

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

PRINTED: 05/14/2013
FORM APPROVED
OMB NO. 0938-0391

1455

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2013
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NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - CLARKSTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1242 ELEVENTH STREET CLARKSTON, WA 99403
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Prestige Care & Rehabilitation - Clarkston on 04/29/2013, 04/30/2013, 05/01/2013, 05/02/2013, and 05/03/2013. A sample of 39 residents was selected from a census of 77. The sample included 32 current residents and the records of 7 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>XXXXXXXXXX, R.N., B.S.N. XXXXXXXXXX, R.N., B.S.N. XXXXXXXXXX, R.N., B.S.N. XXXXXXXXXX, R.N., B.S.N.</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Long-Term Support Administration Division of Residential Care Services, District 1, Unit B Rock Pointe Tower 316 West Boone Avenue, Suite 170 Spokane, Washington 99201-2351</p> <p>Telephone: (509) 323-7303 Fax: (509) 329-3993</p> <p><i>[Signature]</i> Residential Care Services</p>	F 000	<p style="font-size: 2em; text-align: center;">RECEIVED</p> <p style="text-align: center;">MAY 23 2013</p> <p style="text-align: center;">DSHS ADOSA RCS SPOKANE WA</p> <p>"This plan of correction is prepared and submitted as required by law. By submitting this plan of correction Prestige Care & Rehabilitation-Clarkston does not admit that the deficiency listed on this for exist, nor does the Center admit to any statements, findings, facts or conclusions the form the basis for the alleged deficiencies. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, facts and conclusions that form the basis for the deficiencies."</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X8) DATE 5/24/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide care and services in a manner that promoted and protected resident dignity and individuality, when the facility failed to ensure a dignified dining experience for 6 residents in the Robeson Dining Room.</p> <p>Findings include:</p> <p>1. Per observation on 04/29/13 at 4:35 p.m., staff began bringing residents into Robeson dining room. At 4:45 p.m., 6 residents who required assistance were seated with beverages in front of them, never being assisted to drink. At 5:41 p.m., after all other residents were seated in the Robeson dining room, the 6 residents were served. Almost an hour after being seated.</p> <p>At 4:45 p.m. a resident was brought into the dining room and staff referred to her as a "feeder". Staff placed cranberry juice, apple juice and water glasses in front of her, never offering her assistance to drink.</p> <p>2. Per observation on 05/1/13 at 11:45 a.m. the same 6 residents were seated in the Robeson dining room for lunch.</p> <p>At 11:55 a.m., two staff members were observed pointing at the 6 residents calling them</p>	F 241	<p>F241</p> <p>Residents that eat in the Robeson Dining Room (DR) are receiving care and services that promotes dignity and individuality.</p> <ol style="list-style-type: none"> 1) Current residents who are assisted by staff and eat in community DR's are receiving care and services that promote dignity and individuality. 2) Nursing Staff will serve Residents who need assistance first during serve out of meals. Staff will offer and assist with fluids as Residents wait for meals to be served. Staff have been re-educated on Resident Rights for Dignity, Individual choices and confidentiality. By the Social Services Director (SSD) or designee. <p>Resident Care Managers (RCM's) will daily audit the Dining rooms to include fluids being offered and dignity of Residents is being respected. Copies of the audits will be forwarded to the DNS for review and follow up if needed.</p>	6/1/13	

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F 241	Continued From page 2 "feeders," loud enough for anyone in the dining room to hear. Again the residents who required assistance were seated with beverages placed in front of them with no assistance offered. At 12:45 p.m., the residents were served. A full hour after they had been seated and after all other residents were served. During the meal one staff member asked the other "Is she a total feeder?" The other staff responded " yes, she is because she choked last week." This conversation was loud enough to be heard by residents and staff. On 05/03/13 at 11:15 a.m. it was confirmed by Staff #D this was not the expectation for the residents in Robeson dining room.	F 241	Continued from page 2 1) The DNS will track and trend the audit results and present findings to the Quality Assurance (QA) Committee, to identify opportunities for performance improvement, monthly x 3 months and randomly thereafter. 2) The Administrator will ensure compliance.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to allow 2 of 2 residents (#54, 65) in a sample of 39 the right to make choices regarding important daily routines, including accommodating preferences for a tub bath. This failure placed residents at risk for a diminished quality of life and poor hygiene.	F 242	F242 1) Residents #54 & #65 have had their preference for bathing established and In Room Care Plans (IRCP's) updated to reflect their wishes. 2) Current residents have been interviewed for their bathing preferences and IRCP's updated as necessary. 3) Certified Nursing Assistants (NAC's), have been re-educated on offering Resident choices and re-educated on reviewing In room care plans for information that contains residents preferences by the DNS or designee. New admissions will be asked bathing choices upon admit, by the Admission Nurse and IRCP updated.	6/1/13

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F 242 Continued From page 3
Findings include:

1. Resident #65 was admitted with diagnoses that included [REDACTED]. He was able to make his needs known and was independent in his activities of daily living (ADL) with set up needed for bathing.

