

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

PRINTED: 08/08/2013
FORM APPROVED
OMB NO. 0938-0391

1154

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505226	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/02/2013
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NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - SUNNYSIDE	STREET ADDRESS, CITY, STATE, ZIP CODE 721 OTIS AVENUE SUNNYSIDE, WA 98944
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Off-Hours staggered Quality Indicator Survey conducted at Prestige Care and Rehabilitation-Sunnyside on 07/28/13, 07/29/13, 07/30/13, 07/31/13, 08/01/13 and 08/02/13. The survey included data collection on 07/28/13 from 4:10 p.m. to 8:25 p.m. A sample of 32 residents was selected from a census of 52. The sample included 26 current residents and the records of 6 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████ RN ██████████ RD Lisa Johnson RN ██████████ RN</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging and Long-Term Support Administration Residential Care Services, District 1, Unit D 3611 River Road, Suite 200 Yakima, WA 98902</p> <p>Telephone: (509) 225-2800 Fax: (509) 574-5597</p> <p><i>M. Whitney</i> 8/8/13 Residential Care Services Date</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Sunnyside Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p style="text-align: right;">Received Yakima RCS AUG 21 2013</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mary Archer</i>	TITLE <i>Adm</i>	(X6) DATE 8-19-13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225
SS=E

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 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.

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).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

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.

F 225

F. 225
It is the policy of the facility to conduct and ensure that all incident/accidents are properly logged and investigated, in accordance to state law.

Incident/accident for resident #7 was investigated and logged.
Abuse and neglect were ruled out.
Comprehensive care plan was reviewed.

Incidents/accidents for resident # 8 were investigated and logged. His care plan was being followed and has been updated.
Abuse and neglect can be ruled out.

Incidents/accidents will be identified in the morning Managing Alert Condition Change Meeting (MACC) through the review of all residents' progress notes. Any incidents/accidents identified will be investigated and logged per state guidelines by the DNS/Designee.

08/22/13 Education provided to licensed nurses on the legalities and importance of reporting/recording all incidents.

The DNS/Designee will review and investigate all incident/accident reports and log in accordance with State and Federal regulations.
Audits for compliance will be done weekly. Results will be presented to the QAPI Committee for review.

9.2-13

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This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to conduct a thorough investigation of incidents involving potential neglect, abuse or mistreatment in accordance with CFR 483.13(c) (2)(3) for 2 of 4 residents (#7, 8) sampled for investigation. This failure did not allow the facility to attempt to prevent further incidents. Findings include:

Resident #7.
The resident was admitted in 2010 with partial [REDACTED] due to a [REDACTED] and [REDACTED]. She required extensive assistance from 2 staff members to transfer.

Record review revealed on 04/24/13 while transferring from her wheelchair to her bed a Hoyer (mechanical) lift was used to facilitate her transfer. During the transfer a bar struck the resident in the head that resulted in a 3 centimeter (cm; approximately 1-1/4 inches) lump with bruising on the right side of her head. The Staff Member Y, Licensed Nurse noted the injury and completion of an incident report in the progress notes.

On 08/02/13 at approximately 2:10 p.m. Staff Member B, Director of Nursing Services stated she could not find the incident report for the 04/24/13 incident with Resident #7 and did not find it recorded on the incident log. She stated the incident should have been investigated and also should have been recorded on the log.

Resident #8.
Resident #8's admission assessment dated [REDACTED]/13 indicated the resident had moderate

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cognitive impairment, identified as unable to transfer self without extensive two person staff assistance and he was at risk for falls.

On 07/29/13 at 1:30 p.m. Staff Member D, Resident Care Manager stated Resident #8 had several falls in the previous 30 days. Per review of the medical record and fall investigation reports, the resident fell 13 times between 05/21/13 and 07/26/13. Three of the resident's falls were not investigated and only noted in the progress notes.

A progress note dated 06/02/13 at 11:09 p.m. by Staff Member T, Licensed Nurse (LN) documented: "Patient found sitting on floor at bedside at shift change." There was no documentation on the facility incident tracking log or written investigation to rule out neglect.

A progress note dated 07/03/13 at 01:58 a.m. by Staff Member U, LN noted: "Pt (patient) was seen with his gown and shoes on, legs extended and sitting on his bottom (on the floor) facing the bathroom door." There was no documentation on the facility incident tracking log or written investigation to rule out neglect.

