

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

PRINTED: 07/23/2014
FORM APPROVED
OMB NO. 0938-0391

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 07/15/2014
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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 and Rehabilitation-Clarkston on 7/8/14, 7/9/14, 7/10/14, 7/11/14, 7/14/14, and 7/15/14. A sample of 33 residents was selected from a census of 76. The sample included 24 current residents, the records of 9 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>Jessica Dingwall, M.S.W. Lisa Harting, R.N. Colleen Daniels, R.N. Kathleen Robl, R.N. Linda Loffredo, R.N.</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Long-Term Support Administration Residential Care Services, District 1, Unit B 316 W. Boone Avenue, Suite 170 Spokane, Washington, 99201-2351</p> <p>Telephone: (509) 323-7303 Fax: (509) 329-3993</p> <p><i>[Signature]</i> 7/23/14 Residential Care Services Date</p>	F 000	<p style="text-align: center;">RECEIVED AUG 05 2014 DSHS ADSA 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	(X6) DATE 8/6/2014
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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 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; 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.	F 272	F 272 1) Resident #100 & 129 are no longer residents of the facility. 2) Current residents admitted within the last 30 days have been reviewed for urinary continence status. Urinary assessment and care plans updated. Residents who showed a decline in their continence status have been reviewed for appropriateness of a toileting program and/or referred to OT for evaluation and treatment. 3) Resident Care Manager's (RCM's), Licenced Nurses (LN's) and Nursing Assistants (NAC's) educated on documentation in POC for urinary continence status to track residents patterns on initial admit and during entire stay at facility, by the Director of Nursing Services (DNS) or designee. RCM's educated to assess urinary continence upon admit and proceed with care plan based off the MDS CAA's by the DNS or designee.	8/28/14
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F 272	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to complete accurate comprehensive assessments for urinary incontinence for 2 of 2 residents reviewed for urinary incontinence (#100, 129) in a sample of 33. The lack of an accurate comprehensive assessment placed the residents at risk for a lack of consistent interventions to treat urinary incontinence. Findings include: 1. Resident #129 no longer resided in the facility. Per record review, the resident was admitted [REDACTED] 14 with diagnoses including pneumonia and a decline in activities of daily living. Review of the facility assessments dated 2/3/14, 2/10/14, and 2/24/14 revealed the resident was continent of urine and needed extensive assistance with mobility and toileting. Review of nursing progress notes dated 1/29, 2/7, 2/9, 2/13, and 2/16/14 revealed the resident was both continent/incontinent of urine, especially incontinent at night. According to review of the resident's clinical record, there was no evaluation of urinary incontinence to determine if the resident would benefit from a toileting program to decrease episodes of incontinence. In a interview on 7/14/14 at 3:45 p.m., Staff #C and #N reviewed the resident's record and confirmed the resident's comprehensive urinary assessment was inaccurate and the facility did not implement consistent interventions for the incontinence. 2. Resident #100 was admitted on [REDACTED] 14 with diagnoses of pneumonia, history of urinary tract	F 272	Quarterly assessment will be documented in the quarterly nursing assessment, by the RCM's. Audit form created for RCM's to track urinary continence findings, and results will be forwarded to the DNS for review and follow-u if needed. Care plan's will be updated, as needed including potential for initiation of toileting program, if appropriate, based off of audit findings. RCM's, LN's and NAC's have been reeducated on "care plan trigger form" by the DNS or designee. 4) DNS or designee will track and trend audit results and report findings to the QA Committee to identify performance improvement opportunities monthly x 3 months and randomly thereafter. 5) QA committee will ensure compliance	
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F 272	<p>Continued From page 3</p> <p>infections and [REDACTED]. The resident needed extensive assistance with transfers, bed mobility, toileting, hygiene and was able to make her needs known.</p> <p>Per the transferring hospital history and physical, the resident was continent of urine.</p> <p>Nursing admission notes from [REDACTED] 14, noted the resident was continent of bladder and wore a pad for dribbles.</p> <p>Per record review on 1/27/14, an admission assessment noted the resident was also continent of urine.</p> <p>On 2/17/14, per assessment, the resident was occasionally incontinent of urine and still required extensive assistance.</p> <p>In review of the care plan, there was no plan or intervention in regards to urinary incontinence.</p> <p>On 4/29/14, Staff #K initiated a nursing quarterly assessment, the section to address changes in incontinence, why the change, interventions and resident response, toileting plan and effectiveness was not completed.</p> <p>On 7/14/14, 12:00 p.m., Staff #E stated there should be an assessment for urinary incontinence and she was not able to find one for Resident #100. Staff #E was unable to identify why the resident was incontinent of urine or how frequently it occurred.</p> <p>On 7/14/14 at 2:13 p.m., Staff #D stated the nursing aides do not have a system set up currently to track if a resident was incontinent and that should be monitored.</p> <p>The facility failed to provide residents with a comprehensive assessment to identify the reason for their urinary incontinence and to develop a care plan to provide appropriate care and services. This lack of assessment placed the residents at risk for a decline of bladder function.</p>	F 272		
