

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 09/11/2014
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 Quality Indicator and Extended Survey conducted at Prestige Care and Rehabilitation - Sunnyside on 08/27/14, 08/28/14, 08/29/14, 09/02/14, 09/03/14, 09/04/14, 09/05/14, 09/08/14, 09/09/14 and 09/11/14. The survey included data collection on 09/04/14 from 7:10 p.m. to 9:10 p.m. A sample of 46 residents was selected from a census of 63. The sample included 37 current residents and the records of 9 former and/or discharged residents.</p> <p>The survey was conducted by: Lisa Herke, RD Lucy Fromherz, RN Pam Holt, RN Liisa Johnson, RN Brenda Webster, RN</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Long-Term Support Administration Residential Care Services, District 1, Unit C 3611 River Road, Suite 200 Yakima, WA 98902</p> <p>Telephone: (509) 225-2800 Fax: (509) 574-5597</p>	F 000	<p>F000 Initial Comments</p> <p>“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction Prestige Care Sunnyside 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 OCT 13 2014</p>	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cindy LeVelle</i> Residential Care Services		TITLE <i>Adm</i>		(X6) DATE 10-13-14

Cindy LeVelle Adm 9/30/14
Residential Care Services Date

Received
Yakima RCS
OCT 13 2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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=D 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

F225 (a)

Resident # 136 has discharged from facility. Incidents and accidents will be documented and investigated thoroughly and timely in accordance with state and federal regulations.

Staff and residents have been interviewed to ensure no other falls have occurred and no received appropriate interventions and investigations.

Licensed staff were re-educated by DNS on policies and procedures for accidents and incidents. This included timely notification of supervisor, completion of report to initiate investigation including collection of witness statements.

To ensure ongoing compliance RCM/designee will complete random interview of staff and residents weekly times 4 weeks to ensure all falls have been investigated.

10/31/14

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

PRINTED: 09/30/2014
FORM APPROVED
OMB NO. 0938-0391

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F 225	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to ensure it thoroughly investigated and documented findings of fall incidents according to CFR 483.13(c)(2)(3)(4) involving 1 of 3 sampled residents (#136) reviewed for incidents/accidents. The facility's failed practice put the resident at risk for additional falls and repeated injury. Findings include:</p> <p>Resident #136. Admitted to the facility on [REDACTED] 14 after a significant [REDACTED] operation. The comprehensive assessment dated 08/28/14 documented the resident was alert, oriented and able to make her needs known. The resident required the assistance of 1 person for transfers to and from the bed and chair. On 08/27/14 at approximately 11:00 a.m., the resident stated she had fallen the night before and her right shoulder was sore.</p> <p>According to a progress note of 08/27/14 at 6:17 a.m., the resident had fallen in her bathroom and "fell forward and hit right shoulder on shower chair, no bruising noted."</p> <p>On 09/02/14 at approximately 11:30 a.m., Staff Member B, the Director of Nursing (DNS), said she was unaware of the 8/27 fall until today (6 days later). She further indicated there were no witness statements from night shift staff, and no investigation of causal factors for the fall (or modifications to prevent other falls). When interviewed the same day at approximately 11:45 a.m., Staff Member H (a licensed nurse) indicated she was made aware of the fall on 08/27/14 at about 6:00 a.m., but she did not initiate an incident report (or any type of investigation).</p>	F 225	<p>F 225 (b)</p> <p>DNS/RCM (Resident Care Manager) to review all incidents to ensure timely follow up documentation and investigation is completed. Identified issues to be corrected and reviewed at monthly QAPI meeting. Administrator to ensure compliance with above remedies.</p>	10/31/14
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F 225	Continued From page 3 An incident report dated 08/28/14 was reviewed on 09/02/14. The incident report contained no statements from Resident #136, or any staff who were working during the time of the fall. In addition, there was mention of a shower chair that was involved in the fall, but no other information of how it may have contributed to the fall. The resident was "unaware where that came from." The lack of a thorough investigation, to determine possible causal factors for the resident's fall, placed the resident at risk for repeated falls and potential serious injury.	F 225	F 225 see previous page
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide care in a manner that promoted and enhanced resident dignity for 7 of 37 sampled in-house residents; (#'s 65, 76, 82, 32 and 136) for answering call lights timely when needing assistance, and (#'s 2 and 129) for not maintaining body privacy. This resulted in residents placed at risk for frustration and feelings of diminished self worth. Findings include: 1. Resident #76. Her latest comprehensive assessment on 08/24/14 revealed the resident	F 241	F 241 see following page

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F 241	Continued From page 4 was cognitively intact. On 09/04/14 at 3:00 p.m., the resident stated there were "very few staff" on evening shift, and there was a wait from 15 to 40 minutes after the call light was turned on. She indicated, because of the waiting, her right leg pain had increased when staff did not bring her pain medicine fast enough. She further noted one time she had to wait when she needed to be helped to the bathroom and "I had an accident; very unpleasant." She stated it also "makes me constipated waiting for the toilet." The resident said lately it was better than it had been, and attributed the change to having surveyors in the building. 2. Resident #82. The comprehensive assessment dated 08/11/14 revealed he was cognitively intact. On 09/04/14 at approximately 2:00 p.m., the resident stated he was supposed to call for help, but there were not enough nurse aides to help him fast enough when he put on his call light. He explained he had made complaints about it to the staff, but it continued to be a problem for him. He stated he did not always wait for help because he did not want to "wet myself" but often by the time he was taken to the bathroom, "I am wet." He was afraid of falling, and knew he was not supposed to transfer himself from his wheelchair, but did it anyway to try to avoid wetting himself. The resident expressed frustration, and stated "I give up." 3. Resident #32. On 09/04/14 at approximately 7:30 p.m. the resident stated call lights were not answered timely. "I have wetted my chair and bed when they take too long to help me." The resident stated that sometimes "I get up myself; I know I am not supposed to..." but it her made feel awkward to wait because of the potential of	F 241	F 241 (a) Resident # 75 and #136 no longer reside at facility. Residents # 65, 82, 2, and 32 were interviewed and assessed for any follow up with concerns related to call light assistance. Skin Checks were completed with no observed concerns. Resident #2 had a urinary collection bag placed in the privacy cover. Resident#129 had his brief and bare legs covered with appropriate clothing. Licensed Nurses re-educated on completion of care rounds Q shift. Any concerns with dignity or privacy will be immediately corrected to ensure residents dignity and privacy is maintained. Staff re-educated on dignity privacy and promoting care to maintain the resident environment in a dignified manner.	10/31/14
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F 241 Continued From page 5 wetting her clothing or furnishings.

4. Resident #65. Admitted to the facility on 07/29/14 after extensive heart surgery and a fractured ankle. The resident was alert and oriented and able to make her needs known. The resident required extensive assistance of 2 people for transfers.

On 09/04/14 at approximately 7:45 p.m., the resident said that staff had not been "very prompt at times answering the call light" especially when there are "2 people working" the floor. She said she "can't get out of bed to put weight on my legs" and required a bed pan. The resident stated she had to "wait anywhere from 40 minutes to about 1 hour and a half" for someone to help. The resident's family member confirmed the long wait times, and stated he had looked for staff to help after the call light was on for 1 hour and a half. The resident said it made her "feel helpless and worried about who was out there working."

5. Resident #136. Admitted to the facility on [REDACTED] 14 following back surgery, the resident was cognitively intact and required the assistance of one person to transfer.

On 08/27/14 at approximately 11:00 a.m., the resident said she woke up with muscle spasms around 3:00 a.m. (the early morning of 08/27/14). She stated she pushed the call light for assistance, but after 30 minutes there was no response. After another 30 minutes she stated she really needed to use the bathroom. She said she pushed the call light again, because she thought maybe it didn't work the first time. She indicated there was no response, so she transferred herself out of bed and to the

F 241 241 (b)
Licensed nurses re-educated on completion of care rounds. Rounds will be completed by nurses q shift and nurses will correct any issues immediately and audit information will be turned into DNS for any trending and tracking.

Staff re-educated on Ariel call light system and LN-RCM/DNS now carrying pagers to monitor timeliness of call light responses to address resident needs.

DNS/RCM to conduct weekly floor rounds and audits. Findings to be reported and reviewed at monthly QAPI meeting. Administrator to ensure compliance.

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F 241	<p>Continued From page 6</p> <p>bathroom. She stated she wet her pants, but made it to the toilet, and pulled the call light cord. The call light was not responded to. The resident further stated that after sitting on the toilet for a while, she was in pain and her legs were numb. She attempted to transfer back to her feet to return to bed, but lost her footing and fell, causing pain to her right shoulder. She said she had to crawl back to her bed.</p> <p>Staff Member EE, who chose to remain anonymous, stated staff had not been able to consistently answer lights, or care for residents promptly, and residents were "wetting themselves because we can't get to them." Staff Member EE identified residents in rooms 305, 306, 309, 315, 316, 317 and 318 who had experienced incontinence due to the inability "for us to get to their call light timely." The staff member stated that "It makes me cry and the administration won't listen."</p> <p>6. Resident #129. Admitted on [REDACTED] 14 with non-Alzheimer's dementia. Per the comprehensive assessment dated 07/30/14, he had highly impaired hearing, was severely cognitively impaired, and required assistance from staff with transferring.</p> <p>On 09/09/14 at 9:50 a.m., Resident #129 was observed in his room asleep on his bed -his feet were closer to the door than his head. His bed was positioned closest to the door. The privacy curtain was pulled back and the room door was open. The resident was dressed in a shirt and an incontinent brief. His brief and bare legs/feet were visible from the hallway. He remained in that position until 10:05 a.m., when a staff person covered the lower part of his body with a bed</p>	F 241	F 241 see previous page	

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F 241	<p>Continued From page 7</p> <p>sheet. The curtain and room door remained open. Eleven staff passed by his room while he was uncovered, as well as one visitor to the facility.</p> <p>The facility failed to ensure the resident maintained his dignity by being covered when he was not fully clothed.</p> <p>7. Resident #2. Admitted to the facility on [REDACTED] 13 with diagnoses including [REDACTED] and a history of a urinary disorder, which resulted in placement of an indwelling urinary catheter (a small rubber tube used to drain urine from the bladder).</p> <p>Per the admission assessment dated 11/01/13, the resident required extensive assistance of one caregiver for all personal hygiene tasks.</p> <p>Review of the resident's current care plan for the urinary catheter revealed staff were to cover the drainage bag to preserve the resident's dignity.</p> <p>On 09/04/14 at 1:25 p.m. Resident #2's catheter drainage bag was observed, from the hallway, uncovered and laying on floor. Staff Member RR, a licensed nurse, was observed at the resident's bedside talking to the resident. At 1:33 p.m., Staff Member RR left the room, and the catheter bag (that contained urine) was lying on the floor. At 1:43 p.m. the catheter bag was observed on the side rail of the bed, and was still uncovered. At 3:00 p.m., the catheter bag remained uncovered, and was on the foot of the bed just beyond the resident's feet. Urine was visible in the bag.</p> <p>Per interview with Staff Member B, the Director of</p>	F 241	F 241 see previous page	

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F 241	Continued From page 8 Nursing Services, on 09/05/14 at approximately 10:00 a.m., it was verified that correct care of urinary catheter bags was to keep them covered. Leaving the uncovered urinary catheter bag visible placed Resident #2 at risk for loss of dignity.	F 241	F 241 see previous page	
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide medically related social services for 3 of 5 (#136, 129, 22) residents reviewed for social services, in a sample of 46. The facility failed to monitor for depression, provide adequate discharge planning, and assess mental capacity to consent for denture repair. Findings include: 1. Resident #136 was admitted to the facility on [REDACTED] 14 after a [REDACTED]. Other diagnoses included chronic pain and numbness in the lower legs. She was alert and oriented, and needed some assistance with transfers. The social service care plan of [REDACTED] 14 identified the resident at risk for depression, because of chronic pain, and the inability to be as independent as she once was. Additionally, the	F 250	F 250 see following page	

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F 250	<p>Continued From page 9</p> <p>care plan directed staff to observe for "signs and symptoms of depression: tearfulness, withdrawal, loss of appetite" Additional records were reviewed - there was no documented evidence that these indicators of depression were being monitored.</p> <p>When interviewed on 8/27/14, the resident was crying, and said she was afraid that with her condition and pain she would not be able to go home as previously planned. She also stated that she never had panic attacks until she came to the facility, and had made several requests for anti-anxiety medication to help her deal with the problem. No medication to treat anxiety had been ordered.</p> <p>09/03/14 at approximately 1:00 p.m., the Social Services Director indicated that in the past couple of days, the resident had become more assertive, demanding, and emotional "out of the blue." She verified the resident was not being monitored for, or treated with, any medication for anxiety.</p> <p>In addition, a social services note and care plan dated [REDACTED] 14 documented Resident #136 was to be at the facility short-term (approximately 2 weeks) and then was to be discharged home.</p> <p>On 09/08/14 at approximately 3:00 p.m., the resident said she felt it would not be good to go home without being able to bend, or not be able to take care of her 4 children. The resident was very tearful at not being able to go home with her husband and children due to the "lack of her ability to have a safe transfer home." She said that her home was not set-up to allow her to successfully recover there, and that she would</p>	F 250	<p>F.250 (a)</p> <p>Resident #126 no longer resides at facility. Residents who are at risk for anxiety/depression have had assessments completed. The physician has been notified of pertinent findings for follow up as indicated.</p> <p>Social Services/RCM and licensed staff re- educated on policies and procedures for assessing and monitoring residents with potential for anxiety and depression.</p> <p>Care plans to also address potential for emergence of anxiety, depression, symptoms as applicable.</p> <p>Residents assessed as having signs and symptoms anxiety or depression will be reviewed in MACC by SSD/DNS/RCM to ensure appropriate follow up as indicated.</p>	

