

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505181	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/07/2014
NAME OF PROVIDER OR SUPPLIER REDMOND CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7900 WILLOWS ROAD NORTHEAST REDMOND, WA 98052	
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Off-Hours Quality Indicator Survey conducted at Redmond Care and Rehabilitation Center 07/30/14, 07/31/14, 08/01/14, 08/04/14, 08/05/14, 08/06/14 and 08/07/14. The survey included data collection on 08/01/14 from 4:45 a.m. to 8:00 a.m. A sample of 31 current residents and seven former residents were selected for Stage II review from a census of 78.</p> <p>The survey was conducted by:</p> <p>Barbara A. Jackson, R.N., B.S.N. Robin Windhausen, M.S., R.D. Sharon Stephens, R.N., B.S.N. Mavis Kankomba, R.N., B.S.N.</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Adult Services Administration Residential Care Facilities District 2, Unit E 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388</p> <p>Telephone: (253) 234-6000 Fax: (253) 395-5070</p>	F 000	<p><i>This Plan of Correction is the facility's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mike Anbesse</i>		TITLE ADMISSION		(X6) DATE 08/25/14

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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 242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to allow one of three residents (#4) reviewed for choices. The failure to accommodate the resident's choices placed the resident at risk for diminished quality of life.</p> <p>Findings include:</p> <p>Resident #4 was admitted to the facility [REDACTED] 14 with complex health care needs which included [REDACTED]. The admission Minimal Data Set (MDS) dated 06/19/14 revealed the resident was able to make needs known and had an intact cognition. The Care Plan (CP) dated 06/13/14 revealed the resident was totally dependent on staff for activities of daily living which included bathing.</p> <p>On 07/31/14 at about 9:00 a.m., in an interview, Resident #4 stated she did not have the option to choose how many times in a week she took a bath. The resident also stated that she was not given an option to choose whether she took a tub bath, shower or bed bath.</p>	F 242	<p>F242(D): Resident #4 was offered a choice of bathing preference and frequency/schedule and Care plan was updated to reflect residents' preferences.</p> <p>Current residents were asked for their bathing and frequency preferences and care plans were updated as needed.</p> <p>New admits will be asked their bathing and frequency preferences upon admit by the admitting nurse and care planned as required.</p> <p>The Director of Staff Development (DSD) will in-service licensed nurses of the need to ask new admits their bathing & frequency preferences and to have it care planned.</p> <p>The DSD and or designee will perform random audits on new admits to ensure residents bathing and frequency preferences are being accommodated. Findings will be given to the Director of Nursing Services (DNS) to review and follow up as needed.</p> <p>The DNS will bring findings to the Quality Assessment and Assurance Committee to review and make recommendations as needed.</p> <p>The DNS will ensure compliance.</p>	08/15/14	

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F 242	Continued From page 2 On 08/05/14 at 8:00 a.m., review of the MDS dated 06/19/14 under " PREFERENCES FOR CUSTOMARY ROUTINE AND ACTIVITIES" the section was not completed. On 08/04/14 at about 12:30 p.m., in an interview, Staff A, the facility Administrator stated "All resident's bathing preferences and frequencies are captured on admission during nursing assessment and included on to the plan of care for each resident. "Review of the Admission Nursing Assessment and the Care Plan dated [REDACTED] 14 did not include documentation of Resident #4's bathing preference and frequencies. On 08/06/14 around 10:15 a.m., in an interview, when asked, Staff Q, a Registered Nurse stated the facility only provided showers or bed baths and did not have a tub bath to accommodate residents who preferred a tub bath. Physical observation of the facility with the Administrator revealed the facility did not have a bath tub that was accessible to all the residents in the facility. The facility had a bath tub located in a private room occupied by another resident, and it was not accessible to other residents for use. The failure to offer a choice (the right regarding important daily routines including accommodating preferences for the frequencies and/or type of bathing) had the potential to decrease the resident's quality of life.	F 242			
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE	F 247			