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F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to revise a care plan for 1 of 3 residents (#47) reviewed in a sample of 33 related to hearing. The resident was at risk for a decline in function and lack of communication. Findings include: Per record review, Resident #47 had diagnoses of diabetes, [REDACTED] [REDACTED] She was able to make her needs known and required extensive assist with all activities of daily living (ADL's). The resident's annual assessment dated 5/1/14, noted that she wore a hearing aid. A</p>	F 280	<p>F 280</p> <ol style="list-style-type: none"> 1) Resident #47 received new batteries for her hearing aids. NAC's and LN's have been reeducated to offer resident her hearing aid from the nurse's cart every day, by the DNS or designee. Care Plan was reviewed and updated. 2) All current residents have been reviewed for hearing impairment. Those residents which have hearing impairments have been reviewed for need of interventions. Interventions implemented as needed and care plans updated. 3) RCM's, LN's and NAC's reeducated on Prestige policy on care planning by the DNS or designee. RCM's, LN's and NAC's reeducated on "care plan trigger form" utilization which would inform the appropriate discipline when a change has occurred so the Care plan can be reviewed 	8/28/14
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F 280	<p>Continued From page 5</p> <p>comprehensive care plan dated 5/2/14 directed staff to check that the resident's hearing aid was clean, functioning, and properly in place in her left ear.</p> <p>Physician orders instructed facility staff to place the resident's hearing aid in the medicine cart at bedtime after removing; to return it to the resident in the morning and assist with placement in her ear. Special instructions were included that stated the resident kept the hearing aid at her bedside at night.</p> <p>An activities progress note on 5/20/14 noted the resident had a hearing aid for her left ear, but often would not wear it.</p> <p>Nursing Progress Notes on 6/10/14, 6/26/14, 7/3/14 noted that the resident was refusing her hearing aid. There was no evaluation regarding why the resident refused to wear her hearing aid.</p> <p>In an interview on 7/9/14 at 9:15 a.m., during which the surveyor had to speak very loudly into Resident #47's ear and repeat questions multiple times, the resident stated that she had not wore her hearing aid because it needed new batteries. She said her niece had paid for them but the resident needed to order them at Miracle Ear and she kept forgetting.</p> <p>On 7/11/14 during continuous observation from 7:16 a.m. to 7:50 a.m., Staff #F, #G, and #H provided morning care for the resident and did not offer the resident her hearing aid. At 7:50 a.m., the resident was taken to the dining room for breakfast with no hearing aid in place.</p> <p>On 7/14/14 at 12:06 p.m., Staff #I stated that Resident #47 refused to wear her hearing aid. She then located the resident's hearing aid in a drawer of a locked medicine cart.</p> <p>On 7/14/14 at 1:43 p.m., Staff #J stated that Resident #47 had not worn her hearing aid since she had started working there. She did not know</p>	F 280	<p>and update as needed by the DNS or designee. RCM's have been reeducated to utilize the IDT form used on a quarterly basis to assure care plan is appropriate and up to date.</p> <p>4) DNS or designee will track and trend IDT results and report findings to the QA committee to identify performance improvement opportunities monthly x 3 months and randomly thereafter.</p> <p>5) DNS will ensure compliance.</p>	
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F 280	Continued From page 6 why. In a follow up interview on 7/14/14 at 2:03 p.m., Staff #J stated she had just spoken with the resident and the resident stated she would consider wearing her hearing aid when the battery was replaced. On 7/14/14 at 4:20 p.m., Resident #47 was observed sitting in her wheelchair in her room. A hearing aid was observed in the resident's left ear. When asked by the surveyor about her hearing aid, the resident smiled and stated a nurse had brought it to her this afternoon and told her it was working now. The resident stated she could hear well and she was very happy about it. Failure of the facility to re-evaluate and revise Resident #47's plan of care in regards to her hearing aid resulted in impaired communication due to the resident not being able to hear adequately.	F 280		
F 285 SS=E	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2) (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility;	F 285	F285 1) Resident #23 is no longer in facility. 2) Resident #46, #74 and #124 have had new PASRR assessments conducted and were sent to their physicians for Level 1 PASRR reviews or to state approved PASRR reviewer for further assessment for Level 2 assessments. 3) RCM's and LN's educated on proper PASSR protocol and all	8/28/14