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F 250	<p>Continued From page 10 have to stay with another relative.</p> <p>According to the Social Services Director (SSD), progress note for discharge, a late entry dated 09/09/14, revealed the SSD spoke to the Resident on 09/08/14 about the resident's discharge. There was no discharge planning initiated until 09/08/14.</p> <p>09/09/14 at approximately 10:00 a.m., Staff Member W, the Occupational Therapist (OT) stated that the resident required a hospital bed and a wheel chair. She added that the resident was unsafe to go home without having this equipment, and that they could provide a home assessment if they had time.</p> <p>On 09/10/14 at approximately 12:30 p.m., SSD spoke to the resident about whether or not the resident's insurance covered a wheelchair for use at home. After discussion, the SSD, "encouraged the resident to contact her insurance/medical supplier in order to determine coverage of equipment."</p> <p>Even though SSD was aware of the resident's short-term status at the facility, she did not arrange and/or pursue in a timely manner the needed provisions (i.e., a hospital bed, wheelchair and/or home evaluation) for discharge. This failed practice caused the resident to experience emotional distress.</p> <p>2. Resident #129. Admitted on [REDACTED] 14 with diagnoses including pneumonia and non-Alzheimer's dementia. Per the comprehensive assessment dated 07/30/14, Resident #129 had highly impaired hearing, and was severely cognitively impaired. The</p>	F 250	<p>F 250 (b) Resident # 136 no longer resides at facility.</p> <p>Residents with pending discharges have been assessed to ensure safe and appropriate discharge plan is in place with provision as indicated.</p> <p>Social Services/RCM re-educated on discharge planning requirements.</p> <p>Comprehensive discharge planning to be started at admit. Discharge planning to address discharge location, equipment needs, assistance needs, home health needs and any financial concerns.</p> <p>Social Services will review care plans with initial care conference and quarterly for appropriateness.</p> <p>Weekly meetings with interdisciplinary team and therapy to address discharge status and equipment needs. Also to address need for outpatient home therapy needs.</p>	10-31-14
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F 250	<p>Continued From page 11</p> <p>assessment also identified that inattention and disorganized thinking was present at times. The assessment also noted he had no family or legal representative. Subsequent assessments on 8/4 and 8/9/14 indicated there was no change in his cognition.</p> <p>Review of the Medication Administration Record for ██████ 2014 revealed the resident was prescribed Seroquel, an anti-psychotic medication, upon admission to the facility. He was also prescribed Ativan, a psychoactive anti-anxiety medication, beginning on ██████ 14.</p> <p>Review of the resident's care plan dated 07/23/14 revealed the resident was planned to have a tab alarm for his bed and chair (a tab alarm is a system with a line attached magnetically to the alarm and with a garment clasp to the resident's clothing. If the resident moves away from the bed/chair and breaks the connection, the alarm sounds).</p> <p>Review of the 07/23/14 nursing progress note revealed the resident was alert to person only. The facility was aware that the resident had no family and was unable to sign documents.</p> <p>Review of the resident's record revealed three written consents in the record:</p> <p>Consent for ██████ was obtained on ██████ 14 with Resident #129's signature. It contained potential benefits and adverse reactions to the Seroquel and the statement "The information above regarding the risks and benefits of psychotherapeutic medication have been verbally explained to me and/or provided in writing. I understand I have the right to refuse the</p>	F 250	<p>F 250 ©</p> <p>Discharges to be reviewed in MACC to ensure provisions are obtained and provided as indicated.</p> <p>Resident #129 guardianship agency identified and petition completed on 10/7/2014. Guardian ad litem appointment pending court approval.</p> <p>If BIMS assessment reveals cognitive impairment then decision-making will default to legal representative or surrogate family members. If none is available, a guardianship petition will be considered and/ or pursued. Interdisciplinary team to determine guardianship petition.</p>

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F 250	<p>Continued From page 12</p> <p>administration of these medications and the right to withdraw consent of medication administration at any time by informing center staff."</p> <p>Consent for the tab alarm was obtained on 07/25/14 with the resident's signature.</p> <p>On 07/29/14, a Social Services progress note documented that during the cognitive assessment, the resident exhibited disorganized speech patterns and "losing train of thought."</p> <p>Consent for the [REDACTED] use was dated 07/29/14. The consent contained a line with two check boxes, one that stated "I accept the medication" and one that stated "I decline the medication(s)." Neither box was checked. Directly below that line, in the signature line, "resident is unable to sign/no DPOA (durable power of attorney) or family" was typed. To the right of that statement was a large "X" and to the right of that was the resident's signature.</p> <p>On 09/03/14 at approximately 10:10 a.m., Staff Member F, the Social Services Director (SSD), stated she uses a Brief Interview for Mental Status Screen (BIMS) and general "chatting" with the resident to tell if they are able to consent to health treatments. She indicated that they try to find family who is able to be POA (Power of Attorney) or get a guardian. She was not aware of a process on how to evaluate a resident for the ability to consent. It is just something we have always done. Resident #129 does not like to do the BIMS, and he is hard of hearing. Sometimes he does okay (understands) if we use an amplifier. She stated Staff Member II, a charge nurse, got the consents for treatment from Resident #129.</p>	F 250	<p>F 250 (d)</p> <p>Resident # 22</p> <p>No longer resides at facility.</p> <p>On 9/2/2014 The Social Services Director was notified by RCM and family members that dentures were broken. A call was placed to Columbia Denture Care and an appointment made to evaluate and Repair. Repaired dentures were returned to patient. Her normal diet was resumed. Residents with similar circumstances will have timely referrals made.</p> <p>Social Services/licensed nurses re-educated on timely follow up and notification for residents who have broken dentures that require repair or other oral concerns. Additionally licensed staff re-educated on assessing and intervening with dietary changes as indicated in the event that a resident's oral status changes.</p> <p>Resident Concerns to be reviewed with RCM/DNS in MACC meeting to ensure follow up. RCM/DNS to audit system.</p>	
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F 250	<p>Continued From page 13</p> <p>On 09/03/14 at 10:20 a.m., Staff Member II stated Resident #129 had no family. If they don't have family, she stated they tried to get the social worker involved. "We try to get some sort of signature from somebody."</p> <p>On 09/03/14 at 12:00 p.m., Staff Member B, the Director of Nursing (DNS), stated the facility did not have a process in place to evaluate for ability to consent.</p> <p>On 09/09/14 at 2:20 p.m., Resident #129 was observed in bed with his eyes closed. He had an amplifier headphone on his head, but the ear pieces were not positioned over his ears. He opened his eyes and was assisted to position the amplifier over his ears. Even with the amplifier, conversation was difficult. A loud tone of voice and directly facing the resident was required for him to hear the conversation. He stated he signed papers "almost every day." He stated he did not have anyone to take care of his affairs. He said he took a bunch of pills but didn't know what they were for.</p> <p>Even though the facility was aware of the resident's severe cognitive impairment they did not afford the resident the opportunity to involve anyone else in decisions about his healthcare.</p> <p>3. Resident #22. Admitted to the facility on [REDACTED] 14 for therapy services. The resident's comprehensive assessment dated 08/05/14 documented the resident required extensive assistance with denture care.</p> <p>On 08/28/14 at 11:15 a.m., the resident stated she had accidentally knocked her denture off the</p>	F 250	F 250 see previous page	

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F 250	<p>Continued From page 14</p> <p>bedside table two or three days ago, and they had broken in half. The broken denture was observed in a napkin on the bedside table. The resident stated she was "hungry." She said she had mashed potatoes for dinner, some cottage cheese for lunch, and cream of wheat this morning. "Not finding a lot to eat" because she was still receiving her general texture diet, and could not chew the meat. She repeated several times that she was hungry, but had to have someone fix the dentures before she could eat her regular diet. She stated she had told a nurse and was later told by "someone" that they would take her denture to get fixed, yet the broken denture was still in her room.</p> <p>During the interview, at 11:21 a.m., the DNS entered and asked the resident if she had her denture that needed fixed by a dentist. The resident told her she had not used them for two days and she was hungry. The DNS asked the resident about changing her regular diet to a mechanical soft diet with ground meats. The DNS offered no other assistance related to the repair of the resident's dentures.</p> <p>On 09/02/14 at 10:30 a.m., Staff Member E, a Resident Care Manager (RCM), stated the resident had broken her lower denture when they fell off of the bedside table. She added Staff Member F, the Social Service Director, had been told of the broken denture by multiple people, including the resident's family, RCM, and the "floor nurse." The RCM concluded the facility's process is to notify Social Service staff so they can coordinate medically related services such as repair of broken dentures.</p> <p>Record review revealed no documentation</p>	F 250	F 250 see previous page	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 250	Continued From page 15 regarding the resident's broken denture by the licensed nurses or the Social Service Director. Further, the resident's diet was not evaluated and changed to mechanical soft until 08/28/14 (3 days after the dentures broke).	F 250	F 250 see previous page	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential;	F 272	F 272 see following page	

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F 272	<p>Continued From page 16</p> <p>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and</p> <p>Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to complete a thorough assessment for 1 of 3 residents (#22) reviewed for catheter use, and 1 of 3 residents (#6) reviewed for dental services, in a sample of 46. Failure to complete the assessments placed the residents at risk for unmet needs related to a lack of the development of care interventions. Findings include:</p> <p>1. Resident #22. The resident was admitted to the facility on [REDACTED] 14 for rehabilitation to regain strength after being hospitalized with [REDACTED]</p> <p>A physician order on the day of admission indicated a urinary catheter was to remain in place until her urologist's (a doctor specializing in disorders of the urinary tract) appointment. A urinary catheter is a small rubber tube which is inserted to remove urine from the bladder.</p> <p>The admission comprehensive assessment completed on [REDACTED] 14 documented the resident had no urinary catheter, either indwelling or</p>	F 272	<p>F272</p> <p>Resident # 22. No longer resides at the facility. Resident #6 had a comprehensive assessment completed of her dental status and coding inaccuracies corrected.</p> <p>RCM staff re-educated on comprehensive assessments and MDS accuracy. Residents in similar situations have had their comprehensive assessments reviewed to ensure accuracy and correct identification of potential concerns.</p> <p>Comprehensive assessments to be reviewed in MACC meeting per IDT to ensure accuracy is maintained.</p> <p>Residents who have retention catheters will be reviewed in MACC meeting by DNS/RCM to ensure use is indentified and assessed for appropriateness.</p> <p>Inaccuracy will be corrected. DNS/designee to ensure compliance.</p>	10/8/14	

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F 272	<p>Continued From page 17 external. This was not accurate.</p> <p>The resident was observed on 8/28/14 at 11:00 a.m. - she had a urinary catheter with a drainage collection bag clearly visible as she was sitting in her recliner.</p> <p>The nursing progress notes documented multiple times after her admission that the retention catheter was draining clear yellow urine. The facility failed to identify and/or assess that the resident had a urinary catheter, placing her at risk for unmet needs related to it's use.</p> <p>2. Resident #6. On 09/04/14 at 3:45 p.m., while being interviewed, the resident showed her teeth - there were two broken teeth on her upper jaw. She stated she had fallen prior to admission to the facility in [REDACTED] 13, and her teeth were broken at that time. She stated they did not hurt, and did not prevent her from eating meals at the present time.</p> <p>Per review of a comprehensive admission assessment dated [REDACTED] 13, and the most recent quarterly assessment, completed on 08/10/14, there was no identification of broken natural teeth.</p> <p>The facility failed to identify broken teeth, which had been present since admission to the facility in [REDACTED] 13. They did not assess how they could impact her ability to eat, or other possible complications, and did not develop a plan of care related to the dental problem.</p>	F 272	F 272 see previous page	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		

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F 279	<p>Continued From page 18</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for 1 of 3 residents (#24) reviewed for urinary catheter care, and 1 of 3 residents (#63) reviewed for dental services. Failure to plan care for a catheter placed Resident #24 at risk for unmanaged pain and urinary tract infections. Failure to plan care for Resident #63 placed the resident at risk for inadequate oral care. Findings include:</p> <p>1. Resident #24. Admitted on [REDACTED] 13 with diagnoses to include urinary tract infection and a history of [REDACTED] surgery. His latest comprehensive assessment dated 07/13/14</p>	F 279	<p>F. 279</p> <p>Resident #24 has had care plan updates to include interventions and directions for catheter care.</p> <p>Resident #63 has had care plan updates in relation to oral care to identify and include directions on how to complete care.</p> <p>RCM staff educated on accurate and comprehensive care plan requirements for measurable objectives and interventions to meet the residents needs.</p> <p>Care plans for residents in similar situations have been reviewed and corrected as indicated.</p> <p>Monthly audits will be completed by DNS/RCM on resident care plans. Findings will be reviewed in monthly QAPI meeting.</p> <p>DNS to ensure compliance.</p>	10/31/14
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F 279	<p>Continued From page 19</p> <p>revealed he had moderately impaired decision making skills and required extensive assistance with toileting and personal hygiene.</p> <p>Review of the resident's care plan had no documentation regarding catheter care. The In Room Care Plan (the daily care guide used by direct care staff) reviewed on 08/29/14, indicated he was incontinent of bladder, and required two people to assist him to the toilet. It did not contain any reference to, or directions for, caring for a catheter.</p> <p>On 08/29/14 at 1:50 p.m., Staff Member P, a Nursing Aide (NA) stated Resident #24 had a urinary catheter. She stated she did not know of any specific instructions regarding how to care for the resident's catheter, but was relying on what her teacher taught her when she took nurse aide training classes.</p> <p>On 09/02/14 at 10:15 a.m., Staff Member C, a Resident Care Manager (RCM) stated the resident had a catheter placed after a [REDACTED] surgery sometime in [REDACTED] 14. She verified there was no care plan for the urinary catheter. She stated the nurses "have knowledge of catheter care" but acknowledged "that does not replace a written plan of care."</p> <p>2. Resident #63. On 08/27/2014 at 3:30 p.m. the resident was observed to have a broken tooth when asked to smile.</p> <p>Per an 08/10/14 comprehensive assessment, the resident had a diagnosis of dementia, with impaired memory and impaired daily decision-making capabilities. The assessment</p>	F 279	F 279 see previous page	