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F 247	<p>Continued From page 3</p> <p>A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide advanced notification to three of three Residents (#86, #4 and #121) reviewed for room/roommate change. This failure denied the resident the right to be informed of room/roommate changes and had the potential to decrease their quality of life.</p> <p>Findings include:</p> <p>Review of the undated facility's policy regarding room changes titled "Transfer within the facility" indicated "Room changes are discussed with the Resident, family and / or Responsible party as needed by Social Services and/ or Nursing. Discussion regarding room change should be documented in the progress room</p> <p>RESIDENT #86</p> <p>Resident #86 was admitted to the facility [REDACTED] 14 with complex health care needs related to [REDACTED]. The Minimum Data Set dated 06/28/14 revealed the Resident could make needs known and had an intact cognition. On 07/31/14 at about 08.40 a.m., in an interview, Resident # 86 expressed concern about receiving a new roommate without being given an advance notice.</p> <p>On 08/06/14 at about 2:00 p.m., in an interview Staff B, the Director of Nursing (DNS) stated that</p>	F 247	<p>F247(D)</p> <p>Resident #86 interviewed to ensure room accommodations were satisfactory and to ensure resident is provided enhanced quality of life.</p> <p>Resident #4 was interviewed to ensure room accommodations were satisfactory and to ensure resident is provided enhanced quality of life.</p> <p>Resident #121 was interviewed to ensure room accommodations were satisfactory and to ensure resident is provided enhanced quality of life.</p> <p>Current residents that have had a room change and or new roommate since their admit will be interviewed to ensure they are satisfied with their accommodations. If not satisfied solutions and or changes will be made to ensure the highest quality of life is being met.</p> <p>A Room Change Authorization form will now be completed by social services and or nursing to ensure residents receive 72 hour notice prior to new roommate or room change. Residents' will then be put on alert charting for 72 hours after the change occurs.</p> <p>The Director of Staff Development and or designee will in-service social services and nursing on the new Room Change Authorization form to ensure residents</p>	

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F 247	<p>Continued From page 4</p> <p>advance notifications were given to the resident or the resident's representative prior to the resident changing rooms or receiving a roommate. The DNS also stated that discussions regarding room change are documented in nurse's progress notes.</p> <p>On 08/06/12 at 12:00 p.m., review of the nurse's progress and social services notes did not include documentation regarding Resident #86's new roommate. The DNS acknowledged the documentation regarding the roommate change was missing and stated, "Notifications regarding room changes and roommate changes are supposed to be documented, unfortunately it was not done."</p> <p>RESIDENT #4</p> <p>Resident # 4 was admitted to the facility [REDACTED] 14 with complex health care needs which included [REDACTED]. The Minimum Data Set (MDS) dated 06/19/14 revealed the resident was able to make needs known and had an intact cognition. On 08/04/14 in an interview, Resident #86 stated she had been moved to a different room in June, 2014 and she was not given advance notice prior to changing rooms.</p> <p>On 08/06/14 at about 2:00 p.m., Staff B the Director of Nursing acknowledged Resident #4 had changed rooms in June of 2014, but could not find documentation to indicate that advance notice was given prior to the resident changing rooms.</p>	F 247	<p>receive proper notice (72 hours) before the resident's room or roommate in the facility is changed. This training will also include the need to put resident's on alert charting for 72 hours after the change occurs.</p> <p>Medical Records will conduct random audits to ensure residents Room Change Authorization form is being completed as required and give the findings to the Director of Nursing Services (DNS). The DNS will bring findings to the Quality Assessment and Assurance (QA&A) Committee.</p> <p>DNS will conduct random audits to ensure residents with room and or roommate changes are put on alert charting. Findings will be given to the (QA&A) Committee.</p> <p>The QA&A Committee will review findings and make recommendations as needed.</p> <p>The DNS will ensure compliance.</p>		
	<p>RESIDENT #121</p> <p>On 07/31/14 at 10:04 a.m., Resident #121 stated</p>				

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F 247	Continued From page 5 "I was not informed that a new roommate was moving in. I came to my room and found a roommate, and no one talked to me about it." Review of Nurse's progress notes and Social services notes did not include documentation that Resident # 121 was notified of the new roommate moving in. On 08/06/14 at about 2:30 p.m., in an interview, Staff D acknowledged the resident had a new roommate, but could not find documentation to indicate Resident #121 was given advance notice prior roommate moving in. This failure placed the residents at risk for a diminished quality of life.	F 247			
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;	F 272	F272(D) Resident #49 was seen by the dentist on 8/5/14 and 8/22/14 and documentation is in the medical record. MDS has been corrected to reflect residents current oral status and Care plan has been updated. Resident #48 was seen by the dentist on 2/11/14. An oral assessment was completed on 8/25/14. The MDS has been corrected to reflect residents current oral status and care plan updated. Oral assessments have been conducted on current residents by the Resident Care Manager and or designee to ensure residents with broken/missing teeth or oral dental pain have been assessed and offered services and care as needed.		