Per record review, the right to choose between a tub bath, shower, or bed bath was very important to the resident.

Interview with the resident on 04/30/13 revealed he was not offered a tub bath. He stated he had asked about it and was told there was no bath tub. He stated he had not had a tub bath in years and would love to soak in one.

Per interview with Staff #G on 05/02/13 at 2:50 p.m., she stated she knew there was a bath tub downstairs but didn't know how to use it. When asked what she would do if a resident requested a tub bath she stated it would be really hard to do because that would take a nursing assistant off the floor.

Per interview with Staff #H on 05/02/13 at 4:00 p.m., she stated she thought the facility had a bath tub, but was not sure and felt if a resident wanted a tub bath they should be allowed one. She was informed of the resident's request for a tub bath and she stated she would make sure he was offered one that evening.

2. Resident #54 had diagnoses that included [REDACTED] and [REDACTED]. Per record review, the resident had no memory impairments and required extensive assist with most activities of daily living (ADL's).

Per interview on 4/30/13 at 9:30 a.m., the resident was asked "do you choose whether you take a shower, tub or bed bath?" The resident

F 242 Continued from page 3

Weekly Random Audits/Interviews to be performed by RCM's to assure Residents were given choices on bathing preferences. Copies of audit/interviews to be forwarded to the DNS for review and follow up, if needed.

- 4) The DNS will track and trend audit results and present findings to the QA Committee to identify opportunities for performance improvement, monthly x 3 months and randomly thereafter.
- 5) The Administrator will ensure compliance.

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F 242	Continued From page 4 responded no. She stated she only got showers and if she had a choice she would choose a bath. Per interview with Staff #G on 05/02/13 at 2:50 p.m. regarding resident's choice about showers and tub baths, she stated she knew there was a bath tub downstairs but didn't know how to use it. When asked what she would do if a resident requested a tub bath she stated it would be really hard to do because that would take a nursing assistant off the floor. Per interview with Staff #H on 05/02/13 at 4:00 p.m. she stated she thought the facility had a bath tub, but was not sure and felt if a resident wanted a tub bath they should be allowed one.	F 242		
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;	F 272	F272 1) Resident #25's oral cavity has been visually examined, and an appointment made with the Denturist. Care Plan (CP) and IRCP have been updated. 2) Current residents have had their Oral cavities, teeth, plates and dentures examined for abnormalities. Residents had appointments made for follow up, with outside services, if needed. 3) LN's have been re-educated upon initial and routine assessments to check the oral cavity for abnormalities and notify the MD/SSD/RD or appropriate outside agencies for follow up if needed by the DNS /designee. LN's and Department Mangers have been trained on the new Interdepartmental	6/1/13

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F 272 Continued From page 5
Skin conditions;
Activity pursuit;
Medications;
Special treatments and procedures;
Discharge potential;
Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and
Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined the facility failed to ensure an accurate and comprehensive assessment in 1 of 5 residents (#25) reviewed for nutritional assessment in a sample of 39.

Findings include:

Resident #25 was admitted to the facility on 05/13. Diagnoses included aftercare following [redacted], [redacted], [redacted], and [redacted].

Per record review of social services admission note it was recorded that the resident had his own teeth and needed an exam. In an interview with Staff #A regarding the recommendation for an exam she informed surveyor that she did not make an exam appointment and waited for the nutritionist or

F 272 Continued from page 5

Referral form to facilitate communication. Copies of completed form is to be provided to the DNS for review and follow up if needed.

The RCM's will do random weekly audits of resident oral cavities and interview residents for any chewing difficulties and forward copy of audits to the DNS for review and follow up if needed.

4) The DNS will tract and trend audit results and present findings to the QA Committee monthly, to identify opportunities for performance improvement, monthly x 3 months and randomly thereafter.

5) The Administrator will ensure compliance.

