiveness of [REDACTED] when taken with [REDACTED].</p> <p>On 10/27/13 at 10:56 a.m., the Director of Nursing (DNS) indicated the process for follow up</p>	F 428		

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with the pharmacist recommendations was a copy was placed in the Advanced Registered Nurse Practitioner's (ARNP) or physician's box for review. The DNS added, she did not have a system for follow up to address those communications not reviewed as "people are in and out so quick it is hard to follow sometimes." The DNS was asked to provide documentation of the physician being notified of the pharmacist's concerns as the communication was not in the resident record.

At 12:10 p.m., the DNS presented a copy of the pharmacist's communication which indicated a concern of a drug interaction between [REDACTED] and [REDACTED]. The ARNP accepted the recommendation to discontinue the [REDACTED] on 10/27/13. This was more than five weeks after the pharmacist's recommendation. The DNS stated, "somehow this communication was missed, but the order will be noted today".

On 10/28/13 at 10:26 a.m., the resident stated, "my legs are weak and I cannot walk without help." The resident stated, "I'm not getting any better it seems though." The resident was unable to recall what medications he was prescribed, "I just take what they give me."

Review of the medication administration record showed resident #127 received both [REDACTED] and [REDACTED] from 9/8/13 until 10/27/13.

Failure to address the pharmacist's recommendation timely increased the resident's risk of not receiving the full intended benefit of the prescribed medication.

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F 428	Continued From page 131	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review it was determined that the facility failed to ensure staff consistently maintained infection control practices in isolation rooms to prevent potential spread of infection for 3 of 6 Sampled Residents (#s 253, 260, 265) reviewed for isolation procedures. This failure had the potential to place other residents and staff at risk to have contact with an infectious bacteria.

Findings include:

According to the Center of Disease Control (CDC), Clostridium difficile (C. diff) (infectious bacteria in the gut causing bloating and diarrhea) is found in feces. Any surface, device, or material that becomes contaminated with feces may serve as a reservoir for the C. diff spores. The C. diff spores are transferred to patients by the hands of healthcare staff who have touched a contaminated surface or item. The spread of C. diff can be prevented with the use of contact precautions for patients with known or suspected C. diff infection. Gloves and gowns should be used when entering patients' rooms and during patient care. Consider using only soap and water for hand hygiene when caring for patients with C. diff infection.

Resident 253

Resident #253 was admitted to the facility on [REDACTED]/13 with diagnoses to include [REDACTED]

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F 441	<p>Continued From page 133</p> <p>At 5:25 p.m. on 10/20/13, Nursing Assistant (NA) L was observed to take a meal tray to Resident #253. An isolation cart and signage to "see nurse" was outside the entry of the room. NA L did not wear gloves prior to entering the room or wash hands before exiting the room. NA L stated, "You should wash before and after passing tray and if you come in contact with the resident." NA L acknowledged she did not know why the resident was in isolation and she did not wash hands or wear gloves.</p> <p>On 10/21/13 at 11:03 a.m., Nursing Assistants (NA) P and Q entered Resident #253's room without putting on gowns or gloves. NA P and Q transferred the resident from the bed to the wheelchair. The two NAs proceeded to transfer the resident from the wheelchair to the toilet without gowns and gloves. The two NAs put on gloves before the assisting the resident to stand up.</p> <p>As the resident stood over the toilet, stool was noted to have oozed out of her incontinent brief onto her thighs. The two NAs removed the incontinent brief while wearing gloves. No protective gowns were worn.</p> <p>Resident 260 On 10/20/13 at 5:20 p.m., the Activities Assistant (AA) was observed to deliver a meal tray to Resident #260. This room had an isolation cart and signage to "see nurse" outside the room door. The AA did not put on gloves before entering the room or wash her hands before exiting the room. When asked what the cart and sign outside the room indicated, AA said "I don't know why they are on precautions." When asked about the expectation for passing trays in</p>	F 441			