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F 272	<p>Continued From page 6</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to accurately assess two of the 36 residents (#49, #48) reviewed during Stage 2. Failure to ensure accurate assessments placed residents at risk for unidentified and/or unmet needs.</p> <p>RESIDENT #49</p> <p>Resident #49 was admitted to the facility on [REDACTED] 2014. During the stage 1 interview, Resident #49 stated she had several broken and or missing teeth and wished to have them repaired and or replaced.</p>	F 272	<p>The Director of Nursing Services (DNS) and or designee in-serviced the Minimum Data Set licensed nursing staff on ensuring accurate dental assessments have been completed and documented.</p> <p>The Director of Staff Development and or designee in-serviced licensed nursing staff to ensure resident with broken/missing teeth or oral dental pain have been assessed and offered dental service. Also, to ensure appropriate notifications to the Social Services department of residents dental service needs.</p> <p>The Resident Care Manager and or designee will conduct random audits to ensure accuracy of dental assessment and that appropriate referrals have been initiated and documented. Findings will be given to the DNS for review and follow up.</p> <p>The DNS will bring audit findings to the Quality Assessment and Assurance (QA&A) Committee.</p> <p>The QA&A Committee will review findings and make recommendations as needed.</p> <p>The DNS will ensure compliance.</p>	8/15/14
	<p>A review of the resident's admission assessment noted the resident had several carious, missing, or broken teeth however the Minimum Data Set</p>			

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F 272	<p>Continued From page 7</p> <p>(MDS), an assessment tool, had no documentation indicating the residents need for dental evaluation or treatment.</p> <p>During an interview on 08/05/14 at 10:08 A.M., Staff D stated Resident# 49's teeth had been assessed during the admission assessment by the nursing staff in [REDACTED] 2014.</p> <p>The nursing assessment showed Resident #49 had several missing, broken, and carious teeth.</p> <p>According to Staff D, information regarding the condition of Resident #49's teeth was not communicated to her; therefore, it was not included on the MDS.</p> <p>Due to the MDS being inaccurate, the care plan was not generated which may have directed staff to obtain a referral for dental services.</p> <p>RESIDENT #48 Resident #48 was readmitted from an acute care facility on [REDACTED] 13, with multiple medical diagnoses. According to the annual MDS assessment dated, 02/05/14, the resident had broken and or loose teeth. Although the dental issue was identified, a care area assessment was not completed. In addition, the care plan (last updated on 10/2013) did not indicate the resident had dental caries and/or needed dental services. The next quarterly assessment, of 05/08/14, inaccurately reported the resident had no dental issues.</p> <p>On 07/31/2014 at 9:30 a.m., Resident #48 was interviewed. When asked about oral health status the resident reported "my teeth are falling out." The resident did report the facility staff</p>	F 272		

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F 272	Continued From page 8 talked to her about arranging dental services several months ago, but had not heard anything further about seeing a dentist. According to the clinical record a dental exam was completed on 2/11/14. The consult indicated the resident needed tooth extractions and noted the resident had nine broken teeth. A hand written notation on the side of consult stated Resident #49 " had her own dentist for ext (extractions.)" Although the dentist identified the need for treatment for dental caries and broken teeth, there was no evidence the facility staff followed up to arrange the service. The assessment dated 05/08/14 did not accurately identify the resident had dental caries and may have contributed a delay in receiving dental services. See citation for lack of coordination of dental services for these residents under F 412, CFR: 483.55 (b).	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	F 280	F280(D) Resident #120 care plan was updated to reflect current condition and to include to be able to participate in activities of choice. Resident received a new tilt back wheel chair on [REDACTED] 14 and is positioned appropriately with foot rest in place when up. Current residents with a change in condition in the last quarter will have there activity care plan reviewed for accuracy and updated as needed by the Activity Director.		