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F 279	<p>Continued From page 20</p> <p>indicated the resident had "broken or loosely fitting full or partial dentures", and required extensive assistance from staff for personal hygiene that included oral care.</p> <p>The resident's current comprehensive care plan did not include the problem related to the resident's teeth, or give directions on how to care for the resident's teeth and/or partial/dentures. Additional record review indicated on the resident's annual comprehensive assessment (dated 05/11/14) that the problem with the resident's teeth had been identified at that time, and indicated a care plan would be required. Staff Member E, a Resident Care Manager, documented on the 05/11/14 assessment that the "res(ident) has partials, one of which has a missing tooth, but does not inhibit his ability to safely eat. They appear to fit well, he does need assist(ance) when putting in and taking out his partials."</p> <p>Review of the In Room Care Plan dated 07/29/14 indicated the resident had his "own teeth," with no mention of a partial denture or care directives.</p> <p>On 09/03/14 at 9:10 a.m. Staff Member II, Day Charge Nurse, stated she was not aware of any problems with the resident's teeth.</p> <p>On 09/03/14 at 9:15 a.m. Staff Member KK, a bath aide, stated she sometimes provided oral care to Resident #63 during his shower. He could brush his own teeth with very little assistance. She noted he had some missing teeth but was not aware of him having a partial denture.</p> <p>On 09/03/14 at 10:30 a.m. Staff Member PP, a</p>	F 279	F 279 see previous page	
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F 279	Continued From page 21 Nursing Assistant (NA), stated she was assigned to Resident #63 that morning; however, she had not done his oral care yet. She stated when she had done it in the past, she would use some "green swabs" to do his oral care. At 11:10 a.m. the same day, "green toothettes" were noted in the top of the resident's dresser drawer. On 09/04/14 at 3:14 p.m. Staff Member E stated she had seen the resident's partial during her assessment and it should have been on the care plan. Lack of an accurate care plan resulted in inconsistent oral care for Resident #63, and placed him at risk for additional dental problems.	F 279	F 279 see previous page		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F 280 see following page		

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F 280	<p>Continued From page 22</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to update the care plan as conditions changed for 1 of 1 resident (#22) with broken dentures and need of a diet texture change; 1 of 3 residents (#133) reviewed for positioning; and 1 of 2 residents (#30) leaving the facility with medications. This placed the residents at risk of unmet needs. Findings include:</p> <p>1. Resident #22. On 08/28/2014 at approximately 11:15 a.m., the resident stated her lower dentures had fallen off of the overbed table and broke a couple days ago. When asked about chewing or eating, the resident said she had been eating what she could off of her plate at meals (a general texture diet) such as mashed potatoes and cottage cheese. She stated several times during the interview she was hungry.</p> <p>Review of the resident's record for 08/25/14 through 08/27/14 did not contain an assessment evaluating the issue of impaired chewing, with the need to adjust the resident's diet to ensure proper nutrition. The care plan was not reassessed and updated related to the resident's inability to chew regular textures.</p> <p>2. Resident #133. Admitted on [REDACTED] 14 following a surgery for a right hip joint replacement requiring rehabilitation before she returned home.</p> <p>On 08/28/2014 at 09:30 a.m., the resident was</p>	F 280	<p>F 280</p> <p>Resident #22 is no longer residing in the facility. Resident # 138 has had her care plan updated to include using foot rests to support her feet. Resident #30 has had a self- medication assessment completed, a physician's order has been obtained and care plan updates completed.</p> <p>RCM staff educated on requirements for assessments and updates to residents care plans when a resident condition changes.</p> <p>Residents in similar situations have had their care plans reviewed and updated as indicated.</p> <p>Residents condition changes will be reviewed in MACC (Managing Acute Condition Change) meeting by DNS/RCM.</p> <p>Care plan revision will be completed with any resident status change. DNS/designee to ensure compliance.</p>	10/31/14
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F 280	<p>Continued From page 23</p> <p>seated in a wheelchair with her feet dangling and unable to reach the floor. She stated her right hip "hurts a lot." She stated her wheel chair was too high, and it helped to have a footrest in place for her right leg to prevent the dangling and pressure that resulted in pain. She pointed at the foot rests lying against the wall. The resident's family member stated the resident's foot rests were not put on routinely by staff.</p> <p>The admission Care Plan identified the resident had acute pain related to right hip replacement; however, it did not identify the need for the foot rest on the wheelchair for support and to prevent her feet from dangling.</p> <p>Further, the "In Room Care Plan" directing the nurse aides with resident care needs did not identify and/or direct the needed foot rest placement by staff.</p> <p>3. Resident #30. Admitted on [REDACTED] 13 for rehabilitation with diagnosis including a [REDACTED]. The comprehensive assessment dated 06/15/14 revealed the resident had no cognitive impairment.</p> <p>On 09/04/14 at 8:35 a.m. during medication administration, Staff Member RR, a Licensed Nurse (LN), prepared and gave the resident his morning medications. The resident then stated he would be out of the facility through lunch and asked to take his noon medication with him. The LN then gave the resident his [REDACTED] medication [REDACTED] in a small envelope and instructed the resident to take the medication between 12 noon and 1:00 p.m.</p> <p>Review of the resident's current care plan did not</p>	F 280	F 280 see previous page	

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F 280	Continued From page 24 include a plan to self-medicate or take medication with him on outings. On 09/04/14 at 11:15 a.m. Staff Member D, a Resident Care Manager (RCM), stated "sometimes residents take their medications with them if they are going to be out of the facility for the day. We have little envelopes and the LN writes the med, dose, administration instructions, and gives it to a family member or the resident if he/she is cognitively intact. I cannot find a policy regarding this practice; however, there should be a TO (telephone order) that the resident can do that or have it care planned." Review of the current physician orders revealed an order dated 12/13/13 for [REDACTED] to be given four times a day; however, no order for self medication. Review of the resident's medication administration records revealed the following: June 4, 2014, "pt (patient) leaving facility, sent 12:00 pm [REDACTED] with pt (patient)"; and on 09/04/14 at 8:30 a.m. "sent [REDACTED] 100mg with pt (patient) 1200 dose."	F 280	F 280 see previous page	
F 309 SS=H	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,	F 309	F 309 see following page	

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F 309 Continued From page 25
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 have systems in place to address the management of pain experienced by 3 of 6 residents (#'s 24, 133 and 136) related to physical impairments, as a result of surgeries; ineffectual equipment; and/or behavioral contributors. The facility also failed to ensure systems were in place to assist 1 of 1 resident (#9) needing timely medical intervention and 1 of 1 resident (#129) requiring monitoring related to use of blood thinning blood pressure medications. The lack of effective systems in these areas resulted in harm to resident #'s 9, 24, 133 and 129 by unnecessary suffering, and/or delayed progress in healing. Findings include:

1. Resident #24. Admitted on [redacted] 13 with diagnoses to include urinary tract infection and a history of [redacted] surgery. His latest comprehensive assessment dated 07/13/14 revealed he had long and short term memory problems and had moderately impaired decision making skills. He required extensive assistance with toileting and personal hygiene.

On 09/02/14 at approximately 10:15 a.m., Staff Member C, a Licensed Nurse (LN) and Resident Care Manager (RCM) stated Resident #24 had [redacted] surgery to remove tumors and make repairs from a previous surgery. A urinary catheter was placed after the procedure. She

F 309 **F 309 (a)**
Resident #24 had a comprehensive pain assessment completed. Physician was notified and routine pain analgesics were initiated. The resident's care plan updated.

Residents who are identified as having pain or a potential for pain will have a comprehensive pain assessment completed with physician notification as indicated.

A pain plan of care will be initiated for both pharmacological and non-pharmacological interventions.

Licensed staff educated on comprehensive pain assessment and management protocols. NA staff re-educated on reporting to LN residents who are exhibiting signs and symptoms of pain.

DND/RCM to review residents who have actual/potential pain issues in MACC meeting to ensure residents pain is assessed with follow up as indicated.