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F 272	<p>Continued From page 6</p> <p>nursing to make further recommendations for care.</p> <p>Per record review of physician note on 4/8/13 the physician noted the resident had difficulty in chewing.</p> <p>Per record review of the care plan the resident was identified as a nutritional risk related to renal disease, difficulty chewing, and leaving food on the plate uneaten. Interventions included thin liquids, renal diet, supplements and meal monitoring.</p> <p>Per record review of nutritional assessment completed on 4/11/13, the resident had chewing problems and dentures noted in report with mechanical soft diet recommended.</p> <p>During an interview with Resident #25 on 5/1/13 in his room, he was observed sitting in his wheelchair holding a pink bucket in his lap. The resident said he had dentures but they are "worn out, the bottoms are loose, the top fit ok, but they are worn out and I just can't eat anything."</p> <p>During an interview on 5/2/13 at 9:00 a.m. in supervisor office with Staff #C regarding the assessment she said she's known the resident from previous visits at the hospital and she knew he had one side of his denture that was bothering him. She said she had not spoken with him since he came to the facility but would place him on the list for this week.</p> <p>The resident was admitted on [redacted]/13 with diagnoses that included [redacted] and known chewing difficulties. The resident was placed on a mechanical soft diet. The facility failed to conduct an initial comprehensive and accurate assessment of the residents functional capacity related to his nutritional status. This failure placed the resident at risk for decreased quality of life, communication abilities and less than optimal</p>	F 272		

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F 272	Continued From page 7 nutritional intake.	F 272			
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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to re-evaluate and revise care plans for 3 of 16 residents reviewed for comfort care, dental services, and behavior (#84, 99, 150) in a sample of 39. Findings include: 1. Resident #99 had diagnoses including [REDACTED]. Per record review, the resident could make her needs known and required extensive assistance	F 280	F280 Resident # 99 has been assessed and included in the Care Plan process for her Psychosocial, Spiritual and care during medical emergencies. CP and IRCP have been updated to include resident choices and reflect current care needs. Resident # 150's mouth has been re-assessed and is without sores. An appointment was made with the Denturist for Denture relining. Resident # 84 has had a Plan developed. IRCP has been updated. 1) Current residents Care Plans and Behavior Monitors have been reviewed and updated to reflect resident current needs and interventions for staff to meet those needs. IRCP's updated. 2) Staff have been re-educated on monitoring behaviors and documentation on Prestige Care behavior monitors by the SSD. The new behavior monitors will be implemented on 6/1/13. RCM's, SSD, DNS will review residents receiving psychotropic medications and behaviors monthly, during the Psychotropic Drug Meeting. DNS or designee will do random weekly audits of resident Care Plans and IRCP's to ensure timely assessment and CP updates.	6/1/13	

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F 280	<p>Continued From page 8</p> <p>of 1 or 2 staff for activities of daily living.</p> <p>Review of physician visit notes dated 2/25/13, 3/5/13, and 4/24/13 revealed the resident had a [REDACTED] in the [REDACTED] that was currently not bothering her but was at risk to cause infection and skin breakdown in the future. The resident and family had decided not to have aggressive treatment for her medical condition with the focus of care on comfort measures.</p> <p>Per record review, there was no evaluation and update of the resident's care plan, including updating the comfort care choices on the resident's plan for medical emergencies, psychosocial, and spiritual needs. In addition, there was no care plan for the [REDACTED].</p> <p>In an interview on 5/1/13 at 1:50 p.m., Staff #A stated she was aware of the resident's status and periodically visited the resident. Upon review of the resident's care plan, she confirmed she did not develop and document social services interventions related to providing psychosocial support.</p> <p>In an interview on 5/2/13 at 9:00 a.m., Staff #D confirmed the resident's care plan and choices for services were not consistently evaluated and updated.</p> <p>The resident was placed at risk for not having her choices for care consistently implemented by the facility.</p> <p>2. Resident #150 had diagnoses that included a [REDACTED] and [REDACTED]. Per record review, the resident had no memory impairment and was able to make his needs known. He required extensive assist with most activities of daily living (ADL's).</p>	F 280	<p>Continued from page 8</p> <ol style="list-style-type: none"> 1) The DNS will track and trend audit results and report findings to the QA Committee to identify opportunities for performance improvement, monthly x 3 months and randomly thereafter. 2) The Administrator will ensure compliance. 		

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Per record review, an admission assessment dated 4/13/13 identified the resident had upper and lower dentures that fit well and caused him no distress.