A progress note dated 07/07/13 at 11:22 p.m. by Staff Member T revealed: "(Patient) found late in shift kneeling at bedside on fall mat." There was no documentation on the facility incident tracking log or investigation to rule out neglect.

Review of facility Accident/Incident policy dated February 2013 revealed the facility policy was to investigate incidents and accidents in accordance with State and Federal regulations and to be completed within 5 days. Further it identified

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"falls with or without injury" are to be investigated.

On 08/01/13 at 2:00 p.m. Staff Member B, Director of Nursing Services (DNS) was informed of Resident #B's 3 falls without investigations. Later at 2:40 p.m., the DNS stated she contacted Staff Members U and T and confirmed the investigations had not been done. Further she stated the LNs thought they did not need to report these falls because it was a "behavior" of the resident. The DNS stated that the incidents were falls should have been reported on an incident report and investigated by the Resident Care Manager.

F 226
SS=D 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure the required background check for 1 of 6 newly hired employees (Staff Member L) was completed. This failed practice placed the residents at risk for abuse or neglect from staff with unknown qualifications who had unsupervised access to vulnerable adults in the facility. Findings include:

On 08/01/2013 the employee record review revealed Staff Member L had been hired 06/20/13 and there was no current documented evidence

F 225 **F226**
The employee was a re-hire and her back ground check form stating "no criminal record" was 2 ½ year old not the required two years. A current copy of the employee's background check dated 8/10/13 is on hand. Background checks for all other employees are less than 2 years. The payroll clerk will insure that background checks are all less than 2 years and will report at the monthly QAPI meeting. The Administrator will supervise.

F 226 9-2-13

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F 226 Continued From page 5 of a criminal background report.

On 08/01/2013 at approximately 11:00 a.m. the Facility Administrator stated there was no current criminal background report for Staff Member L; "the employee had completed the background authorization form but since it had been completed wrong, the facility was not provided the required report." The facility failed to follow-up to ensure a result was received.

F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure a dignified dining experience for 4 of 19 residents (#13, 23, 60 and 77) in 1 of 3 dining rooms observed. This placed these residents at risk for decreased quality of life and nutrition intake and potentially could place all residents in that dining room at risk of loss of dignity. Findings include:

Dining Room observations.

The following occurred during the evening meal on 07/28/13 between approximately 4:47 p.m. and 6:10 p.m. in Dining Room 1:

There were 19 residents observed in the dining area. A radio was on in one corner of the dining

F 226

F241
It is the policy of the facility to promote care for residents in a manner and in an environment that maintains and enhances each resident's dignity and respect.

F 241

It is the policy of the facility that medications are not administered in the dining room unless it is at the specific request of the resident and is care planned to do so.

Resident # 13 no longer resides at the facility.

Resident # 77 has been assessed and has no noted significant weight loss. Her care plan was reviewed to reflect her need for 1:1 meal assistance thereby promoting uninterrupted dining

Resident # 60 has been assessed. She will be placed at a more convenient table for her specific need with meal assistance. This will enhance her dining experience. Plan of care reflects this change.

Resident # 23 has been assessed. He will be placed so that he may face other diners. This will allow him interaction and socialization with others as desired. Plan of care will reflect change.

08/22/13 Education for nursing staff in regards to proper serving of food and enhancing the dining experience for residents served in the dining room was provided.

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room, tuned to a Spanish language channel. In the opposite corner of the room a television set was on, tuned to an English language movie. The volume of both devices could be heard clearly in all sections of the room, which created a disturbing cacophony of sound not generally associated with a pleasant dining environment. Both devices remained on throughout the dining time.

There were 12 different observations of oral medication administration to residents in the dining room before, during and after the meal service. Two different licensed nurses were observed administering the medication and occasionally included a verbal description of what the medication was for in front of other residents and/or family members.