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F 309	<p>Continued From page 26</p> <p>stated she was not certain about the exact date of the catheter placement, but noted a nursing assessment done on 07/17/14 documented the presence of a catheter.</p> <p>On 09/04/14 at approximately 9:30 a.m., Staff Member P, a Nurse Aide (NA) worked with Resident #24 to provide cleaning around his catheter. Staff Member P stated she had been with the facility for about one month and the resident had the catheter since she started. As she assisted the resident to gently turn onto his right side, he moaned. The NA stated he always moaned when she moved him because he had an open area on his buttocks that hurt and because he "hurt inside." She stated at first she thought she was hurting him, but was told by other staff it was not her handling technique, but because he was very tender "inside" in his lower abdominal area. She then moved the catheter tubing to clean around the insertion site of the catheter. He moaned again when the catheter tubing was moved. She re-positioned him gently once again to complete the cleaning and care. As she re-positioned him, he cried out, then made a fist with his hand and struck the bed mattress several times rapidly as he continued to cry out. At the conclusion of the care, the resident's face and body posture visibly relaxed.</p> <p>On 09/04/14 at approximately 10:30 a.m., Staff Member RR, a LN, stated the resident did not verbally report pain to her when he was not moving, but she observed he had pain with any movement. She stated the resident was incontinent of bowel, so he had to be moved often when cleaning him. She said they did not medicate him for pain prior to moving him.</p>	F 309	<p>F309 (b)</p> <p>Resident #9 POLST form was reviewed and updated. Care Conference held with resident's son to review POLST requirements.</p> <p>LN staff re-educated on resident POLST form as a choice for physician directed emergent and life sustaining care. LN staff educated that family members do not override the resident's choice for emergent or life sustaining care.</p> <p>DNS/RCM to monitor and review that POLST directives are followed in the event of a resident condition change with each occurrence.</p> <p>DNS responsible to ensure compliance.</p>	10/31/14
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F 309	<p>Continued From page 27</p> <p>Review of the August and September 2014 Treatment Administration Record (TAR) revealed the resident received other treatments which also required moving him. The licensed nurses applied a barrier cream to the resident's buttocks every shift to protect the skin, and applied two additional topical treatments to the resident's groin area twice a day. The open sore on the resident's buttocks was also cleansed and dressed every other day.</p> <p>Review of the medication administration record (MAR) for August 2014 revealed the resident had no scheduled pain medications, but was prescribed Acetaminophen (Tylenol), 650 milligrams (mg) to be given on an as needed basis, up to every 4 hours. For the month of August, the resident received one dose of Tylenol on 08/21/14 for a complaint of pain to his buttocks.</p> <p>Review of the MAR on 09/04/14 for September 2014 revealed the resident's pain medication was unchanged from the August 2014 orders. The resident received one dose of Tylenol on 09/04/14 for a complaint of pain to his buttocks.</p> <p>On 09/04/14 at 10:35 a.m., Staff Member C stated she completed the pain assessment dated 07/17/14, and it was the latest pain assessment done for Resident #24. She explained it was compiled through review of the resident's medical record and talking with staff who worked with the resident. The assessment documented no verbal reports of pain and no nonverbal indicators of pain. She stated staff had not told her about Resident #24's pain during care. She stated they should try "to make sure the resident has something on board." (meaning pain medication</p>	F 309	<p>F309 ©</p> <p>Resident #129 in no longer on Coumadin therapy.</p> <p>RCM/LN staff re-educated on assessment and monitoring of potential adverse side effects related to anticoagulant use. Additionally RCM/LN staff re-educated on physician notification of abnormal labs.</p> <p>Residents receiving anticoagulant therapy have had record reviews completed to ensure care plans include monitoring of potential adverse side effects are identified.</p> <p>Residents receiving anticoagulant therapy will have PT/INR's drawn per physician's order. Lab results will be forwarded to the physician for follow up as indicated.</p>	
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F 309	<p>Continued From page 28 should be given).</p> <p>Over the approximately 6 week period since the bladder surgery and placement of the urinary catheter, the facility nursing staff knew about Resident #24's pain, but failed to act to mitigate or minimize the pain. They failed to assess what conditions caused him pain and why he was still significantly painful six weeks after surgery. This caused unneeded pain and suffering for the resident.</p> <p>2. Resident #9. Admitted with dementia, high blood pressure and history of small strokes.</p> <p>The quarterly 07/29/14 comprehensive assessment determined the resident had impaired short and long term memory and required extensive assistance by one person for transfers and toileting.</p> <p>The current care plan contained an update on 12/14/13 identifying the resident was at risk for falls; she did not remember to ask for help when needing to transfer.</p> <p>The official form directing physicians for 'life-sustaining treatment' (POLST) revealed the resident did not want cardiopulmonary resuscitation (CPR) attempted, but she did want interventions that included medical treatment, intravenous fluids, and cardiac monitoring as indicated. (The resident was not receiving comfort measures only or hospice care.) The form was signed by the legal surrogate/representative on 09/13/13. However, hand written on the side of the form was a note to call family prior to any transport.</p>	F 309	<p>F 309 (d) Residents receiving anticoagulants that are exhibiting potential adverse signs and symptoms of therapy will have timely physician notification.</p> <p>RCM/DNS to review PT/INR results in MACC meeting to F ensure physician notification of labs. RCM/DNS to review in MACC that residents receiving anticoagulant therapy are being Assessed for potential ASE with physician notification as indicated.</p> <p>DNS/designee to ensure compliance.</p> <p>Resident #133 had her wheelchair seat lowered and cushion replaced. Wheelchair foot pedals obtained and staff in-serviced on use.</p> <p>Residents pain was assessed with follow up by LN staff as indicated.</p>	
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F 309	<p>Continued From page 29</p> <p>An incident investigation form revealed the resident had a fall on 08/27/14 at 3:40 a.m. She was located on the floor partially under the walker and bleeding from the right side of her head. Three lacerations were noted by the licensed nurse and the physician was notified. He requested family to make the decision to have an emergency room assessment; the resident's representative declined medical treatment. A thorough assessment of the head wound was not documented.</p> <p>On 08/27/14 at approximately 11:30 a.m., Staff Member QQ, a licensed nurse, in the process of administering medications, obtained a report from a nursing assistant that while she assisted the resident to the bathroom, the resident was dizzy and nauseated (symptoms of a potential serious head injury). Staff Member QQ went to the resident's room where she was lying on the bed with gauze wrapped around her head. Most of the gauze and part of the pillow were red with blood. The resident reported to the nurse she had nausea and dizziness. Staff Member QQ told the resident she would rewrap the dressing on her head. Staff Member QQ then stated the resident had fallen around 4:00 a.m. hitting her head and causing a laceration. The nurse stated the resident was not sent to the hospital for an assessment because the resident's family did not want her to be sent. Nurses were treating the injury with a dressing to stop the bleeding and monitoring her neurological signs. The nurse left to obtain dressing supplies. The resident was moaning and said she did not feel well.</p> <p>Immediately after the observation, the Director of Nursing (DNS) was interviewed. She stated the resident was not receiving 'comfort measures</p>	F 309	<p>F 309 (e)</p> <p>Resident equipment audited for appropriateness of use based on condition, changes made as indicated.</p> <p>LN staff re-educated on assessing residents for potential and actual pain pre /post therapy and provide interventions to maintain pain control as indicated. Therapy staff educated on communicating to LN staff any resident changes or concern noted in therapy to ensure follow up as indicated.</p> <p>RCM/DNS and therapy to review residents in MACC meeting to assess and communicate resident needs and provide follow up and indicated.</p> <p>DNS/designee ensure compliance.</p>	
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F 309	<p>Continued From page 30</p> <p>only' nor was she on hospice care. She stated that after the early morning fall, the family member had not wanted the resident to be sent to the hospital for medical treatment. The physician was aware, but deferred to the family's wishes regarding medical attention. When asked about the resident's right to medical care and when informed of the bleeding, the DNS went to the resident's room. She reported back at approximately 12:30 p.m. that a family member had been called to take the resident to the hospital emergency room.</p> <p>At approximately 3:00 p.m., the resident was observed in her room with a clean dressing around her head. Staff Member QQ said the resident's laceration had needed staples to stop the bleeding.</p> <p>The 08/27/14 hospital emergency department documented report revealed the resident was treated for a head laceration with staples.</p> <p>Although the resident's power-of-attorney identified the resident's preference for medical treatment on the POLST form to the physicians, the facility failed to advocate for the resident and seek medical attention following a head injury. The head injury was the result of a fall onto a hard surface, which resulted in a laceration and continued bleeding for approximately eight hours, and further treatment was not initiated until intervention by a surveyor.</p> <p>3. Resident #129. Admitted on [REDACTED] 14 with diagnoses including atrial fibrillation (irregular heartbeat that can cause blood clots), hypertension (high blood pressure), diabetes and non-Alzheimer's dementia. Per the</p>	F 309	F 309 see previous page	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 31</p> <p>comprehensive assessment dated 07/30/14, Resident #129 had highly impaired hearing and was described as severely cognitively impaired.</p> <p>Review of the Medication Administration Record (MAR) revealed the resident was prescribed Coumadin, a blood thinner at admission. The MAR also revealed an International Normalized Ratio (INR) test was done periodically (an INR test checks the effectiveness of the blood thinner. A range of 2.0 - 3.0 is considered to be in the therapeutic range, higher than that level means the blood is too thin). The resident was also on two medications to treat his hypertension.</p> <p>Review of the short term care planning document (MACC) revealed a flow sheet to monitor the resident's INR, and the dosage changes made to Coumadin. It did not include any monitoring of potential adverse effects of Coumadin, such as bleeding.</p> <p>Review of the care plan revealed no documentation related to the resident being on Coumadin and no documentation related to monitoring or treatment of his hypertension.</p> <p>Review of the MAR revealed on 08/15/14 the resident's INR was 6.7, significantly above therapeutic range. A progress note dated 08/15/14 indicated the physician was notified of the 6.7 reading and his instructions were to hold the coumadin, check the INR daily and "monitor vital signs closely." The following day, on 08/16/14, the INR was 5.9. No physician notification of the 5.9 INR was documented in the progress notes.</p> <p>Review of a flow sheet that contained vital signs,</p>	F 309	F 309 see previous page	
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F 309	<p>Continued From page 32</p> <p>between 08/17/14 and 08/20/14, documented the resident had blood pressure readings that were significantly low for him: 82/62 on 08/17/14 at 9:30 a.m., 99/58 on 08/17/14 at 11:15 a.m., 90/60 on 08/18/14 at 12:15 p.m. and 90/59 on 08/19/14 in the p.m. In comparison, the resident's blood pressure at admission and soon after, was 101/71 on 07/23/14, 135/60 on 07/24/14 and 159/89 on 08/04/14. There was no documented evidence that the physician was notified about the low blood pressure readings.</p> <p>Review of the progress notes and the MAR revealed on 08/20/14 in the p.m., the resident's blood pressure continued to be low, at 89/54. On 08/21/14, a progress note timed at 10:26 p.m. described the resident as "lethargic today" and described several episodes of diarrhea that were dark colored. The LN noted his blood pressure was 80/55 and a INR drawn [REDACTED] 14 was 5.8. The LN documented she contacted the physician and the resident was transported to a local hospital.</p> <p>Per a progress note on [REDACTED] 14, the resident was in the ICU of the hospital with a "low H&H (hematocrit and hemoglobin; if low, it is an indication of anemia and/or blood loss) and INR still high."</p> <p>Per the comprehensive assessment, the resident was re-admitted from the hospital to the facility on [REDACTED] 14.</p> <p>On 09/03/14 at 3:15 p.m., Staff Member B, the Director of Nursing Service (DNS) stated residents who are on Coumadin should be monitored for signs of excessive bleeding, such as dark stools.</p>	F 309	F 309 see previous page	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/30/2014
FORM APPROVED
OMB NO. 0938-0391

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 09/11/2014
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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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The facility failed to act on low blood pressure readings, despite the resident diagnosis and treatment for hypertension. They also failed to assess for signs of bleeding or recognize low blood pressure as a potential symptom of blood loss. This resulted in harm for the resident, who was hospitalized for six days.

4. Resident #133. Admitted on [REDACTED] 14 following a surgery [REDACTED] requiring rehabilitation before she returned home. Other diagnoses included [REDACTED] pain) and anxiety. Medications included a routine and an "as needed" (prn) narcotic for pain.

On 08/28/2014 at approximately 9:30 a.m., the resident was seated in her wheelchair in her room. Her legs were both dangling; footrests were not in place. She stated that her right hip "hurts a lot" but the nurses did not check on her pain unless she called for a pain medication, "they rely on me to call." She further stated that by the time she called, she was usually in "a lot of pain." The resident stated, "I get out of bed and sit in a wheel chair that feels too high" pointing to her dangling legs and feet. She stated staff were "supposed to be looking for a new [wheelchair] but have not gotten it yet." The resident stated the wheelchair was given to her because it was wide and would not rub on her incision, but "it's so high." The resident said she would call the nursing assistants after her legs started hurting and ask for the footrests. She pointed to one lying on the floor next to the wall and said when her feet and legs dangle "like this, it causes pain."

In addition, the resident said when she sat, even

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F 309	<p>Continued From page 34</p> <p>with the footrests in place, the edge of the pressure relief cushion reached partway down her thigh, but not to the end of the wheelchair seat. She stated it "cuts under" her right thigh, "it's too short," and that amount of pressure caused thigh pain. She continually rubbed her right thigh during the interview. When describing how she got out of the chair for the transfer to bed, the height of the chair caused a problem with reaching the floor. Scooting herself forward caused pain in her right hip but she had to scoot to touch the floor. She could only weight bear on her left leg during the transfers.</p> <p>On 08/28/14 at approximately 9:45 a.m., one of the resident's family members arrived. She stated staff had been told the wheelchair caused the resident pain and was uncomfortable, but nothing had been done for over a week or so. The family member said they were told extra wheelchairs were stored and they would go check, but "they never returned." Yesterday, the therapist had reportedly noticed her feet "do dangle" but nothing was done. The family member said the nursing assistants did not always put on the footrests. As the interview with the resident and her family continued, the resident had facial grimacing, tried multiple times to shift position, and she stated her hip was "hurting" and her right thigh was "always hurting." The daughter told her it was probably because of how the metal from the surgery procedure went down into her thigh bone.</p> <p>At approximately 10:00 a.m., the resident had poor body alignment in the chair; her hips were not flat on the cushion and she was leaning slightly to the left side (due to her multiple attempts to readjust herself). She said she had</p>	F 309	F 309 see previous page	
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F 309	<p>Continued From page 35</p> <p>to get "straightened out." She put her left foot down between the foot rests, and, with her toe only touching the floor, she attempted to use it as leverage for repositioning herself with her arms. She was unsuccessful in her attempts. The resident continued to grimace, and complained of worsening pain the longer she sat.</p> <p>On 08/28/14 at approximately 10:05 a.m., Staff Member QQ, a licensed nurse (LN), reviewed the resident medication administration record. She stated the resident received an analgesic at 7:00 a.m. but she had a prn narcotic pain medication she could take every four hours. The resident had "none today," but Staff Member QQ stated she would take her some.</p> <p>On 08/28/14 at 10:15 a.m., the resident continued to exhibit non-verbal signs of pain while seated in her wheelchair. She stated she really needed to "have therapy over with" (she had been sitting up waiting for the therapist) as she was in so much pain she needed to lay down. Her spouse, who had arrived, stated her pain needed to be kept "on top of" so it was in better control than he had been noticing.</p> <p>On 08/29/14 at approximately 11:30 a.m., the resident was returning to her room from physical therapy with Staff Member NN, a part-time Physical Therapist (PT). He stated it was the first time he had worked with the resident. The resident's feet were touching the floor rather than dangling; the wheelchair was lower to the floor. The therapist stated he had just lowered the wheelchair as it was "too high" and she was unable to reach the floor with her feet. He acknowledged that feet/legs dangling caused pain. He confirmed that the lowering of the</p>	F 309	F 309 see previous page	
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F 309	<p>Continued From page 36</p> <p>wheelchair would also help with ease of transfers and decrease pain.</p> <p>On 09/04/14 at 10:30 a.m., the resident stated that with the wheelchair lowered her pain was lessened. She had an easier time with the transfers as she could put her feet on the floor without scooting forward.</p> <p>On 09/04/14 at 10:45 a.m., Staff Member P, a nursing assistant, stated that she was not aware of the placement of the foot rests. She did remember that before the wheelchair was lowered, the resident had to scoot forward to try and stand for the transfer. She stated it was "much easier" on the resident when she could reach the floor and then be assisted to stand up.</p> <p>On 09/09/14 at 3:30 p.m., Staff Member E, the Resident Care Manager, stated she was supposed to be the person "putting it all together," but until the discussion with "[the surveyor] right now, I was not aware of the resident's wheelchair being too high," or the need for footrests to reduce pain.</p> <p>The resident's family member provided documentation related to an 08/12/14 observation she had made and written down. The note stated the resident had been complaining about severe knee pain which was warm to the touch and very sensitive to touching; which the physician assessed and reported "it should go away." The family member's note on 08/13/14 revealed the family member arrived at 9:00 a.m. to find the resident being taken to therapy. After she "picked up her room a bit" she went to the therapy room. "She was in therapy in severe pain and crying, nose dripping from crying. [The physical</p>	F 309	F 309 see previous page		

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F 309	<p>Continued From page 37</p> <p>therapist] was still working with her, and she was telling him stop it hurts. When I walked in he stopped and told me "The staff had just given her pain meds about 15 minutes before and it had not taken effect yet." They put her back in bed. Her pain was pretty high. She had occupational therapy just before that, and did not have pain killers then either. So it was two at once in the morning. Too much without the meds. When I asked nurse about it, I was told that it's protocol for therapy to let the nurse know when they will be coming ahead of time so the nurse can give pain meds and prepare patient. That didn't happen either way. Someone dropped the ball..."</p> <p>The 7:00 a.m. progress notes dated 08/13/14 revealed the resident was given her routine morning pain medication with a 8 of 10 pain scale (on a scale of 1-10) documented, but no further pain assessment completed. The 2:00 p.m. entry revealed the resident had received one tablet of Norco (1-2 tablets every four hours as needed for pain) at 10:00 a.m. for hip pain. The progress note and the medication administration record did not contain an assessment of the resident's pain, either before or after administering the medication, other than she "complained of pain." There was no documentation related to the effects of therapy on the resident's pain level.</p> <p>Progress notes and the medication administration record revealed the components of the pain assessment (identified in the care plan for acute pain following a hip replacement) that included location, duration, quality, alleviating/aggravating factors were not completed on an ongoing basis. Despite the fact these were identified in the care plan, staff were not following the intervention to ensure the goal of pain relief was met.</p>	F 309	F 309 see previous page	