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F 280	Continued From page 9 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 the facility failed to ensure the care plan was reviewed and revised for one of 36 residents (#120) reviewed during Stage II. Failure to ensure the care plans for activities of daily living and recreational activities was reviewed and revised after a change in condition placed the residents at risk for social isolation. Findings include: RESIDENT #120 Resident #120 was readmitted to the facility on [REDACTED] 14 with hospice services in place. The Minimum Data Set assessment, dated 05/23/14, identified the resident had a change in condition. The functional assessment of the resident abilities to participate in the activities of daily living documented the resident needed extensive assist from staff with dressing, transfers, mobility and locomotion. The assessment completed on 05/23/14, documented the resident was only transferred out of bed on one occasion during the seven day assessment period.	F 280	The Director of Staff Development and or designee will in-service activities and licensed staff on the importance of updating care plans with residents changes of condition to ensure activities of daily living and recreational activities are reviewed and revised to prevent the risk for social isolation. The Resident Care Manager and or designee will conduct random audits to ensure residents with changes of condition have an accurate and updated activities care plan. Findings will be given to the Director of Nursing Services (DNS) to review. The DNS will bring findings to the Quality Assessment and Assurance (QA&A) Committee. The QA&A Committee will review findings and make recommendations as needed. The DNS will ensure compliance.	9/15/14	

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

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F 280	<p>Continued From page 10</p> <p>According to the care plan the staff needed to escort the resident to activities and at times needed assistance to participate. The care plan directives noted the resident enjoyed music entertainment and social activities. The directives also noted the resident enjoyed sitting in her wheelchair in the entry way watching people and socializing with others.</p> <p>The care plan also directed staff to alternate periods of rest with activity out of bed to prevent respiratory complications, dependent edema, contractures and skin pressure areas. However the directives under hospice indicated staff "only get resident up and in wheelchair when family is present."</p> <p>On 07/31, 08/01, 08/04, 08/05, and 08/06/14, Resident #120 remained in bed in a hospital gown. The resident at times was found fast asleep and /or watching television. At times the resident was easily aroused and able to converse. During the survey the resident was never observed out of bed for activities or during family visits.</p> <p>On 08/05/14 at 2:15 p.m., the resident's Representative was interviewed. When asked why the resident was not assisted out of bed, she reported she had concerns about positioning in the wheelchair. She explained she arrived at the facility, to visit and several times and found the resident seated in her wheelchair but in a poor position (I.e. slumped over and/or with the foot rests missing). She reported she did not want the resident out of bed, unless family members were present and commented the resident has a difficult time sitting upright in the wheelchair.</p>	F 280			

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F 280	<p>Continued From page 11</p> <p>The family reported two visits occurred daily, but the resident was not observed out of bed during the visits. On 08/04/14 at 1:27 pm and 08/05/14 at 2:15 p.m., the resident family was observed to sitting with the resident at her bedside, but the resident remained in bed wearing a hospital gown.</p> <p>On 08/05/14 at 9:40 a.m., Staff I, the Nurse was interviewed about the resident's care. When asked why the resident was not up out of bed, she stated the family members did not want the resident up because of the hospice status. When asked if the risks and benefits of not getting out of bed had been discussed with the resident and or the family, she reported the hospice staff had reviewed it with the resident. She also reported the family directed to the facility staff to call them if the resident requested to be out of bed.</p> <p>On 08/05/14 at 10:00 a.m., the Activities Director, Staff J, was interviewed about the care plan. Staff J also reported the family members did not want Resident #120 out of bed. She stated the staff had "just recently" discussed bring up the issue again with family. She stated the care plan was not updated, because she hoped the Resident would be able to engage in the activities she preferred in the past again.</p> <p>On 08/05/14 at 2:15 p.m., a follow up interview was completed with the Representative. When asked why the family requested the resident stay in bed, she reported she had concerns about safe positioning in the wheelchair. She stated since the resident readmission, she arrived to visit and found the resident in the wheelchair in a poor</p>	F 280		

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F 280	Continued From page 12 position. (I.e. slumped over and /or no foot rests in place.) She stated due to concerns she observed, she did not want the resident out of bed. She then commented the resident had a difficult time maintaining trunk control and sitting upright in the wheelchair. Not ensuring the care plan to meet the needs for activities of daily living (i.e. dressing and transfers) and leisure activities was reviewed and revised after a significant change in condition placed the resident at risk for a diminished quality of life and social isolation.	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to consistently monitor and document skin condition for 3 of 4 Residents (#100, 120 and 184) reviewed for wound care. The failure placed residents at risk of not receiving necessary care and services to attain or maintain the highest practicable physical well-being.	F 309	F309(D) Resident #100 no longer resides in the facility. Resident #120 skin has been assessed and documented as required and care plan updated as needed. Resident #184 Currently has no pressure ulcers. Nursing will continue to conduct weekly skin checks and document as required The Resident Care Manager and or designee will review current residents requiring wound care to ensure that monitoring and appropriate documentation including wound measurements are in place. The Director of Staff Development and or designee will conduct in-services for the licensed nursing staff on the need to ensure residents needing wound care are		