Most residents needed assistance to eat their meal with cueing and/or encouragement. Seven of the residents needed extensive assistance and did not attempt to eat until staff fed them. These seven residents were seated at five different tables. There were two Nursing Assistants - Certified (NAC) available through the meal, with a third NAC coming in to assist for a short while. The two NAC's were going from table to table to try to help those who required assistance. They would help for a few minutes and then change tables, without finishing the meal service for any one resident. Though all food was served by 5:15 p.m., it was approximately 5:35 p.m. (20 minutes later) before all residents were able to start their meals. All food was left uncovered after it was served.

The following occurred during the breakfast meal on 07/30/13 between approximately 8:15 a.m.

F 241

F241 continued
8/22/13 Medication Administration education provided to licensed nurses.

DNS/Designee will monitor for compliance three times per week or until 100% compliance is achieved, then weekly.
Results will be presented to the QAPI Committee for review.
Date of compliance: 09/02/13 9.2.13

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and 9:25 a.m. in Dining Room 1:

There were 17 residents present in the dining area. Medications were observed being administered 3 times in the dining room during the breakfast meal, with some verbal descriptions about the medication in front of other residents. There were 4 NACs assisting while residents were brought to the dining area, then two NACs remained to assist those who needed help with eating. Though food was served to all residents by 8:37 a.m., the last resident to begin eating did not start until 8:52 a.m. (15 minutes later).

Resident #13.

The resident required assistance with set up for meals, as well as cueing and encouragement to eat.

Resident #13 was observed in Dining Room 1 on 07/30/13 at approximately 8:15 a.m. He was seated in his wheelchair in the northeast corner of the dining room. He was facing the corner with his back to other residents. He was the only resident seated at the table. He had glasses of milk and juice to his right. Both glasses were full. At approximately 8:25 a.m. two NACs began serving food to other residents. At approximately 8:37 a.m. an NAC brought Resident #13 a plate of toast and scrambled eggs and a bowl of cereal. She uncovered the plate of food, positioned him closer to the table and verbally encouraged him to eat. She then left to assist other residents. At approximately 9:00 a.m. Resident #13 had not taken any food or beverage. He was observed slumped in his wheel chair on his left side. No staff approached him to encourage or cue him. At approximately 9:06 a.m. an NAC approached him and

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encouraged him to drink his milk, leaving soon after. At approximately 9:15 a.m. an NAC approached Resident #13, spoke to him briefly then removed his food and fluids. No alternate foods were offered to Resident #13. His only food/fluid consumption for that meal was approximately 2 ounces of milk.

Resident #77.
The resident was totally dependent on others for eating.

On 07/30/13 at approximately 8:15 a.m. Resident #77 was observed at a dining room table with three other residents. At approximately 8:21 a.m. NACs began serving beverages and cereal. At 8:35 a.m. the four residents at Resident #77's table were served their foods. At 8:44 a.m. one NAC arrived and began to help Resident #77 and one other resident eat at the same time. After approximately 5 minutes, the NAC left the table, with the meal partly consumed to help with feeding at another table. She returned a few minutes later, and seated herself and continued assisting the two residents, alternating back and forth between them. This denied Resident #77 an enjoyable, uninterrupted dining experience. At approximately 9:10 a.m. dishes were picked up from the table. Resident #77's food was partly eaten.

On 07/29/13 at approximately 1:30 p.m. Resident #77's family member stated she comes in each evening to assist her mother with her meal. She stated there are too many residents that need help in the dining room for the staff available and it would take too long for her mother to receive her meal if she did not assist.

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Resident #23.
Resident #23 was totally dependent on staff for eating.

On 07/30/13 at approximately 8:15 a.m. Resident #23 was observed in Dining Room 1 seated at a table with one other resident. He was facing a window. At approximately 8:30 a.m. his breakfast foods were served and left uncovered when it was placed on the table. At approximately 8:52 a.m. an NAC seated herself next to him and began to offer him food to eat (22 minutes after having the food uncovered and placed in front of him). At 8:57 a.m. (5 minutes after his meal started) NACs began removing dishes from the table around Resident #23, though he was still in the process of eating his meal. This denied Resident #23 adequate opportunity to enjoy his meal.

Resident #60.
The resident required extensive assistance with eating.