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F 309	Continued From page 38 In addition, the resident usually needed to inform the licensed nurse when she was in pain to obtain the prn (as needed) pain medication; the licensed nurse did not routinely assess the resident to intervene, or to anticipate the resident's need for pain management. Therefore, the resident's pain was not being adequately managed. Further, the resident's dangling feet caused her pain for over two weeks, as staff did not lower the wheelchair, or place the footrests, when the resident sitting up in the chair. 5. Resident #136. Admitted to the facility on [REDACTED] 14 with an extensive surgery [REDACTED]. There was removal of [REDACTED] from the [REDACTED] during surgery. There were 3 incisions from the surgery located on the left side of mid-and lower lateral side [REDACTED]. Other diagnoses included chronic pain and numbness in lower legs. The social service care plan dated 08/22/14 identified the residents's mood state as a potential for depression related to chronic pain, and inability to be as independent as she once was. The resident was a short stay placement and would return to her home. The comprehensive assessment dated 08/28/14 documented the resident was alert and oriented, and needed assistance of one person to transfer out of bed. A back brace was to be worn when the resident was assisted out of bed to the wheel chair or while using a walker. The resident had specific procedures from occupational therapy (OT) and physical therapy (PT) to ensure the back brace was correctly placed so it would not	F 309	F 309 see previous page	
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F 309	<p>Continued From page 39 increase her pain.</p> <p>According to the August 2014 and September 2014, medication administration records, (MAR) the resident was to have a routine short acting narcotic medication for pain, and a routine long acting narcotic medication for pain. Additionally, there were 2 other narcotic medications that were used as needed for break through pain and a medication for muscle spasms. There were no documented non-pharmacological interventions for pain relief on the MAR or care plan.</p> <p>During her stay at the facility, the resident experienced incidents which had the potential to increase her anxiety. She fell on 08/27/14 when she attempted to use the bathroom after she felt she waited too long for help; on 09/02/14, she had a disagreement with a LN about her prescribed treatment.</p> <p>OT notes on 09/01/14 documented that the "resident's functional/cognitive testing indicated that the resident was painful with anxiety. This had limited her progress and pain limits her activities."</p> <p>On the 09/02/14 progress note the OT documented she had instructed the resident to deep breathe and calm down secondary to increased anxiety. The resident was uncooperative and stated, "she is calling her husband to leave the facility."</p> <p>On 09/03/14 at 10:00 a.m., Staff Member V, occupational therapy assistant, (OTA) stated that the resident's cognitive assessment showed a decline. The resident was always prepared to work but the pain medications she was receiving</p>	F 309	F 309 see previous page	
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F 309	<p>Continued From page 40</p> <p>decreased her ability to retain and continue her program as she was taught. "Every other day she is getting worse emotionally. The resident's pain level is usually 8 out of 10."</p> <p>On 09/03/14 at approximately 1:25 p.m., Staff Member B, the DNS, was informed by Staff Member D, an RCM, that the resident was experiencing increased pain levels of 8 out of 10 and 10 out of 10. During the discussion, they acknowledged the resident had increased anxiety as well.</p> <p>On 09/04/14 at approximately 11:55 a.m., the resident stated she did not participate in therapy related to pain in her upper left side.</p> <p>On 09/09/14 at approximately 8:50 a.m., the resident stated she had been here since [REDACTED] 14 and the nursing staff had not really helped her get better. "My therapy is slow and I might as well go home."</p> <p>On 09/09/14 at approximately 10:00 a.m., Staff Member W, the OT stated the resident was "scared and feels that there are no choices for her. She is upset because she is not progressing."</p> <p>The facility did not thoroughly evaluate or address the impact the resident's anxiety was having on therapy, pain levels and quality of life in the facility.</p>	F 309	<p>F 309 see previous page</p>	
F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p>	F 312	<p>F 312 see following page</p>	

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F 312	<p>Continued From page 41</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide nail care for 1 of 3 residents (#10) reviewed for grooming who were dependent on staff for care. This failure placed the resident at risk for injury due to elongated toe nails. Findings include:</p> <p>Resident #10. The resident was admitted on [REDACTED] 13 with multiple diagnoses that included diabetes mellitus. According to a 08/03/14 comprehensive assessment, the resident had severe cognitive impairment, required assistance of staff for his activities of daily living including bathing and hygiene such as nail care.</p> <p>Review of the resident's medical record revealed an order dated 04/24/13, "Licensed Nurse (LN) to check finger nails and toe nails once a week on bath day, trim as needed, Mondays" and an order dated 05/11/14 for "fasting blood sugars every week on Monday mornings." The resident, although a diabetic, was not on any diabetes medication such as insulin.</p> <p>The care plan dated 07/12/13 identified a "potential for complications related to diabetes mellitus" with the approach described as "inspect foot for bunions, calluses, cracking, and encourage proper foot care; LN to trim finger and toes nails, refer to podiatrist for foot care PRN (as needed)."</p> <p>On 09/02/14 between 11:40 a.m. and 12:20 p.m.</p>	F 312	<p>F 312 Resident #10 has had nail care completed.</p> <p>Diabetic residents nails were assessed with nail care completed as needed.</p> <p>NA staff re-educated on checking in-room Care Plans to establish if a resident is a diabetic prior to completing nail care.</p> <p>LN staff educated on reviewing resident treatment record and completing weekly diabetic nail care as ordered by physician.</p> <p>RCM to audit treatment sheets weekly to ensure diabetic nail care is completed.</p> <p>DNS/designee to ensure compliance with above remedies.</p>	10/23/14
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F 312	<p>Continued From page 42</p> <p>Staff Member TT, a nursing assistant, was observed to give the resident a shower. While drying the resident's feet, Staff Member TT commented on the resident's long toe nails and offered to clip them for the resident. However, she did not have nail clippers and stated she would try to trim them after the resident's lunch. The resident's great toe nails appeared thick, jagged and extended approximately 1/8" to 1/4" beyond the end of the toe.</p> <p>On 09/03/14 at 11:50 a.m. Staff Member KK, a bath aide, was observed removing the resident's shoes and also noted his long, untrimmed toe nails. She said if the resident was a diabetic, the LN would need to trim his toe nails. She then asked resident "are you diabetic?" and the resident responded "no". Staff Member KK stated she would also ask the nurse to confirm. At 11:55 a.m. Staff Member KK checked with Staff Member SS, an LN, and the nurse responded (without looking at the resident's record,) "No, he is not a diabetic; he is not on my (blood sugar check) list."</p> <p>Later that day between 1:30 p.m. and 1:55 p.m., Staff Member UU, a shower aide, was observed to give Resident #10 a shower. After the shower was completed, Staff Member UU started to apply his socks and noted the resident's toenails were long, and asked the resident if he would like them clipped - he said "yes." This surveyor asked Staff Member UU if she had cut this resident's toe nails before and she stated "yes, I have clipped his toe nails after his shower." She then positioned nail clippers above the right great toe nail of the resident. Before she cut the nail, this surveyor stopped the shower aide, and asked her to check the resident's care plan prior to proceeding. She</p>	F 312	F 312 see previous page	
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F 312	Continued From page 43 stopped and applied the residents socks. At 2:05 p.m. Staff Member UU checked the resident's care guide inside his closet and stated "Oh, I see the nurse needs to cut his toe nails, I was not aware he was a diabetic." On 09/03/14 at 2:15 p.m. Staff Member II, the charge nurse, stated there should be a list of the "non-diabetic residents" for the shower aides to refer to, and that only LNs could cut diabetic resident's toe nails. Review of progress notes and treatment records did not reveal when or who last trimmed the resident's toe nails, as the treatment sheet order was for the LN to "check finger nails and toe nails once a week on bath day, trim as needed - Mondays." His nails remained untrimmed on 09/03/14. On 09/03/14 at 3:00 p.m. Staff Member E, an LN and Resident Care Manager, stated she could not find in Resident #10's record when his nail care was last done, and added that the treatment order did not clearly indicate when nails were actually trimmed. She also stated the resident had not been seen by a podiatrist. The failure of the facility to provide the proper diabetic nail care according to physician's orders put Resident #10 at risk for injury.	F 312	F 312 see previous page		
F 314 SS=D	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	F 314	F 314 see following page		

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F 314	<p>Continued From page 44</p> <p>does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to prevent an avoidable pressure ulcer from developing for 1 of 4 residents (#17) reviewed for pressure ulcers, in a sample of 46. Findings include:</p> <p>Resident #17. Admitted on [REDACTED] 14 with [REDACTED]</p> <p>The resident had a [REDACTED] in March of 2014 (a surgical procedure used to stop the [REDACTED] to decrease pain).</p> <p>A 07/06/14 assessment indicated the resident was alert and oriented, and had no skin issues. On 07/11/14 the resident was identified as needing the extensive assistance of 2 staff for transfers/bed mobility/toileting. In addition, he was identified as having no risk for the development of pressure ulcers. A pressure reduction mattress was on the bed, but nothing was in place to reduce pressure as the resident sat up in his wheelchair.</p> <p>Per the record, on 08/15/14, an open area was observed on the left buttock by a nursing assistant and a registered nurse, when the resident was being changed before bed. The investigation of it's developement indicated the ulcer was reasonably related to his condition, with</p>	F 314	<p>F314</p> <p>Resident #17 no longer resides in facility.</p> <p>Residents identified to have potential risk for pressure ulcer development have been assessed for prevention measures. Interventions have been initiated as indicated. Nursing staff re-educated on identification of pressure ulcer risk and prevention strategies to decrease development of avoidable pressure related sores.</p> <p>On-going monitoring of residents condition changes to be reviewed in MACC meeting by RCM/DNS. Updates and interventions to be completed as applicable.</p> <p>RCM/designee to complete monthly audits of resident equipment and appropriateness as pressure ulcer prevention measures.</p> <p>Findings to be reviewed in QAPI committee meeting.</p> <p>DNS/designee to ensure compliance</p>	10/31/14
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F 314	<p>Continued From page 45</p> <p>risk factors of fragile skin due to diabetes and poor circulation. The temporary care plan (MACC) was updated, with the monitoring of the wound until resolution, but no additional interventions for pressure relief.</p> <p>On 08/15/14, physician orders were obtained for wound cleansing, and application of a dressing to the wound on the left buttock. The 08/15/14 'skin grid' for pressure ulcers identified it as a stage II (open sore) pressure ulcer.</p> <p>During the on-site survey (08/27-08/29/14; 09/02-09/05/14; 09/08/14 and 09/09/14) the resident was observed seated in his wheelchair by the bed on multiple occasions during both the day and evening hours.</p> <p>On 09/11/14 at 10:45 a.m., Staff Member RR, a licensed nurse, verified the resident spent a lot of time up in his wheelchair, and said he probably got the pressure ulcer from sitting so much. He was able to lean forward, raise his arms and his legs, but could not shift weight off of his bottom. He needed staff assistance for that type of movement. She stated he did have therapy sessions, but was not sure how often.</p> <p>On 09/11/14 at 10:00 a.m., Staff Member II, a charge nurse, stated if a concern arose about a resident sitting for a long period of time, the licensed nurses evaluate residents every morning, and would be aware of the need for repositioning (to avoid continual pressure). She stated the Resident Care Manager (RCM) would be told and would then evaluate for pressure ulcer potential.</p> <p>On 09/11/14 at 10:10 a.m., Staff Member E, an</p>	F 314	<p>F 314 see previous page</p>	

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F 314	<p>Continued From page 46</p> <p>RCM, reviewed the resident's care plan. She indicated there had been no identification of the need for readjustment of the resident's position while up in the wheelchair. She stated he had been in therapy for awhile, and that the wheelchair cushion could have been reassessed, and changes made if necessary (i.e., to provide more pressure relief).</p> <p>On 09/11/14 at 11:30 a.m., Staff Member LL, a Physical Therapist (PT), stated the resident was receiving therapy for transfers, ambulation, and strengthening. The resident's knees were observed against the rim of the wheelchair, so that had been adjusted. However, there had not been any review of the cushion he was sitting on. The therapy department had not been told he was sitting for long periods without position changes. Staff LL indicated that the RCM would be the main person to communicate with the rehabilitation department. He said the resident's wheelchair cushion could have been changed, if he had known, to a higher quality of pressure reduction, such as a Roho or a gel cushion.</p> <p>The resident had multiple medical diagnoses limiting his mobility, and causing a potential for fragile skin. In addition, he required extensive assistance with mobility. Although staff were aware of the resident sitting in his wheelchair for long periods of time, the potential risk for pressure ulcer development related to this had not been evaluated. The facility failed to put additional preventative measures in place, and the resident developed a pressure ulcer.</p>	F 314	F 314 see previous page	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315	F 315 see following page	