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F 309	<p>Continued From page 13</p> <p>Findings included:</p> <p>RESIDENT #100</p> <p>Resident #100 was re-admitted to the facility on [REDACTED] 14. The diagnoses included dementia, [REDACTED] aspiration pneumonia. The most recent Minimum Data Set (MDS), a facility assessment tool, revealed the resident needed extensive assist for bed mobility and was always incontinent. Record review revealed the resident was discharged to hospital on [REDACTED] 14 related to a drop in blood pressure.</p> <p>According to the facility's "Evaluations, Screenings and Assessments" policy, each resident is evaluated for special needs related to skin care and receive a weekly skin integrity check performed by licensed personnel. The policy indicated, "On a weekly basis, an in-depth assessment is performed and recorded" and the "Non-pressure skin condition record were used for weekly assessment of the existing wounds." The pressured and non-pressure skin condition record directed staff to document the wound condition (site, size, depth, drainage, odor, color and appearance) as well as "response to treatment."</p> <p>The initial Licensed Nurse (LN) comprehensive assessment dated 07/01/14 revealed documentation of scrotum and coccyx (tail bone) area redness. There was no documentation the wound area's size (i.e., circulatory status, length, width and depth of the assessed areas).</p> <p>More than a week later, the "Skin Assessment/Evaluation" (a weekly assessment)</p>	F 309	<p>consistently being monitored and document skin conditions to include measurements as required. This training will ensure residents receive the necessary care and services to attain or maintain the highest practicable physical well-being.</p> <p>The Resident Care Manager and or designee will conduct random audits to ensure residents needing wound care are consistently being monitored and document skin conditions to include measurements as required. Findings will be given to the Director of Nursing Services (DNS) for review and follow up.</p> <p>The DNS will bring findings to the Quality Assessment & Assurance (QA&A) Committee.</p> <p>The QA&A Committee will review findings and make recommendations as needed.</p> <p>The DNS will ensure compliance.</p>		

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F 309	<p>Continued From page 14</p> <p>dated 07/11/14 included the development of bruises to bilateral upper extremity, purplish in color and redness to scrotum and buttocks. This documentation and subsequent skin assessment completed on 07/18/14 were without wound measurements.</p> <p>The weekly skin assessment dated 07/25/14 revealed ongoing documentation of redness to scrotum and buttocks. Additionally, a reddish rash had developed to the buttocks area. A month since the skin condition developed, monitoring of the wound measurements to determine improvement or deterioration of the skin were not found.</p> <p>In interview on 08/05/14 at 10:29 a.m., Staff N, an LN caring for the resident, stated if skin conditions were greater than a Stage I (no circulation to an area of the skin exhibited by persistent redness which could cause skin breakdown) an assessment or measurements would be done.</p> <p>On 08/05/14 at 10:43 a.m., the Director of Nursing Services stated, staff should document the condition of the skin including size.</p> <p>Without comprehensive assessments which includes wound measurements, residents are risk of not receiving necessary care and services to improve skins condition.</p> <p>RESIDENT #120</p>	F 309		

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F 309	<p>Continued From page 15</p> <p>Resident #120 was admitted to the facility on [REDACTED] 13 with multiple medical diagnoses. According to the annual MDS assessment dated 03/01/14, the resident needed extensive assistance with all activities of daily living, including transfers, bed mobility, locomotion and toileting. The skin assessment section of the assessment noted the resident had moisture associated skin damage (MASD), which is the result of the skin having sustained exposure to moisture.</p> <p>The MDS database noted the resident was transferred to the hospital on [REDACTED] 14 and then readmitted to the facility on [REDACTED] 14. The assessment completed at the time of readmission, dated 5/23/14, indicated the resident had a significant change in condition and was now receiving hospice services. The assessment also noted, in the skin assessment section, the resident had MASD.</p> <p>Review of the skin tracking sheets between 5/25/14 and 7/3/14 noted the resident had excoriation which was described as the groin, buttocks, coccyx area and inner thigh areas at different times. Although the staff noted the presence of the skin issue the exact location and size of the excoriated skin was not documented.</p> <p>On 08/06/14 at 10:00 a.m. Staff I, the nurse, was interviewed about the skin monitoring program. She reported the staff only monitored one areas (or Stage II wounds.) She then explained the excorated areas the weekly assessments identified had not been measured.</p> <p>Additional review of the MDS data base found</p>	F 309			