In an interview on 4/29/13 at 4:00 p.m., the resident was asked if he had mouth/facial pain. He answered, "yes" and stated he had sores on his gums from his dentures. He stated he had loose fitting dentures prior to admission and the sores have been getting worse and have caused more pain with chewing anything tough.

Per record review, there was no evaluation and update of the resident's plan of care for poorly fitting dentures and mouth sores.

On 5/2/13 at 11:10 a.m., Staff #K was interviewed and stated she knew the resident didn't like to wear his dentures because it made his mouth sore. She stated she reported the information to the nurse.

In an interview on 5/2/13 at 4:00 p.m., Staff #L stated he was aware the resident had sores on his gums. He stated he had him take his dentures out to give his gums some relief and if that didn't help he would report it to the nurse.

The facility failed to evaluate the resident's poor fitting dentures and mouth sores which caused the resident pain while eating.

3. Resident # 84 was admitted with diagnoses that included ~~Alzheimer's disease~~, ~~depression~~, and ~~anxiety~~. She was ~~unable to communicate~~ and unable to consistently make her needs known.

Per record review of progress notes, the resident had a new order on 02/28/13 for ~~gabapentin~~ (~~gabapentin~~ medication) as needed for ~~anxiety~~ and ~~pain~~.

Per observations on 04/29/13, 04/30/13,

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F 280	Continued From page 10 05/01/13, and 05/02/13, Resident #84 was in her bed crying and tearful. Staff were observed going into the resident's room, but no consistent methods interventions for the resident's behaviors were observed. Per record review, Resident #84 was given 30 doses of medication in the month of April 2013 for increased anxiety . Record review of the behavior monitoring sheet for the resident was found to be blank for the month of April 2013. Per record review, no care plan was in place for the resident's anxiety . Per interview on 05/02/13 at 11:00 a.m., Staff # H stated her expectation would be the staff would have recorded behaviors on the behavior monitoring sheet. She confirmed there was no care plan regarding anxiety.	F 280			
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to consistently follow the plan of care for 5 of 15 residents(#1, 2, 14, 65, 84) reviewed for activities of daily living (ADL) and unnecessary drugs in a sample of 39. This failure put the residents at risk for diminished quality of life and poor hygiene. Findings include:	F 282	F282 1) Resident #65 has received a shower and had his hair washed. Resident #84 has had a shower, nail care and chin hair trimmed. Resident #1 & # 2 have had oral care provided as needed to keep oral cavity moist. Resident # 14's Behavior Monitor reflects staff monitoring for delusional behavior's and hallucinations. 2) Current residents bathing preferences, ADL needs and and behavioral monitoring have been reviewed and Care Plans / IRCP's updated as needed. 3) NAC's and LN's re-educated on documenting showers including	6/1/13	

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1. Resident # 65 was admitted with diagnoses that included ██████████ and ██████████. The resident was able to make his needs known.

Per record review of resident's care plan dated ████████/13, the goal was for the resident to be neat and clean in appearance everyday. The staff were to offer shower/bath with nail care 2 times per week and as needed. Staff was to chart R for refusals on the ADL flow sheet.

Per record review of ADL flow sheet dated 03/01/13 thru 03/31/13, Resident #65 was offered a shower once during the entire month of March on 03/12/13. There was no documentation of any refusals during the month. Per review of nurse progress notes for the month of March nothing was found regarding resident refusals.

Per interview on 05/02/13, Resident #65 stated he thought he was offered a shower every couple of weeks and he couldn't remember the last time he had been offered a shower. His hair was greasy and appeared dirty.

Per interview on 05/02/13 at 11:00 a.m., Staff #N stated each nursing assistant is responsible for their assigned resident's showers. If they cannot get to them they report to evening shift and if a resident refuses they chart and tell the nurse responsible for that resident.

Per interview with Staff #O on 05/03/13 at 9:20 a.m., she stated if a nursing assistant tells the nurse the resident refused a bath/shower the nurse charts in the progress notes.

Residents #65 had a care plan in place for shower/bath and the facility failed to consistently implement the plan of care. This failure resulted in residents not receiving consistent bathing and grooming.

2. Resident # 84 was admitted on ████████/13 with

F 282

ones given and ones refused, notifying next shift to offer bathing as well as notifying LN with each refusal, and documentation of behaviors, by the DNS or designee. Oral Care competencies completed with NAC's and re-educated on policy of oral care and to document refusals as well as notify the LN of refusals by the DNS or designee. Care Plan's updated to reflect individualized care plans. RCM's to complete weekly random audits for provision of oral care, ADL assistance, baths/shower completion with documentation as well behavioral documentation. Copies of audits will be forwarded to the DNS for review and follow up as needed.