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F 285	<p>Continued From page 7</p> <p>and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>For purposes of this section:</p> <p>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).</p> <p>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, it was determined the facility failed to ensure the Pre-Admission Screening and Resident Review (PASRR) assessments were accurately completed for 4 of 7 (#23, 46, 74, 124) in a sample of 33 residents reviewed for PASRR completion. Failure to ensure PASRR's were done and/or accurately completed placed residents a risk for not receiving timely and necessary specialized services to meet their mental health needs. Findings include:</p>	F 285	<p>new PASSR's are to be submitted to Social Services Director (SSD) day of admission. All current resident's PASSRs were audited to ensure that they were appropriate for current resident. SSD will audit all PASRR assessments weekly x4 and then monthly x3 and then on a quarterly basis. Quarterly audit will be documented in SSD notes. Audit spreadsheet has been developed.</p> <p>4) SSD will track compliance and report findings to the QA Committee to identify performance improvement opportunities monthly x3 months and randomly thereafter.</p> <p>5) DNS will ensure compliance.</p>	

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F 285	Continued From page 8 1. Resident #23 was admitted on [REDACTED] 14 and per the facility assessment had diagnoses of [REDACTED] On 4/15/14 a PASRR was completed which also reported the resident had a mood disorder in section I. Section II would then be required to have a advanced categorical determination checked and must have an attending physicians approval and signature. The PASRR section II had checked 30 day care would be provided, but there was not approval by a physician. Section III marked no Level II evaluation required. This form was not accurately filled out since the 30 day care was marked and there was no approval from the physician. Also, the PASRR form was not re-evaluated after the resident had been in the facility for over 30 days (which would of been 5/14/14). Per the facility behavior monitor form for the month of May 2014, Resident #23 had multiple episodes of anxiety exhibited by crying and anxious statements for 24 out of 31 days. On 7/10/14 at 2:20 p.m., Staff #A reported the resident had not been able to meet her therapy goals while in the facility due to her anxiety. 2. Resident #46 was admitted on [REDACTED] 13 and per the facility assessment had diagnoses of [REDACTED] On 5/1/13 a PASRR was completed which also reported the resident had a mood disorder and anxiety disorder in section I. Section II marked a 30 day care determination with physicians approval and signature on 5/2/13. Section III indicated no Level II evaluation required. The PASRR form was not re-evaluated after the resident had been in the facility for over 30 days (which would of been 6/14/13).	F 285			