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F 309	<p>Continued From page 16</p> <p>that every assessment since admission, documented the resident had MASD, except one quarterly assessment dated 08/31/13. However the weekly assessments did not identify the exact location, the size or include a description.</p> <p>RESIDENT #184</p> <p>Resident # 184 was admitted to the facility on [REDACTED] 14, with multiple medical diagnoses including the surgical repair of a fractured hip. The initial assessment, noted the last day of data collection for the assessment period was 7/28/14. The assessment documented the resident needed extensive assistance with all activities of daily living except eating. The skin section of the assessment indicated the resident had 4 venous stasis ulcers and a stage II pressure ulcer.</p> <p>According to the skin assessment dated 07/22/14, the stage II pressure ulcer on the coccyx that measured 8 x.2 x 1 centimeter. The next weekly skin assessment was dated 07/26/14 noted the presence of a Stage II pressure ulcer in the comment section. However the section intended to document location, size, stage and description, of the ulcer on the coccyx was blank.</p> <p>On 08/06/14 at 10:00 a.m., Staff I, the Nurse was interviewed about the skin monitoring. She reported she did not complete the weekly skin checks. She said the wound healed on 07/30/14, and then found an entry in the progress notes that documented the area had healed. She stated she did not know why the size and description of the area was not noted on the weekly skin check.</p> <p>The facility failed to consistently monitor skin</p>	F 309			

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F 309	Continued From page 17 impairments and or ulcers the staff identified during weekly skin assessments. Failure to ensure skin the policy for monitoring skin issues was consistently implemented left staff without needed information to assess the effectiveness of treatments being administered and placed residents at risk for the further deterioration of wounds and/ or ulcers.	F 309			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	F329(D) Resident #18 [REDACTED] medication was discontinued on 8/22/14 and care plan was updated as needed. Resident #120 received new orders on 8/7/14 to taper then discontinue routine [REDACTED] on 8/20/14. Care plan updated as needed. The Social Services and or designee will review current residents with orders for antipsychotic medications to ensure there is an adequate indication for use and ensure that the staff is monitoring residents behaviors and for potential side effects. Also, to follow up on pharmacy recommendations for gradual dose reductions as required. The Director of Staff Development and or designee will in-service the licensed staff on the requirement of having an appropriate indication of use for Psychotropic medications and of the need for monitoring behaviors and for potential side effects. Also, of the need to follow up on pharmacy recommendations for gradual dose reductions as required.		

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F 329	<p>Continued From page 18</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure two (#s 18 & #120) of five residents reviewed for unnecessary medications an adequate indication and monitoring for the use of antipsychotic medications. Failure to ensure there was an adequate indication for the use of an antipsychotic and ensure the staff monitored residents for potential side effects placed residents at risk for unnecessary medications.</p> <p>Findings include:</p> <p>RESIDENT #18</p> <p>Resident #18 was admitted to the facility with multiple medical diagnoses including dementia on [REDACTED] 13. Review of the initial Minimum Data Set (MDS) assessments reported the resident did not display any behavioral issues. Subsequent quarterly and the annual MDS assessment's completed between 03/15/13 and 06/14/14 were coded the same, no behavioral issues were reported.</p> <p>Resident #18, was observed to attend meals in the main dining room during the survey. The resident appeared somnolent at times and did not always respond to verbal cuing.</p> <p>According to the Physician orders the resident was being administered [REDACTED] medication for [REDACTED] behavior and [REDACTED] at the same dosage since 05/03/13. According to the behavior monitors the medication was administered for yelling, threatening, and negative statements, however</p>	F 329	<p>The Social Service Director and or designee will conduct random audits to ensure residents with orders for antipsychotic medications have an adequate indication for use and ensure that the staff is monitoring residents behaviors and for potential side effects. This audit will include the need to follow up on pharmacy recommendation for gradual dose reductions as required. Findings will be given to the Director of Nursing Services (DNS).</p> <p>The DNS will bring findings to the Quality Assessment & Assurance (QA&A) Committee.</p> <p>The QA&A Committee will review findings and make recommendation as needed.</p> <p>The DNS will ensure compliance.</p>	9/13/14