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F 441	<p>Continued From page 134</p> <p>isolation rooms, the AA said "good question, I would guess wash before and after entering." AA acknowledged she did not wash her hands or utilize gloves in this room.</p> <p>On 10/22/13 at 10:03 a.m., Resident #260 stated, "I remind the staff to wear gowns to clean me up. I don't want them to spread it to others."</p> <p>On 10/25/13 at 9:20 a.m., the Medical Records Assistant (MRA) entered Resident #260's room to answer a call light. The MRA touched the resident on the shoulder before leaving the room. The MRA did not wear gloves when entering the room or wash her hands prior to leaving the room.</p> <p>At 8:15 a.m. on 10/26/13, Licensed Nurse (LN) I entered the room to give medications to Resident #260. LN I did not wear gloves and exited room without washing hands. When LN I asked about precautions for this room she said, "Should wash hands every time before you leave the room." LN I acknowledged she did not wash her hands or wear gloves and said, "Felt I did not need to since only doing medications."</p> <p>Resident 265</p> <p>On 10/26/13 at 7:47 a.m., NA M delivered a tray to Resident #265. This room had an isolation cart and signage to "see nurse" outside the room door. NA M did not wear gloves into the room and did not wash hands prior to exiting the room. NA M continued to deliver trays to two other rooms. Licensed Nurse (LN) B verified the resident on isolation was Resident #265.</p> <p>At 7:58 a.m., NA M verified the carts outside the rooms are for C. diff isolation. NA M said,</p>	F 441		
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F 441	Continued From page 135 "Should wash hands so we don't spread germs from one room to another....wash after deliver tray." NA M stated, "I did not wash hands, but should have." On 10/31/13 at 9:00 a.m., the Assistant Director of Nursing (ADNS) said, "the new recommendation from CDC is to glove when go into the room no matter what going in for. And, the must wash their hands prior to leaving the room." The ADNS verified the facility expectation was to follow the CDC recommendations.	F 441		
F 490 SS=H	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to administer operations and use resourses to ensure resident safety, health, and well being related to water temperatures, oxygen, falls, skin care, investigations, weights, infection control, food service, and quality assurance. These failures resulted in an immediate jeopardy/substandard care (abated on 11/1/13), actual harm, and/or widespread scope. Findings include:	F 490		

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F 490	<p>Continued From page 136</p> <p>1) Administration failed to evaluate and respond in a timely manner to known environmental hazards placing residents at risk for injury related to fluctuating water temperatures, unsecured oxygen tanks and resident falls (#'s 214, 263, 182, 222).</p> <p>a) On 10/21/13, the facility's water temperatures were observed to fluctuate between 90 degrees Fahrenheit (F) and 138 degrees F in residents' rooms. Interviews with dietary staff, nursing assistants, the bath aide, and the beautician indicated the Administrator (ADM) and the Maintenance Department (MD) knew about the fluctuating water temperatures over a period of months.</p> <p>b) On 10/21/13 at 9:30 a.m., the facility staff was observed securing a portable oxygen tank in a pillowcase with one knot to the back of Resident #253's wheelchair. At 9:56 a.m., two oxygen tanks were observed unsecured in the outside storage room. Record review revealed seven in-service training sign-in sheets addressing the safety of oxygen tank use and storage dated back to 10/11/12.</p> <p>c) Falls:</p> <p>- Resident #214 was admitted on [REDACTED]/13 and had 14 falls between 8/13/13 to 10/28/13 resulting in the resident receiving skin tears and after the ninth fall the family requested a CT scan which revealed a fractured [REDACTED] ([REDACTED] located at the base of the [REDACTED]).</p>	F 490		

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F 490	<p>Continued From page 137</p> <ul style="list-style-type: none"> - Resident #263 was admitted to the facility [REDACTED]/13 Six days later, Resident #263 fell twice in her room within an hour sustaining a hip fracture. - Resident #182 was admitted to the facility on [REDACTED]/13 with a history of [REDACTED] with [REDACTED]. Record review revealed the resident had an un-witnessed, injury fall while standing at her sink brushing her hair the morning of [REDACTED]/13. The resident was diagnosed with [REDACTED] fracture after being transferred to the emergency room. After readmission the resident had two non-injury falls on 8/27 and 8/29. There was no documentation of what specific measures were implemented for seizure precautions or to prevent additional falls/injury. - Resident #222 was admitted on [REDACTED]/13 with diagnoses of multiple [REDACTED] from a [REDACTED] accident to include [REDACTED] and [REDACTED]. Resident #222 had eight falls within 14 days to include four on one day and four with complaints of head injury. <p>Refer to F323 This is a repeat citation from 2011 and 2010.</p> <p>2) Administration failed to ensure thorough investigations to rule out abuse and/or neglect for Resident #s 65, 214, 263, 224 & 204 reviewed for incidents and investigations. Refer to F225.</p> <p>3) Administration failed to ensure nursing service implemented Resident #133's plan of care for the treatment of her pressure sore to prevent the development of new avoidable pressure sores. This caused harm to Resident #133. Refer to F314 for details.</p>	F 490	