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F 315	<p>Continued From page 47</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 1 of 3 residents (#24) reviewed for use of an indwelling urinary catheter, had an adequate indication for use of the catheter. Failure to have a physician order for the catheter, and to have an adequate diagnosis for the use of the catheter, placed the resident at risk of having an unnecessary catheter and not receiving appropriate care of the catheter. Findings include:</p> <p>Resident #24. Admitted on [REDACTED] 13 with diagnoses to include urinary tract infection and a history of prostate surgery. His latest comprehensive assessment dated 07/13/14 revealed he had moderately impaired decision making skills and required extensive assistance with toileting and personal hygiene. The assessment noted he did not have an indwelling urinary catheter at that time.</p> <p>On 08/28/14 at approximately 1:15 p.m., Staff Member B, the Director of Nursing Services (DNS) and Staff Member C, a Resident Care Manager (RCM) stated the resident had an</p>	F 315	<p>F. 315</p> <p>Resident #24's Urologist was contacted. Specific orders for retention catheter with medical justification for use was obtained.</p> <p>Resident's Care Plan updated with directives on follow up care identified for staff. Residents with retention catheters had record reviews completed to ensure specific orders and medical justification for use was in place.</p> <p>Care Plans updated as indicated.</p> <p>LN staff educated on requirement for medical justification for continued resident retention catheter use.</p> <p>NA staff educated on providing follow up care for retention catheter use.</p> <p>RCM/DNS to audit resident with retention catheter records monthly to ensure aspects of follow up care is in place. Report findings to QAPI committee DNS/designee to ensure compliance</p>	10/31/14

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F 315	<p>Continued From page 48</p> <p>indwelling urinary catheter. They stated they thought he had it placed after a surgery to remove bladder tumors, but could not find documentation to confirm the diagnosis.</p> <p>Record review of the physician order's on 08/28/14 revealed no orders pertaining to a urinary catheter.</p> <p>Record review of the resident's care plan and In Room Care Plan (the daily care guide used by direct care staff) on 08/29/14 found no mention of a urinary catheter, or any guidance regarding care of a catheter.</p> <p>On 08/29/14 at 1:50 p.m., Staff Member P, a Nursing Aide (NA), described how she cleaned around Resident #24's catheter while providing care for him, and also said she emptied the bag once a shift. She stated she did not know of any specific instructions about how to care for the resident's catheter, but was relying on what her teacher taught her when she took nurse aide training classes.</p> <p>On 09/02/14 at 10:05 a.m., Staff Member J, a Licensed Nurse (LN), stated she did not know what size the catheter was, but the information about the size of his catheter, and the care of the catheter should be in either the Medication Administration Record (MAR) or the Treatment Administration Record (TAR). She checked the MAR and the TAR and stated there wasn't any information about the catheter. "That will make it hard for me. The aide just told me the catheter was leaking. I'll have to check that he has the right size."</p> <p>On 09/02/14 at 10:15 a.m., Staff Member C</p>	F 315	F 315 see previous page	
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F 315	<p>Continued From page 49</p> <p>stated Resident #24 had [REDACTED] surgery to remove growths and a catheter was placed after the surgery. She thought it was about 3 weeks ago. After reviewing the medical record, she corrected herself about how long the catheter had been placed. She stated she found documentation regarding the catheter on a nursing assessment dated 07/17/14, so he had the catheter at least since then. After reviewing the physician orders, she stated she could not find any order for the catheter or indication for use.</p> <p>Failure to have an order for a catheter, and failure to have an indication for use of a catheter placed Resident #24 at risk for unmanaged pain, inadequate catheter care, and urinary tract infections. It also placed the resident at risk for continuing use of a catheter when the use may not have been medically justified.</p>	F 315	F 315 see previous page	
F 323 SS=D	<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 ensure 1 of 2 residents (#83) with transfer poles were free from an entrapment hazard. Failure to evaluate the</p>	F 323	F 323 see following page	

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F 323	<p>Continued From page 50</p> <p>placement of the transfer pole in relation to the bed, and interventions to maintain the position of the bed, put the resident at risk for entrapment between the pole and bed. Findings include:</p> <p>Resident #83. On 08/29/14 at approximately 11:15 a.m., the resident was observed lying in bed on his back. His bed was against the wall on the left side, and to the right he had a transfer pole (extending from ceiling to floor approximately 8 to 10 inches from the side of the bed). The resident was observed turning in bed from back to side holding the transfer pole (at chest level) with both hands. He stated he used the pole to get "up and down."</p> <p>Review of the comprehensive assessment dated 06/22/14 revealed the resident had moderate cognitive impairment. He also required extensive assistance with cares, including mobility and transferring from bed to wheelchair. The assessment also indicated he had one fall in the past quarter.</p> <p>Per review of the progress notes, the resident had a fall from his bed on 06/12/14 at 4:30 p.m. The resident was found kneeling on the fall mat "still holding onto bedside pole."</p> <p>Review of the resident's record did not include a safety assessment for the transfer pole, nor was there a care plan that identified a safe distance between the bed and pole to decrease the risk of entrapment.</p> <p>On 8/29/14 at 4:20 p.m. Staff Member E, a Resident Care Manager, stated she had not done an entrapment assessment, or included care plan interventions to decrease the risk.</p>	F 323	<p>F323</p> <p>Resident # 83 had an enabler devise assessment completed for use of transfer pole.</p> <p>Care plan and in-room care plan updated to identify placement of pole. Residents using transfer poles or enabling devise have had audits completed.</p> <p>Assessments and care plan updates completed as indicated.</p> <p>RCM and Licensed Nurse Staff have been re-educated on policy for enabler devises.</p> <p>Residents will be assessed using RAI process upon admission, quarterly, and with any change of condition MDS for the continued need for the devise and evaluation of the effect on the residents. Compliance to be monitored per IDT review</p> <p>DNS/designee to ensure above remedies are sustained.</p>	10/31/14
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F 329 SS=G 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:
Based on observation, interview and record review, the facility failed to ensure anti-psychotic drugs were not used without adequate indication for use, and appropriate monitoring for 1 of 3 residents (#129) reviewed for psychoactive medication use. This failure caused harm for the resident, who experienced increased drowsiness, continued falls and weight loss. Findings include:

F 329

F329 (a)

Resident #129 have had medication review completed to assess that medications are necessary to treat specific conditions.

Additionally gradual dose reduction requirement reviewed with MD interventions in place to ensure that all elements of medication therapy are in compliance with accepted standards.

Residents receiving psychoactive medications have had reviews completed to determine that all elements of use are in place.

Licensed nurse staff were re-educated on policy and procedure requirements to assess and monitor for adverse side effects of resident medications.

DNS to ensure compliance.

11/10/14

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F 329	<p>Continued From page 52</p> <p>Resident #129. Admitted on [REDACTED] 14 with multiple diagnoses including non-Alzheimer's dementia. Per the comprehensive assessment dated 07/30/14, Resident #129 had highly impaired hearing, was described as severely cognitively impaired, but had clear speech and could usually understand and be understood. He required assistance from staff with transferring.</p> <p>Review of the Medication Administration Record (MAR) dated July 2014 revealed the resident was prescribed [REDACTED] an anti-psychotic medication, 50 milligrams (mg) twice a day upon admission to the facility. The reason noted on the MAR for the use of [REDACTED] was dementia with behaviors. The MAR also documented use of Ativan, an anti-anxiety medication, beginning 07/29/14, to be given as needed every 6 hours. No reason was documented on the MAR for the use of [REDACTED]</p> <p>Review of the care plan revealed the facility identified the resident had dementia with behavioral disturbance. The behaviors the facility identified were physical abuse, verbal abuse, continual yelling, hallucinations and delusions. Some interventions identified to address the behaviors were: assess for pain or discomfort, use distraction tools (Bible, prayer, music, television, activities), accommodate his demands and wants within safety parameters, to attempt to find logical reasons for hallucinations, and attempt reality orientation.</p> <p>Further review of the care plan revealed the goal for the psychoactive medications, Seroquel and Ativan, was "No adverse reaction related to psychoactive medication use." The approaches included administering the medications as</p>	F 329	<p>F 329 (b)</p> <p>Pharmacist will continue to conduct monthly review and ensure that all aspects of use for residents medications have justifications and diagnosis in place.</p> <p>Psychotropic Medication Review meeting is conducted monthly with Pharmacist and Interdisciplinary team</p> <p>Residents on psychoactive medications will have comprehensive reviews completed to ensure medications remain necessary to treat specific conditions. Dosage reduction, care plans, ASE's will be reviewed at this time to determine that all elements of psychoactive medication use is in place.</p> <p>SS/RCM/LN re-educated on policy and procedure for assessments, care planning and monitoring requirements of residents receiving psychoactive medications.</p>	10/31/14
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F 329 Continued From page 53
ordered, monitor for adverse reactions, and notify the physician if adverse effects occurred. The care plan called for a monthly or as needed review and assessment of the medication use. The care plan did not include information about how the medication's effectiveness would be measured.

Further review of the MARs for July 2014 and August 2014 revealed the dose of [REDACTED] was doubled to 100 mg twice a day, beginning on 07/29/14. Ten days later, on the evening of 08/08/14, the dose of the [REDACTED] was again doubled to 200 mg twice a day.

Note: Per the manufacturer [REDACTED] dosage is not recommended to exceed 200-300 mg per day in geriatric patients. Adverse effects can include dizziness and somnolence (drowsiness). [REDACTED] carries a "Black Box Warning" indicating it is not approved for dementia-related psychosis, and can increase the risk of death.

Potential side effects of [REDACTED] were documented on the MARs in July 2014, August 2014 and 09/01/14 through 09/03/14. Possible side effects included sedation, drowsiness, dry mouth, weight gain, edema, loss of appetite and postural hypotension (decreased blood pressure upon standing). Per review of the MARs, no side effects were noted by nursing.

Potential side effects of [REDACTED] were not monitored on the July 2014 or August 2014 MAR. Review of the September 2014 MAR, revealed possible side effects included sedation, drowsiness, ataxia (drunk walk), dizziness, confusion and blurred vision. No side effects were noted by nursing through 09/03/14.

F 329 F 329 ©
RCM/DNS to audit care plans and progress notes in MACC meeting to ensure adequate indications of psychoactive drug use is in place. DNS/designee to ensure Compliance with all remedies.

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F 329	Continued From page 54 Review of incident reports revealed Resident #129 had no falls between 07/23/14 and 07/28/14, but suffered 8 falls between 07/29/14 and 08/17/14. All falls occurred in the resident's room, and were related to self-transfer attempts. The falls correlated with the first dose increase of [REDACTED]. In 4 of the 8 falls, [REDACTED] had been given in the hours prior to them. The incident reports did not evaluate or assess whether medication side effects could have been a causal factor of the falls. The resident was observed multiple times each day on the following days: 08/28/14, 08/29/14, 09/02/14, 09/03/14 and 09/04/14. On all observations, unless he was in the dining room for meals or a snack, the resident was in bed, typically with his eyes closed. Observations on 09/04/14 included evening time observations as well as day time observations. During the evening observation, the resident was escorted to the dining room for a snack, then back to bed. He appeared restless when in bed during the evening hours. On 09/03/14 at 10:10 a.m., Staff Member F, the Social Services Director (SSD) stated she organized monthly meetings to review those residents receiving psychoactive medications. She indicated behaviors were reviewed as a part of the process. For Resident #129, she said his last review was on 08/27/14. Review of the 08/27/14 psychotropic drug assessment for [REDACTED] and [REDACTED] revealed the reason for the drug use was depression. Indicators for use included "outbursts of anger" and "sometimes feels depressed." The	F 329	F 329 see previous page		

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F 329	<p>Continued From page 55</p> <p>non-pharmacological interventions included: taking the resident outside when weather permitted, encouraging fluids, and encouraging activities. The described benefits of using the drugs were to decrease behaviors.</p> <p>Review of the resident's record revealed his weight had decreased, from [REDACTED] lbs. (pounds) on 08/06/14, to [REDACTED] lbs. on 08/19/14. In a progress note dated 08/29/14, Staff Member N, the Registered Dietitian (RD), noted the significant weight loss over the last 30 days, and attributed the loss to declined consumption (she noted he was taking only 25% of his dinner meal) and possibly to changes in body fluids.</p> <p>On 09/03/14 at 11:40 a.m., Staff Member C, a Licensed Nurse (LN) and Resident Care Manager (RCM), said she was responsible for coordinating the care of Resident #129. She indicated that she had not seen a lot of behaviors from the resident, but he did have a number of falls. She further stated, "He is a cantankerous guy. As long as you let him have his way, it is fine." She stated the resident's behaviors would be documented on the Behavior Report Sheet, or in the progress notes. After she reviewed the progress notes for the resident, she said she did not see behaviors documented. She stated she did not know why the resident's Seroquel was increased, and did not find documentation in the medical record about the reason for the increased doses.</p> <p>In reviewing the Resident Behavior Report Sheets for July 2014, there were 4 documented episodes of behavior. In 3 of the episodes, the resident exhibited restlessness, and was attempting to self-transfer. During the fourth episode, on 07/29/14, the resident was verbally and physically</p>	F 329	F 329 see previous page	

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F 329	<p>Continued From page 56</p> <p>aggressive toward the Speech Language Pathologist, while in the dining room, during a trial of puree textured food. After he was given different textured food, his aggressive behaviors stopped. The Resident Behavior Report Sheets for August 2014, and 09/01/14 through 09/04/14 did not have any behaviors logged.</p> <p>On 09/03/14 at 12:05 p.m., Staff Member F, the SSD, stated she did not remember what behaviors the resident had.</p> <p>On 09/03/14 at 12:10 p.m., Staff Member B, the Director of Nursing (DNS) stated the doctor did not make a note on why the [REDACTED] was increased. "I don't see anything in the progress notes about staff communicating with the doctor about the increase in [REDACTED]"</p> <p>Review of the progress notes dated between 07/23/14 and 08/12/14 revealed frequent episodes of restlessness and/or self-transferring to or from his bed. There were two instances documented of the resident raising his voice to the staff, one instance of yelling out, and one instance when he stated he thought 4 people were in his room and the nurse documented there were not that many people in the room. This episode occurred one day after a room change.</p> <p>On 09/04/14 at approximately 8:00 p.m., Staff Member U, a Nursing Assistant (NA), stated the resident was much easier to care for now that he was on more medicine. She stated before the increase in the medication, he required a lot of attention and time. She explained now "he stays in bed."</p>	F 329	F 329 see previous page	
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F 329	Continued From page 57 The resident was observed multiple times each day on the following days: 09/08/14, 09/09/14 and 09/11/14. The resident was observed in one activity. During the activity, the resident was seated in his wheel chair in the chapel with his eyes closed. Most other times the resident remained in bed. The facility failed to ensure there was adequate indication for use of [REDACTED] (restlessness is not an indication for use). There was a low frequency of other documented behaviors besides restlessness. Despite that, the [REDACTED] dose was increased twice without a rationale for the increase. The [REDACTED] was administered with no monitoring for side effects, until 5 weeks after the medication was started. These failures resulted in harm to the resident as evidenced by excessive somnolence (drowsiness), increased falls, and weight loss.	F 329	F 329 see previous page		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing	F 353	F 353 see following page		