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F 285	<p>Continued From page 9</p> <p>Per the facility behavior monitor form for the month of May and June 2014, the resident had behaviors of [REDACTED] and insomnia.</p> <p>3. Resident #74 was admitted on [REDACTED] 14 and per the facility assessment had a diagnosis of an anxiety disorder.</p> <p>On 5/9/14 a PASRR was completed which also reported the resident had an [REDACTED] in section I. Section II determined the resident would be in the facility for 30 days care and was approved and signed by the physician on 5/9/14. Section III determined that no Level II evaluation was required. The PASRR form was not re-evaluated after the resident had been in the facility for over 30 days (which would of been 6/8/14).</p> <p>Resident #46 was re-admitted on [REDACTED] 14 after a brief time out of the facility and a PASRR form was not completed until 7/10/14 and it was determined the resident continued to have a mental health indicator of a [REDACTED] and a Level II evaluation referral was now required.</p> <p>Per the facility behavior monitor form for the month of May and June 2014, the resident had behaviors of [REDACTED] and insomnia.</p> <p>Per the resident's most recent care plan, the resident had received medication and had a problem with [REDACTED] loss of appetite (weight loss), insomnia, and [REDACTED]</p> <p>4. Resident #124 was admitted on [REDACTED] 14 and was re-admitted on [REDACTED] 14. Per the most recent social services assessment, the resident was alert and oriented and could make her needs known. The resident had a history of [REDACTED] with [REDACTED] and a diagnosis of [REDACTED]</p>	F 285		
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F 285	<p>Continued From page 10</p> <p>Per the initial admission on [REDACTED] 14, there was no PASRR form completed or found in the resident's chart. Per the [REDACTED] 14 admission, the PASRR indicated the resident had a [REDACTED] disorder in section I. Section II did not have a determination indication marked but the physician provided a signature dated 6/9/14. Section III was completely blank, there was no determination of evaluation and no name/title of person who completed the form.</p> <p>The most recent care plan for the resident indicated the resident had a problem with [REDACTED] and had anger over loss roles and declined health.</p> <p>On 7/10/14 at 2:00 p.m., Staff #B stated the PASRR forms are in the admission packet when the residents are admitted. Then the PASRR forms are put into the resident's charts. Social services rely on the nursing staff to inform them if the PASRR forms are incorrect. Staff #B stated if the resident had a mental health determination on admission and initially it was determined the resident would only be in the facility for up to 30 days and the resident stayed past the 30 days, then the physician would re-assess the resident and a new PASRR form would be completed. The only other way social services would know if another PASRR form needed to be completed or changed was if the staff audited the charts. Staff #B confirmed the PASRR forms were not filled out correctly and the nursing staff had not informed social services of the incorrect PASRR forms.</p> <p>The facility failed to accurately complete the mandatory PASRR forms accurately and timely which resulted in the residents not receiving the Level II evaluation. The facility not identifying appropriate</p>	F 285		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 285	Continued From page 11	F 285	F313	8/28/14	
F 313 SS=D	<p>specialized services put the residents at risk for unmet mental health needs.</p> <p>483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION</p> <p>To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure that 1 of 2 residents (#47) in a sample of 33 reviewed for hearing received proper treatment and assistive devices to maintain hearing abilities. This failure placed the resident at risk for impairment in communication due to not being able to hear adequately. Per record review, Resident #47 had diagnoses of diabetes, [REDACTED]. She was able to make her needs known and required extensive assist with all activities of daily living (ADL's). The resident's annual assessment dated 5/1/14, noted that she wore a hearing aid. A comprehensive care plan dated 5/2/14 directed staff to check that the resident's hearing aid was clean, functioning, and properly in place in her left ear. Physician orders instructed facility staff to</p>	F 313	<p>1) Resident #47 received new batteries for her hearing aids. NAC's and LN's have been reeducated to offer resident her hearing aid from the nurse's cart every day by the DNS or designee. Care Plan was reviewed and updated.</p> <p>2) All current residents have been reviewed for hearing impairment. Those residents which have hearing impairments have been reviewed for need of interventions. Interventions implemented as needed and care plans updated.</p> <p>3) RCM's, LN's and NAC's reeducated on Prestige policy on care planning. RCM's, LN's and NAC's reeducated on "care plan trigger form" utilization which would inform the appropriate discipline when a change has occurred so the Care plan can be reviewed and update as needed.</p>		

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F 313	<p>Continued From page 12</p> <p>place the resident ' s hearing aid in the medicine cart at bedtime after removing, to return it to the resident in the morning and assist with placement in her ear. Special instructions were included that stated the resident kept the hearing aid at her bedside at night.</p> <p>An activities progress note on 5/20/14 noted the resident had a hearing aid for her left ear, but often would not wear it.</p> <p>Nursing Progress Notes on 6/10/14, 6/26/14, 7/3/14 noted that the resident was refusing her hearing aid. No indication was documented as to the reason for the refusal.</p> <p>Review of the Medication Administration Record (MAR) for this order showed blanks or circled staff initials for the months of April, May, Jun, and July up through 7/11/14.</p> <p>In an interview on 7/9/14 at 9:15 a.m., during which the surveyor had to speak very loudly into Resident #47's ear and repeat questions multiple times, the resident stated that she was not wearing her hearing aid because it needed new batteries. She said her niece had paid for them but the resident needed to order them at Miracle Ear and she kept forgetting.</p> <p>On 7/11/14 during continuous observation from 7:16 a.m. to 7:50 a.m., Staff #F, #G, and #H provided morning care for the resident and did not offer the resident her hearing aid. At 7:50 a.m., the resident was taken to the dining room for breakfast with no hearing aid in place</p> <p>On 7/14/14 at 11:35 a.m., Staff # F stated that the resident " had hearing aids several years ago but she would't wear them. I don't know why. We tried to get her to wear the headphones but she won't. "</p> <p>On 7/14/14 at 1:43 p.m., Staff # J stated that Resident #47 had not worn her hearing aid since she had started working there. She didn't know</p>	F 313	<p>RCM's have been reeducated to utilize the IDT form used on a quarterly basis to assure care plan is appropriate and up to date.</p> <p>4) DNS or designee will track and trend for compliance and report findings to the QA committee to identify performance improvement opportunities monthly x 3 months and randomly thereafter.</p> <p>5) DNS will ensure compliance.</p>	