On 07/30/13 at approximately 8:15 a.m. Resident #60 was observed in Dining Room 1 seated at a table with three other residents. At approximately 8:25 a.m. the breakfast food was served to the other residents at her table. The other residents required less assistance and began eating their meals, but Resident #60 could not eat without staff assistance. She remained at the table while the other residents consumed their food until approximately 8:48 a.m. (23 minutes), when an NAC began helping her eat her meal. The other residents were finished with their meal by the time Resident #60 started her meal and two had left the table, denying her the opportunity to eat with others socially.

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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 the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, record review the facility failed to provide an ongoing program of activities designed to meet the interests of 1 of 5 residents (#7) sampled for activities. This failure placed this resident at risk of not achieving the highest practicable level of physical, mental and psychosocial well-being. Findings include:

Resident #7 was admitted with multiple diagnoses including [REDACTED] from a [REDACTED]. She communicated verbally with difficulty. She required assistance from staff to move about the facility in her wheelchair.

Record review of the 06/05/13 quarterly assessment of her activities preferences revealed that Resident #7 indicated it was very important to her to have books, newspapers or magazines to read; it was very important to keep up with the news; it was very important to do things with groups of people; and it was very important for her to participate in religious activities. It was somewhat important to listen to music.

Activity flow sheets revealed attendance at the following activities: July 2013, 4 activities (1 bible study and 3 music activities); June 2013, 1 activity (music); May 2013, 2 activities (1 bible

F 248:

F248

It is the policy of the facility to provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, interests and well-being of each resident.

The comprehensive care plan for resident # 7 has been reviewed and updated to reflect her specific interests.

- ❖ Her activities of interest are books, magazines and newspapers.
- ❖ They are presently available to her in her room.
- ❖ Resident # 7 has been placed on the 1:1 list for visits and will receive individual readings from Activity Staff twice per week.

Activity Director will monitor twice weekly for compliance.

Findings will be reported to QAPI Committee for review.

Date of compliance 09/02/13

9-2-13

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F 248	<p>Continued From page 11 study and 1 birthday party).</p> <p>Observations on 07/29/13, 07/30/13, 07/31/13, 08/01/13 and 08/02/13 of Resident #7's room revealed no books, magazines or other reading material. There was a television set, but it was not observed to be on during the observations. There were no puzzles, crafts or other in room activities.</p> <p>On 08/01/13 at approximately 3:30 p.m. Staff Member H, Activities Director stated Resident #7's health had declined and she attended activities less often. She stated she invited Resident #7 to various activities but did not document the invitations or refusals. She stated they did not have specific in room activities set up for Resident #7.</p>	F 248	<p>F279</p> <p>It is the policy of the facility to ensure that residents who are on psychoactive medications are assessed and comprehensive care plan is developed to monitor their health care needs. Resident 97 and 70 received updated MARS that included a flow sheet for monitoring potential adverse side effects (ASE) related to psychotropic medication use. The flow sheets are to be completed every shift by LN staff to ensure that effectiveness of medication and specific ASE's are consistently monitored. Resident #97 and 70 have received care plan updates Residents receiving psychotropic medications have had flow sheets initiated listing potential ASE's related to specific medications used. Additionally RCM'S/ Social Services to update care plans and determine that elements of psychotropic medication use are current, including behavioral interventions, diagnosis, justification for medication use and consents with evidence of risks and benefits are in place. RCM/Social Services will review orders for new psychotropic medications to ensure all elements of medication use are in place. LN staff educated on requirements for monitoring of ASE in association with psychotropic medication and use of flow sheets to be completed each shift. Psychotropic Drug Review Meetings will be held with Consulting Pharmacist and Interdisciplinary Team (IDT) on a monthly basis. Residents receiving psychotropic medications will have comprehensive reviews completed to ensure medications remain necessary to treat specific conditions. Dosage reductions, behavioral interventions, ASE's, diagnosis and care plans</p>	
F 279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided</p>	F 279		

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OMB NO. 0938-0391

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F 279 Continued From page 12
due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to develop comprehensive care plans for 3 of 20 residents (# 97, 70, 64) reviewed for multiple health issues. Failure to develop care plans with measurable goals and objectives to meet residents' healthcare needs placed the residents at risk for not having needs met that included psychoactive medication management. Findings include:

MEDICATION

Resident #97.
The resident had an original admission to the facility on [REDACTED]/13 and had readmits on [REDACTED]/13 and [REDACTED]/13. The resident had multiple diagnoses that included [REDACTED] and [REDACTED].