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F 353	<p>Continued From page 58 personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide sufficient nursing staff to provide care and services in accordance with resident care plans for 7 of 37 current sampled residents (#s 17, 32, 65, 76, 82, 135, 136) reviewed for sufficient nursing staff. This failure placed residents at risk of not attaining or maintaining their highest practicable physical, mental and psychosocial well-being. Findings include:</p> <p>RESIDENT INTERVIEWS 1. Resident #136 was admitted to the facility on [REDACTED] 14 following [REDACTED] surgery. The resident was cognitively intact and required the assistance of one person to transfer.</p> <p>On 08/27/14 at approximately 11:00 a.m., the resident stated she woke up with muscle spasms around 3:00 a.m. that morning and she pushed the call light for assistance, but after 30 minutes there was no response. After another 30 minutes she stated she really needed to go to the bathroom, so she transferred herself out of bed and to the bathroom. She stated she pulled the call light cord in the bathroom, but no one came to help her. She attempted to transfer back to her wheel chair and fell in the bathroom. She stated she had to crawl back to her bed.</p>	F 353	<p>F 353 (a) Resident #136, 75, 65, 17 no longer reside at facility.</p> <p>Resident #82 was interviewed and assessed. No residual concerns were noted. Skin check completed no new skin impairments observed.</p> <p>Resident #32 was interviewed and assessed. No residual concerns were noted.</p> <p>Resident #135 was interviewed and assessed no residual concerns noted.</p> <p>Skin check completed no new skin impairment observed.</p> <p>Residents identified at risk to have been effected by nursing staffing have had interviews and assessments completed with follow up as indicated.</p> <p>Additionally LN/RCM/NA staff have been re-educated on Ariel pager system.</p>	<p>10/16/14</p>
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2. Resident #82. Admitted [REDACTED] 13 with a diagnosis of congestive heart failure The comprehensive assessment dated 08/11/14 revealed he was cognitively intact, and required two person extensive assistance for transfers and toileting.

On 09/04/14 at approximately 2:00 p.m., the resident stated he was supposed to call for help, but there were not enough nurse aides to help him fast enough when he put on his call light. He explained he had made complaints about it to the staff, but it continued to be a problem for him. He stated he did not always wait for help because he did not want to "wet myself" but often by the time he was taken to the bathroom, "I am wet." He was afraid of falling, and knew he was not supposed to transfer himself from his wheelchair, but did it anyway to try to avoid wetting himself. The resident expressed frustration, and stated "I give up."

3. Resident #76 was admitted on [REDACTED] 14 with cancer, pain, anxiety and [REDACTED] fractures. The 08/24/14 quarterly comprehensive assessment revealed the resident was cognitively intact. She required extensive one-person assist for transfers and toileting.

On 09/04/14 at 3:00 p.m., the resident stated there were "very few staff" on evening shift and there was a wait from 15 to 40 minutes after the call light was turned on. She stated, because of the waiting, her right leg pain had increased when staff did not bring her pain medicine fast enough. She further noted one time she had to wait when she needed to be helped to the bathroom and "I had an accident, it was very unpleasant." The

F 353

F 353 (b)
Ariel pager distributed to licensed nurse, /RCM/ and DNS to provide enhanced monitoring of call lights timely.
NA staffing schedules reviewed and modified to ensure sufficient staffing is maintained to avoid prolonged wait-times of call lights and maintain resident dignity

Will continue to assess and interview residents about call light timeliness and if facility is providing sufficient staffing to meet needs.

Resident council to be held weekly on above issues for six weeks and at every monthly Resident Council meeting.

Results forwarded to DNS/Administrator/SSD for review and follow up as indicated.

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F 353	<p>Continued From page 60</p> <p>resident stated lately it (call light response) was better since the state inspection started.</p> <p>4. Resident #32 was admitted to the facility on [REDACTED] 14. According to the Comprehensive Assessment dated 08/13/14 the resident required extensive assistance of 1 person to transfer. The resident was a fall risk due to chronic pain in the right knee and was not to ambulate without assistance.</p> <p>On 09/04/14 at approximately 7:30 p.m., the resident stated that her legs hurt and call light was not answered timely. She stated she had to wait "40 minutes or more" because there were not enough nursing assistants (NA's) on duty. "I wait and wait and no one comes." She explained because the staff had not answered her light, she had "transferred herself," which caused pain in her legs. Additionally, she had concerns about getting her pain medication on time, due to the fact that the "nurse is busy and can't always come on time when I request the medication." The resident said she tried to "request the pain pill earlier" to give staff time but if "I do they are still late and my pain doesn't always go away."</p> <p>5. Resident #65. Admitted to the facility on [REDACTED] 14 after extensive [REDACTED] surgery and a [REDACTED]. The resident was alert and oriented and able to make needs known. The resident required extensive assistance of 2 people to transfer.</p> <p>On 09/04/14 at approximately 7:45 p.m., the resident stated that the staff had not been "very prompt at times answering the call light" especially when there are "2 people working" the floor. She stated she used a bed pan and had to</p>	F 353	F 353 see previous page	
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F 353	<p>Continued From page 61</p> <p>"wait anywhere from 40 minutes to about 1 hour and a half" for someone to help." The resident's family member confirmed the long wait times, and stated he had looked for staff to help after the call light was on for 1 hour and a half on another occasion. The resident said it made her "feel helpless and worried about who was out there working."</p> <p>6. Resident #135. The resident was admitted on [REDACTED] 14 with [REDACTED] of the [REDACTED]. The resident was oriented and able to make needs known. He required extensive assistance of two people for transfers and used a bed pan.</p> <p>On 09/04/14 at approximately 8:00 p.m., the resident stated the wait for call lights was about 1 hour, but he had waited as long as 2 hours. The resident said he didn't like to have a bowel movement in his pants and it's difficult to get more than 1 nursing assistant to help.</p> <p>7. Resident #17 was admitted to the facility on [REDACTED] 14. A comprehensive assessment dated 07/07/14 revealed the resident was cognitively intact and required the extensive assistance of two staff for transfers.</p> <p>On 09/05/14 at 2:45 p.m., the resident's family member said she visited most afternoons, and had observed "there were not enough nursing assistants to help these residents." She continued, "There are too many people who need two nurse aides to help them. They work fast and hard but there just aren't enough of them to take care of the residents."</p> <p>STAFF INTERVIEWS</p>	F 353	F 353 see previous page	
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F 353	<p>Continued From page 62</p> <p>Staff Member EE, who chose to remain anonymous, stated that the staff had not been able to consistently answer lights, or care for residents promptly, which has caused resident's to be incontinent by "wetting themselves because we can't get to them." The staff doesn't have time for breaks due to the fact if "someone takes a break there is only 1 nursing assistant left on the floor to answer the call lights."</p> <p>Staff Member EE continued, "staffing had been increased while you guys (state surveyors) have been here, but once you leave they will reduce the staffing." The staff identified residents on the 300 hall that had experienced incontinence due to the inability for us to get to their call light timely. The staff member stated that "It makes me cry and the administration won't listen. If we had lights down the hall or over the rooms we probably could see the rooms that need help. It is hard to read this beeper when you are in the middle of caring for a resident."</p> <p>Staff Member DD, who chose to remain anonymous, stated when we have a full house, it was "impossible to answer the needs of the all the residents" especially with only 2 nursing assistants." If one staff person had to go on break the remaining 1 NA on the floor would have 20 residents or more to care for until the other person returned. Staff Member #2 stated that "It makes me feel I have let the residents down by the time we had gotten to their room and they were incontinent or in pain for a long time."</p> <p>Staff Member CC, who chose to remain anonymous, stated that it is too overwhelming to have just 2 nursing assistants and 1 nurse on the floor with 20 plus residents, and giving showers</p>	F 353	F 353 see previous page	
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F 353	<p>Continued From page 63 (which takes time) - there had been "many times when we have 2 NA's that we have not been able to answer a call light or return after answering a call light."</p> <p>On 09/04/14 at approximately 8:00 p.m. Staff Member I, a Licensed Nurse (LN), stated "the 100 hall usually has 2 NA's and 1 LN and on the 200 hall we have 1 LN and 2 NA's, and there had been complaints from the residents that they wait too long."</p> <p>On 09/04/14 at 7:28 p.m., Staff Member T, a NA, was observed sweeping and straightening the Eden dining room. He stated it was a part of his daily duties to clean the Eden dining room. He stated the other NA was at lunch so he was the only aide on the 100 hallway. He stated they try to get the residents who require a mechanical lift to bed before they take their meal breaks. He stated that sometimes this plan works, but sometimes it doesn't get done. He stated tonight there were 2 residents who did not get to bed, so they would have to stay up until the other aide returned from her break. He stated of the 22 residents he and the other aide were responsible for, 7 of them required lifts.</p> <p>On 09/08/14 at 3:00 p.m., in a meeting with the Administrator and Director of Nursing, the Administrator said staffing in the building was based off the facility census. The Administrator or Director of Nursing could not describe how the care needs of the residents were determined to ensure appropriate staff was in place. The facility admitted an average of 2-6 residents per week. The population of the building was mostly long term care, short term, and rehabilitation.</p>	F 353	F 353 see previous page	

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F 353	Continued From page 64 Failure to have sufficient staffing resulted in negative outcomes for multiple residents resulting in incontinence, dignity and pain. Refer to F241 and F309 for additional information.	F 353	F 353 see previous page	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356	F 356 Daily Nursing staffing posted in morning. Administrator/designee to monitor that information is accurate posted daily. Licensed staff educated on requirement to update and maintain accurate staffing information Q shift. Weekly audits will be completed by administrator/designee and presented at QAPI meeting. Administrator to ensure compliance.	10/23/14

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F 356	Continued From page 65 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to consistently post nursing staffing information, and the current resident census, on a daily basis. This failure left residents and visitors without access to current information of the facility's staffing numbers and population. Findings include: During the dates 08/27/14, 08/28/14, 08/29/14, 09/02/14, 09/03/14, 09/04/14, 09/05/14, 09/08/14, 09/09/14 and 09/11/14 of survey the facility failed to consistently update and accurately post staffing and the resident census. On 09/08/14 at approximately 2:00 p.m., the Administrator stated she failed to update the information, in order to provide the accurate number of staff on duty, and actual number of hours worked by staff during the time of survey. The facility failed to post corrected nurse staffing data and the resident census on a daily basis as required.	F 356	F 356 see previous page		
F 363 SS=G	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.	F 363	F 363 see following page		

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F 363	<p>Continued From page 66</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to follow the planned menu for 1 of 2 (#136) residents identified with food allergies. Failure to serve the correct foods to the resident caused harm as evidenced by Resident #136 having an allergic reaction when served pieces of bananas in a dessert to which she was allergic. This facility practice caused the resident harm, as exhibited by an itchy throat and numbness, with a cough that also caused the resident anxiety and fear; medical intervention was required. Findings include:</p> <p>Resident #136. Admitted to the facility on [REDACTED] 14 with a [REDACTED]. The resident was alert and oriented and able to make her needs known.</p> <p>The resident's allergy to bananas was identified on the nursing admission assessment, the history and physical, and the nutrition assessment.</p> <p>On 08/29/14 at approximately 10:00 a.m., the resident stated she had consumed banana pieces in pudding at the lunch meal on 08/28/14. She stated she "did not realize the pudding had banana in it." After consuming the pudding the resident experienced "an itchy throat with numbness and coughing." She stated she was given Benadryl (a medication for allergic reaction).</p> <p>According to the progress note the physician came to see the resident that same evening and ordered Valium for the resident's increased anxiety related to the incident.</p>	F 363	<p>F363</p> <p>Resident #136's physician was contacted. Orders received secondary to allergy. Resident placed on alert charting to monitor for condition change.</p> <p>Immediate re-education was completed by DNS with Dietary and Nursing to review tray cards for allergies prior to serving resident food.</p> <p>Dietary Service Manager initiated an additional work sheet listing resident food allergies for quick reference on tray line.</p> <p>DSM to perform weekly audits of tray cards and report findings monthly at QAPI committee.</p> <p>Administrator to ensure compliance.</p>	10/31/14
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F 363 Continued From page 67

On 08/29/14 at approximately 11:00 a.m., Staff Member D, a licensed nurse (LN), said that on 08/28/14 the resident stated she was experiencing a "tickle" in her throat and believed she ate something on her lunch tray that caused an allergic reaction. Staff Member D notified the physician and received an order for Benadryl. She verified with dietary that there were banana pieces in the dessert pudding. The kitchen staff made "a mistake" and place the wrong dessert on Resident #136's tray. Staff Member D, stated she was "worried" about the reaction that the resident was experiencing and sat with her for "an hour and a half" after the incident.