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F 313	Continued From page 13 why. In a follow up interview on 7/14/14 at 2:03 p.m. Staff # J stated she had just spoken with the resident and the resident stated she would consider wearing her hearing aid when the battery was replaced. On 7/14/14 at 4:20 p.m., Resident #47 was observed sitting in her wheelchair in her room. A hearing aid was observed in the resident's left ear. When asked by the surveyor about her hearing aid, the resident smiled and stated a nurse had brought it to her this afternoon and told her it was working now. The resident stated she could hear well now and she was very happy about it.	F 313			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to restore as much normal bladder function as possible for 2 of 2 residents reviewed for urinary incontinence (#100, 129) in a sample of 33. Findings include:	F 315	F 315 1) Resident #100 & 129 are no longer residents of the facility. 2) Current residents admitted within the last 30 days have been reviewed for urinary continence status. Urinary assessment and care plans updated. Residents who showed a decline in their continence status have been reviewed for appropriateness of a toileting program and/or referred to OT for evaluation and treatment.	8/28/14	

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F 315	<p>Continued From page 14</p> <p>1. Resident #129 no longer resided in the facility. Per record review, the resident was admitted [REDACTED] 14 with diagnoses including pneumonia and a decline in activities of daily living.</p> <p>Review of the facility assessments dated 2/3/14, 2/10/14, and 2/24/14 revealed the resident was continent of urine and needed extensive assistance with mobility and toileting.</p> <p>Review of nursing progress notes dated 1/29, 2/7, 2/9, 2/13, and 2/16/14 revealed the resident was both continent/incontinent of urine, especially at night.</p> <p>According to review of the resident's clinical record, there was no evaluation of urinary incontinence to determine if the resident would benefit from a toileting program to decrease episodes of incontinence. On 1/31/14, the resident fell in his room while attempting to stand up to go to the bathroom. On 2/1/14, staff offered toileting every 2-3 hours to reduce the risk of falls. There was no indication regarding how long this intervention was implemented and whether or not episodes of urinary incontinence decreased.</p> <p>Per record review, the resident was hospitalized on [REDACTED] 14. Upon readmission to the facility on [REDACTED] 14, the resident presented with a decline in activities of daily living and episodes of urinary incontinence. There was no evaluation of urinary incontinence and no care plan interventions developed to address the urinary incontinence. On [REDACTED] 14, the resident was discharged.</p> <p>On 7/14/14, staff members working on the unit where the resident resided either did not remember the resident or had been hired since the resident's stay at the facility.</p> <p>In an interview on 7/14/14 at 3:45 p.m., Staff #C and #N reviewed the resident's record and</p>	F 315	<p>3) RCM's, LN's and NAC's educated on documentation in POC for urinary continence status to track residents patterns on initial admit and during entire stay at facility, by the DNS or designee. RCM's educated to assess urinary continence upon admit and proceed with care plan based off the MDS CAA's, by the DNS or designee. Quarterly assessment will be documented in the quarterly nursing assessment. Audit form created for RCM's to track urinary continence and will be forwarded to the DNS for review and follow-up if needed. Will update care plan as needed including potential for initiation of toileting program if appropriate based off of audit findings. RCM's, LN's and NAC's have been reeducated on "care plan trigger form", by the DNS or designee.</p>		