According to the July 2013 physician orders the resident took three [REDACTED] (affecting brain activities associated with mental processes and behavior) medications that included [REDACTED] and [REDACTED]. Per review of the July 2013 Medication Administration Record (MAR), the resident received the medication as ordered that included 14 doses of [REDACTED] as needed for anxiety.

The resident's medical record did not contain a plan to monitor for the psychoactive medication

F 279 **F279 CONTINUED**
will also be reviewed at this time. Social Services to present findings at quarterly QA meeting. DNS/Social Services are responsible to ensure compliance.
9-2-13

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F 279 Continued From page 13
effectiveness, presence of adverse consequences or a plan for dosage reduction or discontinuation.

Resident #70.
Per review of the 06/30/13 comprehensive assessment, the resident's diagnoses included [REDACTED] and [REDACTED].

According to the July 2013 physician orders the resident took three psychoactive medications that included [REDACTED] ([REDACTED] and [REDACTED]). Per review of the July 2013 MAR, the resident received the medication as ordered.

The resident's medical record did not contain a plan to monitor for the [REDACTED] medication effectiveness, presence of adverse consequences or a plan for dosage reduction or discontinuation.

On 08/02/13 at 10:30 a.m. the Director of Nursing Services (DNS) stated "There should be a care plan for [REDACTED] medication that lists the medication and includes monitoring for side effects and the effectiveness of the medication, I was not aware these were missing."

Resident #64.
The resident diagnoses included [REDACTED] disorder, which was treated with the medication [REDACTED] daily. Additionally, Resident #64 takes [REDACTED] and [REDACTED] ([REDACTED] medication).

Diuretic and blood pressure medications could interact negatively with [REDACTED] potentially resulting in an increase in [REDACTED] levels to a toxic

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F 279	Continued From page 14 and dangerous level. The resident's medical record did not contain a care plan the included monitoring for the signs and symptoms of lithium toxicity or other adverse consequences. The care plan did not include any monitoring of the effectiveness of the psychoactive medication. On 08/02/13 at 1:30 p.m. Staff Member C stated the resident "doesn't have any behaviors... I do not think that these (behaviors) were in the care plan."	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in 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 consistently monitor 1 of 1 sampled resident (#122) who was experiencing knee pain following recent surgical intervention. Failure to consistently monitor the effectiveness of the pain medication did not allow the resident to obtain his highest level of function by participating in therapy. Findings include: On 07/29/13 at approximately 12:40 p.m. Resident #122 was rubbing his right knee,	F 309	F309 It is the policy of the facility to ensure that each resident has a plan to consistently monitor the effectiveness of pain medications by assessing pre/post pain levels to attain the highest physical, mental, and psychosocial well being. Resident #122 has had a pain assessment completed to ensure effectiveness of current pain medication regime. The residents Medication Account Record (MAR) has been updated to include boxes for LN'S to document pre/post pain level assessments with each PRN pain medication administered. Residents receiving PRN pain medications have received updated MARS with boxes for LN'S to document pre/post pain level assessments to ensure residents pain and effectiveness of medication intervention is consistently monitored. LN'S educated on documentation requirements for pre/post pain medication administration. Orders for new pain medications will be reviewed by the RCM's ensuring that the appropriate pre/post pain level MARS are initiated. DNS/designee will review MARS to ensure that pre/post pain assessments are consistently completed with administration of analgesics. DNS/designee to ensure compliance.	9-2-13