RCM's will complete random weekly audits of resident care to ensure completion of oral care, shower/bath given or refusal documented, and documentation on behavior sheets completion. Copies of audits will be forwarded to the DNS for review and follow up if needed.

4) The DNS will track and trend audit findings and present results to the QA

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diagnoses that included ~~_____~~ and ~~_____~~. She was ~~_____~~ and unable to make her needs known. Per record review, the resident required total assist for her activities of daily living (ADL).

Per record review, the resident's care plan indicated the resident was to be offered a shower/bath 2 times per week with nail care and as needed. Staff was to chart refusals on the ADL flow sheet.

Per record review of ADL flow sheet and Point of Care tracking form, Resident #84 had not had shower/bath between 03/27/13 and 04/15/13. No refusals were charted on the flow sheets or in the nurse progress notes.

Per observation on 04/29/13, 04/30/13, 05/01/13, 05/02/13 the resident had long white facial hair on her chin.

Per interview on 05/02/13 with Staff #N at 11:00 a.m., she stated a shower or bed bath included head to toe washing, nail care, and facial hair removal. When asked what happened when residents refuse, she stated after reproaching the resident she would inform nurse of refusal.

Residents #84 had a care plan in place for shower/bath and the facility failed to consistently implement the plan of care. This failure resulted in residents not receiving consistent bathing and grooming.

3. Resident #1 had diagnoses including ~~_____~~ ~~_____~~. Per record review, the resident was ~~_____~~ had ~~_____~~, and required the total assistance of 1-2 staff for all activities of daily living. The resident was unable to safely swallow and had tube feedings for all nutrition and fluids.

Review of the resident's care plan for mouth

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Committee to identify opportunities for performance improvement monthly x 3 months and randomly thereafter.

5) The Administrator will ensure compliance. Committee to identify opportunities for performance improvement monthly x 3 months and randomly thereafter.

6) The Administrator will ensure compliance.

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F 282 Continued From page 13

care directed staff to provide total assistance with no additional information about the resident's individualized needs.

During observation of medication pass with Staff #I on 4/30/13 at 11:30 a.m., the resident had no teeth and frequently protruded her tongue with her mouth otherwise closed. Her lips were dry, cracked and coated with a white film. Staff #I did not provide any treatment to the dry lips, and did not instruct nursing assistants to provide oral care.

On 5/1/13 at 10:30 a.m. and 4:00 p.m., the resident had dry, flaky skin on her lips. Chap stick was on the bedside table.

Similar observations of the resident's mouth were made on 5/2/13 at 8:40 a.m.

At 8:45 a.m., Staff #E stated the dry skin should be easily removed using a washcloth and confirmed staff should be providing this care daily.

At 9:25 a.m., Staff #F provided mouth care using moistened toothette sponges. He moistened her lips with a toothette but the resident would not open her mouth. The surveyor asked Staff #F about using a wash cloth. Staff #F stated he saw the nurses do that but it seemed to make the resident's lips bleed a bit. He stated he tried to perform mouth care several times on 4/30/13 as well but the resident would not open her mouth.

On 5/2/13 at 4:00 p.m., Staff #D stated she observed another nursing assistant provide mouth care and the resident cooperated and opened her mouth.

The facility's failure to consistently provide daily mouth care as planned resulted in the resident having dry, cracked lips and mouth.

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F 282

4. Resident #2 had diagnoses including ~~performed in the past~~ disabilities. Per record review, the resident was ~~unable to speak~~, had ~~provision~~, and required the total assistance of 1-2 staff for all activities of daily living, including eating and mouth care.

Review of the resident's care plan for oral care directed staff to provide total assistance with no additional information about the resident's individualized needs.

On 5/1/13 at 11:00 a.m. and 4:00 p.m., the resident had dry lips coated with a white film.

On 5/2/13 at 8:40 a.m., the resident again had dry, coated lips.

At 8:45 a.m., Staff #E stated the dry skin should be easily removed using a washcloth and confirmed staff should be providing this care daily.

At 9:25 a.m., Staff #F used a moist wash cloth to remove most of the dry skin on the resident's lips, except for the left lower lip. The resident refused to open her mouth for mouth care.