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F 315	<p>Continued From page 15</p> <p>confirmed the resident's comprehensive urinary assessment was inaccurate and the facility did not implement consistent interventions to restore as much normal bladder function as possible.</p> <p>2. Resident #100 was admitted on [REDACTED] 14 with diagnoses of pneumonia, history of urinary tract infections and [REDACTED]. The resident needed extensive assistance with transfers, bed mobility, toileting, hygiene and was able to make her needs known.</p> <p>Per the transferring hospital history and physical, the resident was continent of urine.</p> <p>Per record review on 1/20/14 and on 1/27/14, the resident was continent of urine.</p> <p>On 2/17/14, per assessment, the resident was occasionally incontinent of urine and still required extensive assistance.</p> <p>In review of the care plan, there was no plan/intervention or evaluation in regards to urinary incontinence.</p> <p>On 4/29/14, Staff #K initiated a nursing quarterly assessment and the assessment, but the section to address changes in incontinence, why the change, interventions and resident resident response, toileting plan and effectiveness was not completed.</p> <p>On 7/14/14, 12:00 p.m., Staff #E stated there should be an assessment for urinary incontinence and she was not able to find one for Resident #100. Staff #E was unable to identify why the resident was incontinent of urine or how frequently it occurred.</p> <p>On 7/14/14 at 2:13 p.m., Staff #D stated the nursing aides do not have a system set up currently to track if a resident was incontinent and that should be monitored.</p> <p>On 7/15/14 at 11:45 a.m., Staff #C stated the</p>	F 315	<p>4) DNS or designee will track and trend audit results and report findings to the QA Committee to identify performance improvement opportunities monthly x 3 months and randomly thereafter.</p> <p>5) DNS will ensure compliance.</p>	

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F 315	Continued From page 16 resident was frequently more incontinent of bladder towards the end of her stay at the facility and she ended up discharging to the hospital. The facility failed to provide the residents with appropriate assessments and failed to monitor bladder incontinence to identify the reason/interventions for this primary incontinence. The facility failed to provide care and services to restore and maintain bladder function for residents.	F 315		8/28/14	
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 interview and record review it was determined the facility failed to provide appropriate treatment and services for 1 of 3 (#23) residents to maintain ROM (range of motion) and prevent functional decline. Findings include: Resident #23 had been admitted to the facility after surgery on her [REDACTED]. The resident admitted with decreased ROM and needed extensive assistance with most of her cares. Per therapy documentation, the resident began specialized therapy with physical and occupational therapy on 4/15/14 and was	F 318	F318 1) Resident#23 is no longer a resident of the facility 2) Current residents who have recently been discharged from the therapy and have maintained as residents of the facility within the last 3 months have been reviewed for restorative programs. Identified residents, who were appropriate for a program and did not have one, had a program initiated per the RCM. Care plans and In Room Care Plans have been updated. 3) In serviced RCM's and therapy on new protocol regarding transition from therapy program to restorative when appropriate by the DNS or designee. Therapy will fill out section of the "72 hour notice D/C		