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F 309	<p>Continued From page 15</p> <p>wincing and commenting he was in a lot of pain. He added he was in constant pain "it hurts around my knee all the time it is at a level 10, I guess it is to be expected with this knee surgery. I hurt so bad I cannot do my physical therapy." While interviewing the resident, Physical Therapy staff came in to take him to therapy. He told them he could not participate in therapy due to his pain.</p> <p>Record review of the July 2013 Medication Administration Record (MAR) revealed the resident received 4 doses of [REDACTED] and 7 doses of [REDACTED] between 07/26/13 and 07/30/13. There was no evidence staff consistently monitored the resident's level of pain before or after administering the medication.</p> <p>On 07/29/13 at approximately 1:00 p.m. Staff Member, O stated "staff was forgetting to document the resident's level of pain."</p> <p>On 07/30/13 at approximately 2:00 p.m. the Corporate Nurse stated facility policy was to document the residents' pain level before and after administering medication on an as needed basis.</p>	F 309	<p>F329</p> <p>It is the policy of the facility to ensure that residents who are on psychoactive medications are assessed and monitored for ASE's Q shift.</p> <p>Resident 97 and 70 received updated MARS that included a flow sheet for monitoring potential adverse side effects (ASE) related to psychotropic medication use. The flow sheets are to be completed every shift by LN staff to ensure that effectiveness of medication and specific ASE's are consistently monitored. Residents receiving psychotropic medications have had flow sheets initiated listing potential ASE's related to specific medications used. LN's to assess Q shift. Additionally RCM'S/Social Services to update care plans and determine that elements of psychotropic medication use are current, including behavioral interventions, diagnosis, justification for medication use and consents with evidence of risks and benefits are in place. RCM/Social Services will review orders for new psychotropic medications to ensure all elements of medication use are in place. LN staff educated on requirements for monitoring of ASE in association with psychotropic medication and use of flow sheets to be completed each shift. Psychotropic Drug Review Meetings will be held with Consulting Pharmacist and Interdisciplinary Team (IDT) on a monthly basis. Residents receiving psychotropic medications will have comprehensive reviews completed to ensure medications remain necessary to treat specific conditions. Dosage reductions, behavioral interventions, ASE's, diagnosis and care plans</p>	
F 329 SS=E	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any</p>	F 329		

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Continued From page 16
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:

Based on record review and interview the facility failed to ensure residents were free of unnecessary medications related to adequate monitoring for side effects in accordance to CFR 483.25 (I)(1)(ii)(iii)(2)(ii) for 2 of 5 residents (#97, 70) reviewed for unnecessary medication. These failures placed the residents at risk for medications in excessive and/or ineffective doses. Findings include:

Resident #97.

The resident had diagnoses that included [REDACTED] and [REDACTED]. Per record review, the resident received an [REDACTED] medication [REDACTED]; however, no monitoring was found for adverse side effects of [REDACTED] medications.

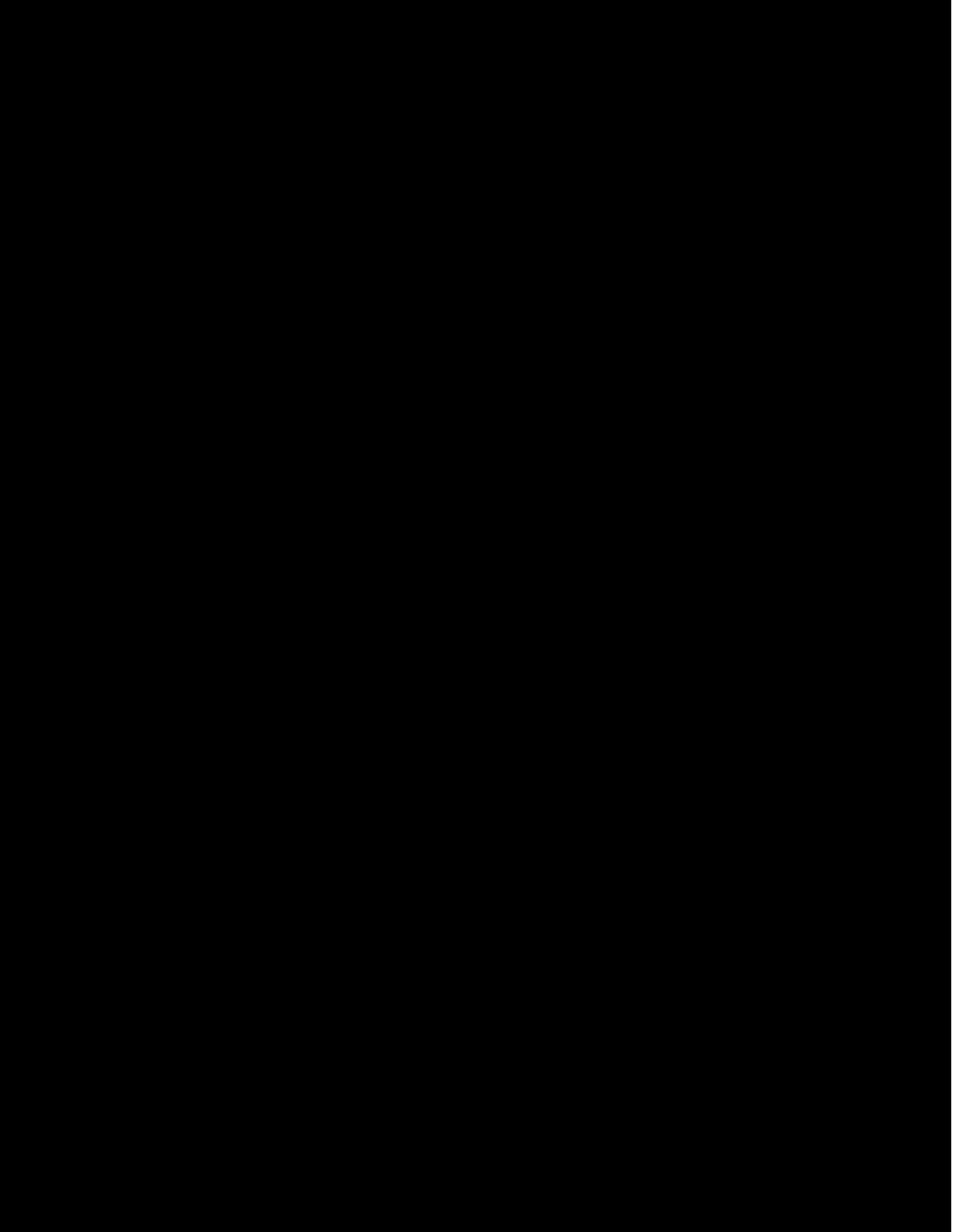
On 08/02/13 at 10:15 a.m. Staff Member O stated