On 5/2/13 at 4:00 p.m., Staff #D stated she observed another nursing assistant provide mouth care and the resident cooperated and opened her mouth.

The facility's failure to consistently provide daily oral care as planned placed the resident at risk for dry, cracked lips and mouth.

5. Resident #14 had diagnoses that included ~~depression~~, ~~depression~~ and ~~psychosis~~ with ~~delusions~~ and ~~delusions~~. Per record review, the resident was confused and had difficulty making his needs known. The resident required extensive assist with most activities of daily living.

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Per review of the medication administration record (MAR), the resident received an [redacted] medication twice a day and an [redacted] daily.
Per record review, the resident had an appointment with mental health January 2013 due to an increase in his [redacted] and being more difficult with cares. It was noted by the provider that the resident had a dramatic decrease in his [redacted] medication and the recommendation was to move his medication back to twice a day.
Review of the behavior monitors for March and April 2013 showed no behaviors had been documented. Per review of progress notes, there was no documentation showing an increase in his [redacted] or how he adjusted to his medication changes.
Per review of the resident's plan of care, staff was instructed to monitor the residents behavior and response to medications as well as monitor the resident's functional status every day.
In an interview on 5/1/13 at 1:50 p.m., Staff #A confirmed there was a lack of information on the behavior monitors.

F 282

F 309
SS=G 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

F 309

F309

- 1) Resident #59 is no longer a resident in the facility. Resident # 54's medication's were reviewed and is now on a stool softener twice per day to assist in prevention of constipation.
- 2) Current residents have been reviewed for constipation and skin risks. Physician notification,

6/1/13

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F 309	<p>Continued From page 16</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 necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care related to bowel management and skin conditions for 2 of 2 residents (#54, 59) in a sample of 39.</p> <p>The facility's failure to consistently monitor Resident #59's bowel pattern and implement timely interventions resulted in the resident suffering harm from fecal incontinence, increased anxiety, restlessness, and delirium.</p> <p>Findings include:</p> <p>Bowel Management</p> <p>The facility Bowel Protocol included the following interventions:</p> <ul style="list-style-type: none"> - Bowel records are monitored on a daily basis. -Residents who have not had a bowel movement (BM) in 3 days (9 shifts) will be given Milk of Magnesia (MOM) at bedtime. -If no bowel movement by the following morning (10 shifts) a Dulcolax suppository is given. -If resident continues without BM a Fleets enema will be given the afternoon of the 4th day (12 shifts). -If resident exceeds 4 days without a BM the physician will be notified for further orders. 	F 309	<p>Continued from page 16</p> <p>new orders received, CP's and IRCP's updated as needed.</p> <p>3) LN's were re-educated on notification to family and MD when current Plan of care is not effective. Re-educated LN's on types of medications which are at highest risk for constipating effects and following the facility bowel protocol. NAC's re-educated on documentation of BM's in Point of Care (POC) every shift.</p> <p>RCM's and IDT (Interdisciplinary Team) will review new resident medications, during the morning MACC (Managing Acute Condition Changes) meeting for routine bowel medications. Facility bowel program list to be reviewed by the IDT, the next business day, for compliance of following bowel program.</p> <p>4) DNS will track and trend compliance and report findings to the QA Committee to identify performance improvement opportunities monthly x 3 months and randomly thereafter.</p> <p>5) The Administrator will ensure compliance.</p>	
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F 309	Continued From page 17 1. Per record review, Resident #59 was receiving [redacted]. The resident had [redacted] and required total assistance of 1-2 staff for all activities of daily living. The resident was refusing solid food and was drinking small amounts of health shakes, supplements, and water. Review of the resident's medications noted physician orders for [redacted] patches and as needed [redacted], which the resident received daily. [redacted] was a common side-effect of both medications. Review of the April 2013 bowel records noted the resident had no BM from 4/6 until 4/14/13 (7 days) when a licensed nurse administered MOM. Nurse's notes dated 4/12/13 and 4/13/13 noted the resident did not have a distended abdomen with no additional evaluation regarding why the resident did not receive medication or why the physician was not notified (per the Bowel Protocol). Additional review of the April 2013 bowel record noted the resident had no BM and no bowel medications per the Bowel Protocol from 4/16/13 through 4/22/13 (6 days). A nurse's note dated 4/23/13 on the night shift noted the presence of hard BM present in the rectum. The resident received a [redacted] suppository at that time. There was no results/effectiveness of the suppository documented until the night shift of 4/24/13 when the licensed nurse administered a Fleets enema due to no results from the suppository for 24 hours. Per the nurse's note, the resident was "seeping" stool. There was no results/effectiveness of the Fleets enema documented until the night shift of	F 309			

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4/25/13 when the licensed nurse noted she asked the resident if he needed to have a BM and he replied "no." The night shift licensed nurse noted she left a communication for the day shift staff to ask the family if they wanted further bowel program interventions. There was no communication to the physician.