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F 490	Continued From page 138 4) Administration failed to ensure an effective system in place to prevent avoidable weight loss. This caused harm to Resident #s 91 & 134. Refer to F325 5) Administration failed to ensure an effective infection control system in place to offer and administer required PPD screening for residents and staff, pneumococcal immunizations for residents and prevent the spread of infectious diseases. Refer to F441, F334, WAC 388-97-1380, and WAC 388-97-1400. This is a repeat citation from 2012, 2011 and 2010. 6) Administration failed to ensure food was stored prepared and served under sanitary conditions. Repeat citation from 2011 and 2010. Refer to F371. 7) Administration failed to implement an ongoing, comprehensive Quality Assessment and Assurance Program addressing care systems and management practices enhancing residents' quality of life and resident choice. Refer to F520	F 490		
F 508 SS=D	483.75(k)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility	F 508		

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F 508 Continued From page 139
failed to ensure timely radiology services for 1 of 1 former sampled residents (# 263) reviewed for falls with radiology services: This failure allowed a resident with a broken hip to go over 24 hours before being sent to the hospital for an Orthopedic evaluation.

Findings include:

Resident #263 was admitted to the facility with diagnosis to include [redacted] sided [redacted] Accident ([redacted]) (Acute [redacted]) and [redacted] ([redacted]).

A review of the record revealed on 10/3/13 resident # 263 had two falls within an hour. Further review of the nursing notes showed the following:

At 3:15 p.m. on 10/3/13 the resident complained of pain and received [redacted].

At 5:18 p.m. on 10/3/13 Resident Care Manager (RCM) A received an order from the Advanced Registered Nurse Practioner (ARNP) to obtain an x-ray of the left hip (2 views) due to increased pain after the fall.

At 3:13 a.m. on 10/4/13 Licensed Nurse (LN) G documented the resident complained of her leg hurting when the head of her bed was raised. The documentation indicated the resident was scheduled for an x-ray in the AM. No documentation was found regarding the reason the x-ray was delayed until morning.

At 2:53 p.m. on 10/4/13 LN H documented "x-ray pending"

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F 508	<p>Continued From page 140</p> <p>At 5:07 p.m. on [redacted]/13 (approximately 24 hours after the order was obtained) the results of the x-ray indicating a [redacted] hip fracture were called to the facility. The ARNP was notified and the resident was transferred to the hospital.</p> <p>During an interview on 10/31/13, RCM A indicated the mobile x-ray company the facility used did not have after hours service. He further indicated if a resident is showing symptoms, the resident would be sent to the Emergency Room (ER) rather than waiting until morning to conduct the x-ray.</p> <p>During an interview on 10/31/13 RCM C indicated the x-ray company did not come out in the evenings. If the resident required an x-Ray in the evening, the resident would be sent to the ER.</p> <p>A review of the x-ray company manual at the nursing station showed the hours Monday - Friday, 8 am-5 pm.</p> <p>During an interview with the DNS on 10/31/13, she indicated "if the resident was in acute pain we would send them out to have the x-ray done. If it was on a weekend, there is no x-ray service so we should send them out. If we have an order for a stat x-ray they will come between 5:30 and 6."</p> <p>During an interview with the Administrator (ADM) on 10/31/13, she indicated "We had an Issue with the x-ray on (Resident # 263). We contacted mobile x-ray to get the x-ray. It was a late call. We anticipated them the following morning. I received a call in the morning that the x-ray company never came so I started trying to find out why they had not come yet. I needed info to determine whether we should send her out to ER.</p>	F 508		

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F 508	Continued From page 141 I was assured they would be here within 5-10 minutes after I called the corporate offices " The ADM further indicated the facility could put in for stat orders for an x-ray and the x-ray company would have come after hours. If the mobile x-ray couldn't come, the facility could send a resident out to the ER. When asked why the facility did not send the resident out to the ER the night the order was obtained, she stated "I will have to talk to (RCM A) about that." When asked why the facility waited 24 hours from the time of the order for the x-ray was received until the time the resident was sent to the hospital for a fractured hip, the ADM stated "I will have to ask (RCM A) and look in the record." No further explanation or documentation was provided.	F 508		
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure 2 of 5 staff (Licensed Nurse G & Nursing Assistant H) interviewed were knowledgeable in emergency procedures. This failure placed residents at risk for injury or harm during an emergency situation. Findings include: 1. On 10/21/13 at 12:50 p.m., Nursing Assistant H	F 518		

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F 518	Continued From page 142 stated she did not know what to do when the facility lost power. 2. On 10/26/13 at 5:00 a.m., Licensed Nurse (LN) G, the charge nurse on night shift, was asked the location and use of the fire extinguisher. LN G walked to a fire extinguisher located in the wall enclosed behind a locked transparent door. She stated she did not know which key fit the lock to open the door. LN G took her set of charge nurse keys placing eight different keys into the lock in an attempt to unlock the door. None of the keys worked. LN G stated, "let's try this" while aggressively pulling the door open. LN G said she could not recall when was the last time she received emergency preparedness training. When asked if specific outlets were used if the facility loses power, LN G replied the outlets with the dots on them. She walked down the hall to locate such outlets and stated, "Well all I see are red outlets, maybe the dotted ones are in the rooms." On 10/29/13 at 1:20 p.m., the Maintenance Supervisor stated the doors for the fire extinguishers were not locked, "have to pull hard." When informed him of a night charge nurse not knowing and looking for emergency outlets with dots, he stated training was always being done.	F 518		
F 520 SS=H	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the	F 520		