F 329

F329 CONTINUED

will also be reviewed at this time. Social Services to present findings at quarterly QA meeting. DNS/Social Services are responsible to ensure compliance.

9-2-13



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F 431 Continued From page 18

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure that medications stored in the 200 hall medication room and the 300 hall medication cart were consistently locked when unattended by licensed nurses. Failure to consistently secure medications placed residents at risk of potential harm or exploitation. Findings include:

On 07/28/13 during initial facility tour at 4:20 p.m. the medication room door on the 200 hall opened when tested and was not locked. Staff Member

F 431 **F431**

It is the policy of the facility to store all drugs and biologicals in locked compartments, and permit only authorized personnel to have access to the keys.

On 08/02/13 the door lock on the 200/300 hall medication room was replaced. Only the licensed nurse has the key.

Nurse" V" is an agency nurse and no longer works at the facility.

8/22/13 Education provided to licensed nurses on the importance and legalities of proper storing of medications and the locking of medication carts when out of eye site.

The DNS/Designee will monitor for compliance weekly. The results will be presented to QAPI for review.
Date of compliance: 09/02/13

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V, Licensed Nurse (LN) was at her cart across the hall and stated "You can get in there? I tried my key a little while ago and could not get in." The LN then left the area down the 200 hallway.

From the doorway a plastic bag containing liquid haloperidol and a bottle of lorazepam tablets could be seen.

On 07/28/13 at 4:25 p.m. Staff Member W, LN, approached the med room door, checked it, opened it and then used his key to lock the door. He stated that when you use your key it unlocks and you have to relock it with your key after you shut the door.

Staff Member V stated that she tried to unlock the med room at approximately 3:55 p.m. "I turned the key over and over, but I could not open the door."

On 07/28/13 at 4:30 p.m. the 300 hall medication cart was sitting across from the nurse's station, no staff or residents were in sight. Staff Member X, LN came from a resident's room. She was informed the medication cart was not locked and she stated "I am supposed to lock my cart if I go away from it."

On 08/02/13 at 9:36 a.m. the 200 hall medication room door was unlocked and no Licensed Nurses were in the area. The room contained unsecured medications in the refrigerator, a large drawer of approximately 150 medication cards and two emergency kits.

On 08/02/13 at 9:46 a.m. Staff Member B, Director of Nursing Services (DNS) stated that only the medication nurses have keys to the med

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room and the door should be locked at all times.