Per record review, the resident had a small and medium BM on 4/25 and 4/26/13.

Per record review, during the night shift on 4/28/13, the resident was "~~unresponsive~~ and ~~unresponsive~~" and had a large amount of BM he could not ~~pass~~. He "appeared uncomfortable and was groaning." The licensed nurse ~~assess~~ an ~~unresponsive BM~~ and gave a ~~laxative~~, MOM, and 2 doses of as needed ~~laxative~~ during the shift. The resident had a small bleeding skin tear from the amount of impacted BM. The licensed nurse sent a Fax to the physician notifying him of the resident's impaction and requesting routine bowel medications.

On 5/2/13, Staff #D was informed of the lack of monitoring and intervention to ~~prevent~~ ~~impaction~~. After record review, Staff #D confirmed facility staff did not consistently implement the Bowel Protocol and had no additional information to offer.

The facility's failure to consistently monitor and implement Bowel Protocol interventions for the resident who could not make his needs known resulted in harm.

2. Resident #54 had diagnoses that included ~~Alzheimer's~~, ~~dementia~~, and ~~depression~~. Per record review, the resident had no memory problems and was able to make her needs known. She required extensive assist with activities of daily living (ADL's).

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Review of the April 2013 bowel records noted the resident had no bowel movement (BM) from 4/10/13 night shift until 4/15/13 evening shift (5 1/2 days). No medication was administered to the resident and the physician was not notified per the Bowel Protocol.

Additional review of the April 2013 bowel record noted the resident had no BM from 4/16/13 night shift through 4/20/13 day shift (4 1/2 days). It was documented the resident had a small BM on 4/20/13, received a [REDACTED] suppository on 4/21/13 and then had a large BM on 4/21/13 day shift.

A nurse's note on 4/22/13 noted that the resident had problems with [REDACTED] and the physician was faxed for an order for a routine bowel medication. The physician ordered [REDACTED] to be given once a day and the resident received her first dose of [REDACTED] on 4/23/13 a.m.

Further review of the April 2013 bowel record, the resident had no BM from 4/24/13 evening shift until 4/29/13 day shift (over 4 days). On the 4th day she was offered and refused some Milk of Magnesia (MOM). She was then given a [REDACTED] 4/29/13 on night shift of the 5th day and had a large BM on 4/29/13 day shift.

On 5/3/13, Staff #D confirmed facility staff did not consistently implement the Bowel Protocol and had no additional information to offer.

The facility failed to consistently monitor and implement the Bowel Protocol which placed the resident at risk for an impaction.

Skin Condition

Per record review, Resident #59 was receiving [REDACTED]. The resident had [REDACTED] and required total assistance of 1-2

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staff for all activities of daily living. The resident had a ~~_____~~ and ~~_____~~.

Per record review, on 4/21/13 the resident was scratching at his skin, the physician was notified, and ordered an as needed medication which had helped before. On 4/22/13, the resident developed a small open area at the ~~_____~~ with a 7x5 centimeter (cm) red area around the open area, possibly related to scratching the area.

Per record review, the resident received the medication for itching on 5 of 8 days between 4/22/13 through 4/30/13.

A night shift nurse's note dated 5/2/13 noted the resident removed his hip dressing, and was scratching the open area which had increased in size and was inflamed.

On 5/2/13 at 1055 a.m., the resident was uncovered and laying on his back. He had removed the dressing to the ~~_____~~ exposing a superficial open area with dark brown drainage in front of an ~~_____~~. The resident had red scratch marks of the ~~_____~~ and ~~_____~~ and periodically scratched the ~~_____~~. Staff was informed.

Staff #M was interviewed after providing wound care. Staff #M stated the resident had intermittent problems with itching since admission several months earlier.

Later the same day, Staff #E confirmed the ~~_____~~ condition was worse due to scratching and the physician had not previously been notified that despite the current ordered medication, the resident continued itching.