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F 520	<p>Continued From page 143 facility, and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility's did not maintain a Quality Assessment and Assurance Program (QA&A) of active full membership participation that identified deficiencies and implemented preventive corrective actions. The facility failed to recognize care and services that were resulting in resident actual harm, immediate jeopardy/substandard care, and/or widespread scope.</p> <p>Findings include:</p> <p>Throughout the survey the following deficiencies were identified:</p> <p>Refer to F-225 for failure to implement facility</p>	F 520		
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F 520	<p>Continued From page 144</p> <p>policies to investigate and report allegations of abuse neglect or mistreatment (actual harm) Refer to F314 for failure to prevent pressure sores (actual harm) Refer to F-323 for failure to ensure all residents were free from accident hazards (immediate jeopardy/substandard care - abated 11/1/13) Refer to F-325 for failure to maintain nutritional standards for residents unless unavoidable (actual harm). Refer to F441 for failure to provider infection control (widespread failed practice) Refer to F371 for failure to store, prepare, and serve food in a sanitary manner (widespread failed practice)</p> <p>On 10/20/13 at 6:00 p.m., the Administrator (ADM) was interviewed regarding the QA & A process. The Administrator stated the committee met quarterly and addressed facility quality care issues monthly as needed. The ADM stated the committee included the Director of Nursing (DNS) Social Work Director (SSD) and the Dietary Manager (DM.) The ADM stated the Medical Director nor any other physician had attended QA meetings over the past year.</p> <p>On 10/31/13 at 1:00p.m.</p> <p>F-225: The ADM reported during the survey time frame issues related to investigations had been identified and the facility was working on a plan "going forward."</p> <p>F-323: Regarding potential accidents hazards in the facility during the survey an Immediate Jeopardy (IJ) was called on 10/21/13 due to unsecured oxygen tanks in use by residents and in storage. The ADM reported everyone was</p>	F 520		

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F 520	<p>Continued From page 145</p> <p>responsible on daily basis to ensure a safe environment for all residents.</p> <p>F-325: The ADM stated, "The computerized system to tracks all weight loss and a report is pulled for QA."</p> <p>The ADM stated, "In the QA meetings discussion of facility processes are discussed. Information about deficiencies is collected in different way, for example, resident council minutes, random questioning throughout the building ... we look for trends and review them ... We pull things forward to QA like abuse protocol, or infection control ... monthly or quarterly it just depends."</p> <p>< Management Staff Interviews ></p> <p>On 10/30/13 at 4:00p.m., the Social Service Director (SSD) was asked how the facility identified quality deficiencies, and how concerns were brought to the QA committee? The SSD stated, "We look at resident and family concerns. Whatever concerns we discuss are resident focused, and we figure out what we need to do, and investigate more. QA meetings are sporadic we used to have them one time per month; I don't remember the last time we had one."</p> <p>On 10/31/13 at 10:30a.m., the Director of Nursing Services (DNS) stated, "If quality deficiencies are identified, I get calls at home...If it is less urgent the RCM brings it to the standup meeting and we discuss it as a team... We have a QA meeting, I think it's quarterly. When asked who attended the QA meeting the DNS stated, "department heads, but, not at the same time, they come in and out." When asked what concerns had been discussed recently (over the</p>	F 520		

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F 520	Continued From page 146 past year generally) by the QA committee, the DNS could not recall anything specifically. The Dietary Manager (DM) at 2:30p.m., was not able to provide any information regarding topics discussed at the QA meetings over the past year. 10/31/13at 4:00p.m., Residential Care Manager (RCM) A, when asked how he notified management of a quality concerns stated, "I just go into the office and talk to them (the ADM and DNS). I cannot think of a specific incident I have brought to them." When asked, how are resident concerns identified and brought to management? RCM A stated, "Really, our processes should be there to notify management and we are working at getting that into place." The facility did not have an effective system to identify quality of care concerns to address in the QA committee and did not have an effective plan in place to ensure plans for improvement were implemented once concerns were brought forward. The facility did not have a medical doctor on the QA committee for over a year and did not recognize this as a potential deficit in ensuring quality of care for all residents in the facility.	F 520		

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