F 463 SS=F 483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH

The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined that the facility failed to maintain an optimal resident call light system that led to call light delays in 3 of 3 wings of the facility (100, 200 and 300). This failure placed residents, staff and/or visitors at potential risk for not being able to summon staff for assistance if needed.
Findings include:

Resident room 114.
On 07/29/13 at approximately 10:38 a.m., the call light was activated by the resident, but no audible sound was heard. Approximately 2 minutes later the call light was turned on again and there was no audible sound. The Nursing Assistant Certified (NAC) caring for the resident stated the beeper she carried to alert her to call light requests did not display room number 114. She also checked the reader board that displayed room numbers that have call lights engaged. She stated it did not appear on the reader board. At approximately 10:42 a.m. the call light cord was

F 431 **F463 call lights**

Call lights throughout the building were pulled and tested to insure that the numbers appeared on the reader board and on the individual pagers.

F 463 The call lights responded appropriately. Each nurse aide was re-trained in the use of the pagers, given a copy of the instructions, and demonstrated they understood the use of the paging system. The Plant Operations Manager will calibrate the central system weekly. Executive Housekeeper will check call light signals to reader board and pagers and will report at QAPI meeting. Plant Operations Manager will supervise. 9-2-13

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 pushed more firmly into the call light receiver mounted on the wall in room 114. When the call light was tested again, an audible beep was heard and the NAC stated that room 114 was displayed on her beeper.

Resident room 116.
 On 07/29/13 at approximately 11:10 a.m. the call light for the resident in room 116 was activated. An audible sound was heard. Staff Member R, NAC stated her beeper didn't work even after the batteries were changed. She stated room 116 was not displayed on her beeper. Staff Member S, NAC stated room 116 was displayed on her beeper but the beeper did not vibrate to alert her to the new call light. She stated "the beepers are supposed to vibrate whenever there is a new call light request." Both Staff Members checked the reader board and stated room 116 was not on the reader board.

Resident room 310.
 On 07/29/13 at 11:10 a.m. the resident activated the call light. It did not sound or appear on the reader board located at the end of the hallway. Staff Member N, NAC stated that the room number did not show on the reader board or on the beeper. Staff Member Q, NAC confirmed the room number had not appeared on her beeper either.

On 07/29/13 the Administrator was made aware that the call light system was not consistently alerting the staff beepers to vibrate or displaying the resident's room number when the call light was activated. The Administrator stated the beepers are part of the call light signal system and the potential problem was that the batteries needed to be replaced.

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Resident room 111.
On 07/30/13 at approximately 10:50 a.m. the resident's call light in room 111 was activated. No audible sound was heard and the reader board did not display room number 111. Staff Member K, NAC stated room 111 was not displayed on her beeper.

On 08/01/13 at 1:07 p.m. Staff Member N stated when she works on the 200 hall the alert on the beeper does not always show the room number. "If I am in a room helping a resident then I do not know if there is a resident's call light I miss. I can't always look on the reader board."

On 08/01/13 at 1:30 p.m. Staff Member M stated that the "beepers do not always work for the call lights. We get to the residents as quickly as we can."

On 08/02/13 at approximately 11:00 a.m. Staff Member I, Plant Manager stated the call light system would alert him if a call light became unplugged from the wall, as apparently happened on 07/29/13 in room 114. He said that he would be alerted that something was wrong if the call light appeared to be activated for a long period of time. Staff Member I stated there was not a specific alert or warning that would cue the nursing staff to check the functioning of the call light.

Additionally, Staff Member I stated when the call light was activated a signal goes to the system and then to the staff beepers. The call light and the beepers require batteries. The call light batteries were to last 5 years but he had to change them more often. He was unaware of

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505226	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/02/2013
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NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - SUNNYSIDE	STREET ADDRESS, CITY, STATE, ZIP CODE 721 OTIS AVENUE SUNNYSIDE, WA 98944
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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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any scheduled maintenance on the beepers that were part of the call light system.

On 08/02/13 at approximately 12:30 p.m. the call light system shut down and the call lights were not being activated and the signal to the staff beepers had stopped. Staff Member B, Director of Nursing Services instructed staff to do room checks of resident rooms until the system was back-up at approximately 4:00 p.m.

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