On 08/29/14 at approximately 1:30 p.m., Staff Member N, a Registered Dietician (RD), stated that the trays were set-up in the kitchen with the resident's dietary card which identified name, room number, diet and allergies. "The kitchen tray line made a mistake placing the dessert with bananas instead of the alternative which was peaches."

On 08/29/14 at approximately 3:00 p.m., the Director of Nursing stated she spoke to the dietary manager. The dietary manager told her the dietary aide prepared the peaches as an alternate but placed the pudding with bananas on the resident's tray.

On 08/30/14 at approximately 10:00 a.m., the Dietary Manager, stated that there was a mistake in placing the dessert on Resident's #136's tray and the resident was served bananas. She stated the cook dished and labeled the peaches for the resident but it was not placed on the tray. "We have allergies and food likes posted above the steam table for the cooks to look at while

F 363 **F 363 (b)**

Licensed staff re-educated on requirement to update and maintain accurate staffing information Q shift.

Weekly audits will be completed by administrator/designee and presented at QAPI meeting.

Administrator to ensure compliance.

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F 363	Continued From page 68 serving." The dietary aide had the dietary slip to refer to while setting up the residents tray and that included allergies. She further explained the nursing assistants serve the resident trays in the different dining areas, and to some residents in their room. "They do have the diet slip that is on the residents' trays. It identifies the resident's name and diet allergies." The facility failed to ensure that the resident was not served a food containing a known allergen. This caused the resident to have an allergic reaction requiring medical treatment, and fear for her health. This caused the resident to lack confidence about her care, and resulted in physical and psychosocial harm.	F 363	F 363 see previous page	
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that 2 of 6 residents (#'s 46, 87) reviewed for frequency of physician visits were seen by a physician at least once every 60 days. This failure placed the residents at risk of inadequate supervision of medical care. Findings include:	F 387	F 387 see following page	

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F 387	<p>Continued From page 69</p> <p>1. Resident #87. Admitted on [REDACTED] 13 with multiple diagnoses, including hypertension, [REDACTED]</p> <p>Review of the resident's medical record revealed a physician progress note dated 03/08/14. The next physician progress note was dated 08/04/14, a span of 149 days between documented visits.</p> <p>On 09/11/14 at 10:30 a.m., Staff Member II, a charge nurse, reviewed the resident's chart and stated she did not find any other physician progress notes or physician visit documentation.</p> <p>On 09/11/14 at 10:35 a.m., Staff Member UU, Medical Records, stated she would review the resident's record as well as the overflow record kept in her department for evidence of other physician visits. After she reviewed the records, she stated there was no other documentation of visits by a physician between March 2014 and August 2014.</p> <p>2. Resident #46. Admitted [REDACTED] 14 with diagnoses including hypertension, diabetes and dementia.</p> <p>Review of the resident's medical record on 09/11/14 revealed the latest physician progress note was dated 06/26/14, 77 days ago.</p> <p>On 09/11/14 at 11:30 a.m., Staff Member UU stated she there was no record of a physician visit for Resident #46 since 06/26/14. "She was due [to be seen] on 08/25/14 and has not been seen."</p> <p>On 09/11/14 at 1:10 p.m., Staff Member B, the</p>	F 387	<p>F. 387</p> <p>Residents # 46 and 87 have been seen by their physician.</p> <p>Residents' records reviewed to ensure that physician's visits have occurred timely as required.</p> <p>Medical Records and Nursing Staff re-educated on frequently and timeliness for physicians visits.</p> <p>Medical records to complete monthly audits and present to DNS/RCM her findings of any residents who will require a physician visit. The resident's physician will be contacted to schedule follow up appointment as indicated.</p> <p>DNS/designee to ensure compliance.</p>	10/31/14

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F 387	Continued From page 70 Director of Nursing Services stated, "If Staff Member UU couldn't find record of physician visits, I'm sure it didn't happen." She further explained Medical Records was responsible to audit the medical records to ensure residents were seen regularly by physicians. She thought perhaps the audits were not thorough enough.	F 387	F 387 see previous page	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the pharmacist's recommendations and physician's order were followed related to the use of a blood thinning medication for 1 of 5 residents (#17) reviewed for medication use. This failure increased the resident's risk for developing blood clots that could lead to stroke secondary to his irregular heartbeat. Findings include: Resident #17. Admitted to the facility on [redacted] 14 after [redacted] surgery for rehabilitation with multiple diagnoses including atrial fibrillation (an irregular heartbeat), high blood pressure and heart failure.	F 428	F 428 Resident #17 no longer resides at the facility. Pharmacy Consultant recommendations dated back one year reviewed to ensure follow up as obtained. RCM/LN staff re-educated on timely completion of pharmacy recommendations. Pharmacy recommendations will be reviewed in MACC meeting by RCM/DNS to ensure physician follow up occurs. DNS/RCM designee to audit that pharmacy recommendations are completed within 7 days of receiving to ensure timely follow up is maintained. DNS/designee to ensure compliance.	10/31/14

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F 428	Continued From page 71 Per record review, a "Note to Attending Physician/Prescriber" dated 05/20/14 from the facility consultant pharmacist noted "pt (patient) was not on any blood thinners (aspirin, Coumadin ...) for his afib/risk of stroke. If you would like to start any blood thinners please notate below." The physician response on 05/30/14 was "I would prefer ASA (aspirin) 81 (milligrams) qd (every day)." Review of the resident's physician orders for May, June and July 2014 revealed no orders for aspirin. Another "Note to Attending Physician/Prescriber" from the consultant pharmacist dated 07/18/14 repeated the same recommendation for a blood thinner for Resident #17. The physician's response dated 08/28/14 read, "Has a hx (history) of falls. Not a candidate for warfarin (Coumadin). Should be on ASA (aspirin) 325 mg (milligram) qd (every day)." Per review of August physician orders and medication administration record, aspirin 325 mg was ordered on 08/28/14 and the resident received his first dose on 08/30/14 (102 days after the pharmacist's recommendation on 05/20/14). On 09/03/14 at 3:30 p.m. Staff Member B, the Director of Nursing, stated she could not find an order for Aspirin 81 mg in the resident's record after the 05/20/14 consultant pharmacist recommendation, and did not know why it was missed.	F 428	F 428 see previous page		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441			

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F 441 SS=E	Continued From page 72 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	F 441 Residents # 77 and 10 have been assessed. Acute infection has been ruled out. Licensed Nursing staff re-educated on infection control practices in relation to wound care to include criteria for hand washing, glove changing, and disinfecting equipment after use. All nursing staff educated on infection control practices in relation to retention catheter bag placement with hand washing requirements after handling resident items. NA staff educated on standard precautions to change gloves and wash hands if moving from one contaminated body part to another.	10/31/14	

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F 441	<p>Continued From page 73</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staff completed hand hygiene and/or changed gloves for 3 of 46 sample residents, after becoming soiled during a dressing change (Resident #77), handling urinary catheter tubing (Resident #2) and during a resident's bath (Resident #10). This failure put residents at risk for an environment that was not sanitary, and increased the chance of the spread of infection. Findings include:</p> <p>1. Resident #77. Admitted to the facility on [REDACTED] 14 with two deep pressure ulcers; one on the left hip and another on the right hip. A wound vacuum was present in both pressure wounds (to aid in healing). The resident had significant infections in the wounds, as well as a urinary infection, and was being treated with antibiotics.</p> <p>On 08/29/14 at approximately 1:00 p.m., Staff Member G, a Registered Nurse (RN), had prepared the resident for a dressing change. She put on gloves, turned off the wound vacuum machine using her gloved hand (potentially contaminating the glove), and then removed the resident's dressing and packing from the wound on the right hip. She then cleansed the wound, without changing gloves or washing her hands. The RN then placed a sterile gauze over the cleansed wound of the right hip with the same gloves (which were contaminated).</p> <p>When the dressing change was complete, Staff Member R, a Nursing Assistant (NA), assisted Staff Member G, to turn the resident. At this time, Staff Member G changed her gloves; however,</p>	F 441	<p>F 441 (b) Infection control rounds will be completed will be completed weekly. information will be reviewed at monthly QAPI meeting. DNS/designee to ensure compliance.</p>	

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F 441	<p>Continued From page 74</p> <p>she did not wash her hands. She then removed the dressing from the left hip, removed the tubing from the wound vacuum within the wound, removed an approximately 4 inch long by 1 inch wide strip of a black sponge dressing from the wound, and cleansed the wound and surrounding area. Without changing her gloves or washing her hands, she proceeded to pack and redress the wound using sterile supplies while wearing the same gloves used to remove the soiled dressing.</p> <p>During the dressing change, the RN used scissors to cut a small hole through both sides of a clear dressing (which was used to secure the tubing for the wound vacuum). After completion, she placed the scissors back into the resident's cupboard, without cleaning them. Staff Member G stated that they "keep the scissors for the next dressing change", and indicated no cleaning of scissors was necessary for the same resident.</p> <p>On 08/29/14 at approximately 2:30 p.m., the Director of Nursing (DNS) stated that all reusable equipment such as scissors should be cleaned with a disinfectant. She also said that according to the facility's policy on "Hand Hygiene", staff were required to use hand hygiene (wash their hands) before and after glove use, before and after dressing changes, and after any contact with resident body fluids.</p> <p>2. Resident #2. On 09/04/14 at 1:25 p.m. Resident #2's urinary catheter bag was observed from the hallway, uncovered, and laying on the floor. Staff Member RR, a Licensed Nurse, was observed at the resident's bedside talking to him. She touched the catheter tubing, and elevated the bag from the floor. She then set the tubing down,</p>	F 441	F 441 see previous page		

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	<p>Continued From page 75</p> <p>and the bag went back on the floor. At 1:33 p.m., when Staff Member RR exited the room, she carried an empty clear plastic cup in her hand, and was not observed to complete hand washing. The catheter bag was still lying on the floor.</p> <p>Per interview with Staff Member B, the DNS, on 09/05/14 at approximately 10:00 a.m., it was verified that correct placement of urinary catheter bags would not include direct placement on the floor.</p> <p>Placement of the uncovered catheter bag on the floor placed Resident #2 at risk for infection.</p> <p>3. Resident #10. On 09/02/14 between 11:40 a.m. and 12:20 p.m. Staff Member TT, a nursing assistant (NA), was observed to give Resident #10 a shower. The NA failed to change her gloves after washing a soiled body area, just prior to washing the resident's face.</p> <p>Staff Member TT was observed to apply a pair of gloves prior to starting the resident's shower at approximately 11:55 a.m., and did not remove the gloves until after drying the resident. During the shower, the NA washed the resident's genitals and buttocks with a wash cloth, then used a new wash cloth to wash the resident's face, without first changing her soiled gloves or washing her hands.</p> <p>Staff Member TT stated after the observation at 12:20 p.m. "Oh, I was supposed to wash the perineal area last and I did not."</p> <p>On 09/03/14 at 3:30 p.m. the DNS was informed of the observation during the shower on 09/02/14 with Resident #10 and she stated "the bath aide</p>		

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F 441	Continued From page 76 should have cleaned the perineal area last and or at least changed her gloves prior to washing his face." She also added that it was part of standard precautions and would provide the facility policy. The policy provided was a page from a nursing assistant training manual: "Standard Precautions, change gloves during care if your hands will move from a contaminated body site to a clean body site."	F 441	F 490 Refer to detailed plans of correction listed above for each of the F tags noted. <ol style="list-style-type: none"> Pain Management: Review monthly with DNS/designee the audit of timeliness of pain assessment, care planning, and updating of MAR. Medication Management: Review monthly with DNS/designee the audit of lab draws for anticoagulants and justification for anti-psychotic meds. Timely Treatment: Review monthly with DNS/designee the audit of Response time for treatment following an incident or accident. Accurate Diet: Review monthly audit with Dietary Services manager that allergies on the H & P match the tray cards/tray line list of cook/diet aide and items are not served. Reports included in QAPI meeting. 	10/13/14
F 490 SS=E	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 resources to ensure resident safety, health, and well-being related to pain management, medication management, timely care, and accurate diets. These failures resulted in substandard care and actual harm. Findings include: 1. Pain Management. a) For Resident #24, the facility failed to manage pain effectively during treatments and cares, resulting in pain for this resident over an approximate 6 week period. Refer to F309. Repeat citation from 2013.	F 490		

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F 490	<p>Continued From page 77</p> <p>b) For Resident #133, the facility failed to ensure the resident's pain was minimized through appropriate adjustment and proper use of her wheelchair, causing the resident, who had recently had hip surgery, pain through dangling legs. Refer to F309. Repeat citation from 2013.</p> <p>2. Medication Management.</p> <p>a) For Resident #129, the facility failed to ensure a system was in place to manage medications effectively, including blood thinner medication and anti-hypertensive medication, causing harm for the resident. Refer to F309. Repeat citation from 2013.</p> <p>b) Also for Resident #129, the facility failed to have adequate justification for the use of an anti-psychotic medication and to monitor the use of an anti-anxiety medication, resulting in harm to the resident from falls, weight loss and increased somnolence (drowsiness). Refer to F329. Repeat citation from 2011 and 2013.</p> <p>3. Timely Treatment. For Resident #9, the facility delayed treatment for approximately 8 hours for a significant head laceration sustained in a fall. The laceration required staples when eventually treated. The delay caused harm to the resident, who experienced pain, dizziness, and nausea while waiting for treatment. Refer to F309. Repeat citation from 2013.</p> <p>4. Accurate Diet. For Resident #136, the facility failed to ensure the resident did not receive foods containing bananas, a food the resident was known to be allergic to. Following ingestion of the bananas, the resident suffered an allergic reaction requiring treatment with medications for an allergic reaction and anxiety. Refer to F363.</p>	F 490	F 490 see previous page	