The facility's failure to consistently monitor and take action to control the resident's itching. This contributed to continued discomfort and

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/03/2013
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NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - CLARKSTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1242 ELEVENTH STREET CLARKSTON, WA 99403
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F 309	Continued From page 21 worsening of the [redacted] condition.	F 309	F 318	6/1/13
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure 1 of 3 residents (#63) reviewed with limited range of motion received treatment to increase range of motion and/or prevent further decline in a sample of 39. Findings include: Resident #63 had diagnoses that included history of a [redacted] and [redacted]. Per record review, the resident had [redacted] and was not able to make her needs known. She was totally dependent with activities of daily living (ADL'S). Per record review, a Physical Therapy (PT) evaluation on 6/1/12 identified the resident was [redacted] and [redacted]. Per record review, on 10/29/12 a restorative evaluation was done and the resident was provided with passive range of motion (PROM) to [redacted]. Nothing was mentioned about the resident's upper extremities. In an interview on 5/2/13 at 11:10 a.m., Staff #K stated the resident was real stiff in her arms	F 318	<ol style="list-style-type: none"> 1) Resident #63 is receiving OT and will be evaluated for ability to tolerate a Passive Range of Motion (PROM)Program to upper extremities (UE). 2) Current residents identified with contractures and/or limited Range of Motion (ROM) has been reviewed for need of PROM programs to prevent decline or promote increased functional ability. CP's and IRCP's have been updated to reflect any changes. 3) RCM's have been educated on the Restorative Nursing P & P's by the DNS. NAC's have been re-educated on the importance of providing Restorative nursing programs to help maintain resident's functional ability to complete ADL's. RCM's will evaluate each resident, quarterly and with change in condition, for effectiveness of Restorative Nursing Programs with the RAI process/schedule. 4) The DNS or designee will do monthly random audits of Quarterly and Change of Condition Nursing Assessments to ensure residents are receiving Restorative Nursing Programs to assist in maintaining the functional ability of each individual resident. The DNS will track and trend the results 	6/1/13

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F 318 Continued From page 22
and her legs. She stated she experienced pain when she was dressed.
On 5/2/13 at 4:10 p.m., Staff #L stated the resident had contractures in both her arms and her legs. He stated she was real stiff when he got her dressed and had been that way since he was hired about a year ago.
On 5/3/13 at 9:20 a.m., Staff #H stated she did a quick assessment and found the resident maybe had 35% to 40% muscle tone in her upper arms which had been a decline since admission. She ordered Occupational Therapy (OT) to come and evaluate the resident.
The facility failed to ensure the resident received services to prevent further decline in range of motion of her upper extremities which placed her at risk for discomfort and worsening contractures.

F 318 Continued from page 22

individual resident. The DNS will track and trend the results of audits and present findings to the QA Committee to identify opportunities for performance improvement monthly x 3 months and randomly thereafter.

5) The Administrator will ensure compliance.

F 431 SS=E 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

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

In accordance with State and Federal laws, the

F 431

F431
1) There were no residents identified.
2) There were no residents adversely affected.
3) LN's were re-educated on proper security of medication storage including the "Standards of Practice" which would include locking of medication carts by the DNS or designee. RCM's will conduct random daily audits for locking of medication carts and forward results to the DNS.
4) The DNS will track and trend the audit results and present findings to the QA Committee to identify opportunities for performance monthly x 3 months and randomly thereafter

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F 431	<p>Continued From page 23</p> <p>facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the Cabin Cove medication cart was consistently locked when unattended by licensed nurses. Failure to consistently secure medications potentially allowed residents and visitors in Cabin Cove access to potentially harmful medications.</p> <p>Findings include:</p> <p>Cabin Cove included resident rooms 201 through 219.</p> <p>Per observation on 04/29/13 at 1:30 p.m. the Cabin Cove medication cart was observed to be unlocked, Staff # E was behind the nurse's station out of view of the cart. Staff # E was informed and the medication cart was locked.</p> <p>Per observation on 05/02/13 at 10:26 a.m. the Cabin Cove medication cart was observed</p>	F 431	<p>Continued from page 23</p> <p>5) The Administrator will ensure compliance.</p>	
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F 431	<p>Continued From page 24</p> <p>unlocked, Staff# M was behind the nurse's station out of view of the cart. Staff # M was informed and the cart was locked.</p> <p>Medication/treatment carts are to be locked and/or in full view of the licensed nurse in order to be considered secure from possible misuse or accidental ingestion by residents.</p>	F 431		
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