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F 318	<p>Continued From page 17</p> <p>discharged from therapy on 6/30/14 using a sit to stand mechanical machine for transfers. The resident had been measured for her [REDACTED] range of motion on her discharge, which was 0-130 degrees.</p> <p>On 7/10/14 at 2:20 p.m., Staff #A stated Resident #23 no longer qualified for skilled therapy and was not unable to meet some of her goals. Staff #A stated the resident's "anxiety played a role" in why she had not been able to reach some of her therapy goals. Staff #A reported the resident made progress on her [REDACTED] ROM.</p> <p>Per the resident's care plan under activities of daily living and rehabilitation, the resident had impaired mobility related to [REDACTED] surgery and a decline in function of the [REDACTED]. The care plan noted an intervention for a restorative plan and exercises to occur once a day created on [REDACTED] 13 (from the residents previous admission).</p> <p>Per record review, the resident did not receive specialized therapy or restorative therapy since 6/30/14 (15 days).</p> <p>On 7/13/14 at 3:00 p.m., Staff #D stated the resident had not received restorative therapy after she discharged from therapy. Staff #D said the therapists usually set up restorative therapy and she was not sure why they had not done so.</p> <p>On 7/15/14 at 8:30 a.m., Staff #O reported the resident used a hooyer lift (mechanical lift with a sling, totally dependent on staff) and she had [REDACTED] pain which had made her range of motion worse. When staff "tried to move the resident's [REDACTED] she did not like it." Staff #O reported the nursing assistant's do no do any restorative therapy on the resident.</p> <p>Per the facility initial and most current assessments, the resident had declined in bed mobility and activities of daily living</p>	F 318	<p>from therapy" form regarding referral to a restorative program. If one has not been written by therapy then nursing will assess resident for possibility of nursing written program when appropriate. RCM's and therapy educated on above by the DNS or designee. RCM's reeducated on Prestige policy for restorative programs by the DNS or designee.</p> <p>4) DNS will track by receiving copy of the "72 hour notice D/C from therapy form" and will be provided a copy of the restorative plan by either therapy, if therapy written, or by RCM of nursing written. Results will be tracked and trended by the DNS and results presented to the QA Committee monthly x3 to identify opportunities for performance improvement.</p> <p>5) QA committee will ensure compliance.</p>	
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F 318	<p>Continued From page 18</p> <p>assistance/toilet use from extensive assistance (resident involved in activity, staff provide weight bearing support) to total assistance (full staff performance every time).</p> <p>The therapy staff was requested to measure the resident's ROM for her [redacted] on the morning of 7/15/14. Staff #A reported the residents ROM was 0-121 degrees. This was a 9 degree (in 15 days) decline from her progress she had made when she discharged from therapy.</p> <p>The facility did not ensure the resident received appropriate treatment and services after she discharged from skilled therapy and continued to reside in the facility, which lead to a decline in function and decreased range of motion for the resident's [redacted]</p>	F 318		
F 366 SS=D	<p>483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE</p> <p>Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to offer food of equal nutritive value to 3 residents (#7, 59, 87) in 2 of 4 facility dining rooms who refused food on the menu. The residents were placed at risk for not consistently receiving meals according to the comprehensive assessment and plan of care. Findings include:</p> <p>1. Review of the lunch menu on 7/8/14 revealed</p>	F 366	<p>F366</p> <p>1) Resident # 59, 87 have all been talked to by the DSM regarding diet preferences. Resident # 7 is unable to be interviewed due to nonverbal communication. After reviewing resident preferences kitchen added an additional alternate of sandwiches to be provided each day with protein. Cooks have been reeducated regarding Resident #59 dislike for ham and when ham is on the menu and alternate protein will be prepared for</p>	8/28/14



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F 366	<p>Continued From page 19</p> <p>the main offering was breaded fish, potatoes, peas, corn bread, and fruit. The alternate choice was a turkey sandwich and soup or chef salad.</p> <p>During observation of lunch in the Robeson Lane dining room on 7/8/14, Resident #78 stated that the facility always had "nice lunches". During the meal, staff served her a cup of soup and fruit. The resident asked why she was not served more food and staff stated to her that she did not like fish or turkey so they did not serve her either of those foods. The resident told the staff that was fine. Staff left and returned with a plate of mashed potatoes with gravy and corn bread. The resident refused and said she could not eat that much corn bread or potatoes. Staff did not offer a chef salad.</p> <p>In an interview on 7/10/14 at 9:00 a.m., Staff #L stated a sandwich and soup, chef salad, or cottage cheese and fruit were available alternates for residents at lunch and dinner. Before the meal, staff ask the residents their food preferences and send the list of substitutes to the kitchen. Review of the lunch list for 7/8/14 with Staff #L revealed Resident #78 was not included on the list. Staff #L stated she did not know why the resident was not on the list because staff knew she did not like fish or turkey.</p> <p>2. During observation of lunch in the Robeson Lane dining room on 7/9/14 at 12:10 p.m., Resident #59 was seated in the hall outside the dining room eating lunch. The resident was served mashed potatoes, pureed green beans, a pureed dessert, and 3 mugs of pudding thick fluids. Staff #L, the dietary manager, confirmed the resident was not served a protein item and stated the resident did not like ham and refused the sandwich and soup, chef salad, or cottage and fruit which were offered before the meal.</p>	F 366	<p>her. NAC's have been reeducated that when a resident who receives puree food refuses then the resident will be offered and encouraged another puree food item provided by the kitchen.</p> <p>2) Current residents have food preferences in which the DSM maintains in the kitchen office and in the matrix observation. All new admissions will be interviewed by the DSM for food preferences within 3 days of admission and follows up in 14 days on additional food preferences. This is documented in matrix under the "dietary observation".</p> <p>3) Cooks, RCM's, LN's, DSM and NAC's have been educated on providing menus to the residents prior to meals by the DNS or designee. Also educated on residents right to choose food alternates and ability to change their mind at any time. Educated NAC's to communicate to Dietary</p>	
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