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F 329	<p>Continued From page 19</p> <p>the monitors revealed the resident had no behavioral episodes. The staff did sporadically note the resident experienced side effects of the medications described as "sedation."</p> <p>Review of the clinical record found the Pharmacist recommended a dose reduction of the antipsychotic medication on 12/05/13. The physician declined the recommendation and noted the resident family indicated the resident was still exhibiting symptoms of [REDACTED] behavior."</p> <p>Two additional pharmacy recommendations for a dose reduction of the [REDACTED] dated 03/07/14 and 07/10/14, were in the clinical record. On 03/07/14, the physician declined the recommendation noting "behavior was being successfully treated." On 07/10/14, the physician documented the resident had "long standing" [REDACTED] behaviors and declined a dose reduction again.</p> <p>On 08/07/14 at 10:30 a.m., the Director of Nursing Services was interviewed about Resident #18's medication regime. After reviewing the Physician's responses to the pharmacy recommendations, she stated the clinical rationale to continue the medication without attempting a dose reduction was not documented. She could not find any evidence the risks and benefits for the continued use of the medication had been considered.</p> <p>RESIDENT #120</p>	F 329		
	<p>Resident #120</p> <p>Resident #120 was readmitted to the facility on</p>			

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F 329	<p>Continued From page 20</p> <p>██████████14, with hospice services in place. At the time of admission the resident had an order to administer 3 mg of ██████████ an ██████████ medication routinely three times a day. A routine ██████████ medication, ██████████ had been ordered twice a day. The orders also noted a second ██████████ medication, ██████████ could be given if needed, and an additional 1 mg dose of the ██████████ could be administered. On 07/09/14, a routine dose of ██████████ an ██████████ administered twice a day, was added to the drug regime.</p> <p>On 07/31, 08/01, 08/04, 08/05, and 08/06/14, the resident was observed to remain in bed dressed in a hospital gown. The resident at times was found fast asleep and at other times was easily aroused and able to converse the resident was never out of bed and or dressed for meals or activities during the survey.</p> <p>According to the care plan two ██████████ medications, ██████████ was "administered for dementia ██████████ agitation and ██████████ per hospice orders." And the other ██████████ was administered for ██████████</p> <p>A pharmacy recommendation dated 07/15/14, noted the resident was on multiple ██████████ medications and recommended one of them ██████████ be discontinued. The physician's declined the recommendation. The entry on the consult, dated 07/16/14, indicated the resident was on hospice and the current medications "are effective" for comfort. However, the clinical rationale and justification for continued use of ██████████ was not found. There was no evidence the risks and benefits for the continued use of the</p>	F 329		

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F 329	Continued From page 21 medication were considered. On 08/06/14 at 2:45 p.m., the Representative was interviewed about the resident's daily care. When asked about the use of the [REDACTED] medication, she confirmed the resident experienced [REDACTED] at times. She reported the behavior had been long standing and was managed in the past with [REDACTED]. She explained the [REDACTED] had recently been reinitiated after she insisted. The Representative stated she did not know why the other [REDACTED] medication, [REDACTED] was being administered. On 08/07/14 at 10:30 a.m., during an interview the DNS reported she did not know why the order for the routine [REDACTED] was initiated. She explained that at the time of re-admission the order was in place and explained the hospice nurse coordinated medication services. She explained a conference had been arranged later that day and the medication, and use of the Haldol would be reviewed.	F 329			
F 406 SS-D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a	F 406	F406(D) Resident #406 will be offered to receive mental health services as required and care plan updated as needed. Medical Records will audit current residents who have had a positive preadmission Screening (PASSAR) and give the list of names to Social Services. Social Services will review the list to ensure those residents are offered and provided mental health services as required.		

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F 406	Continued From page 22 provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure specialized rehabilitation services were coordinated for a one of one residents (#114) who had a positive preadmission screening, (PASSAR). Failure to ensure the facility coordinated the specialized mental health services placed the resident at risk for a diminished quality of life. Findings include: Resident #114 was admitted to the facility on [REDACTED] 14 with multiple diagnoses including [REDACTED]. The resident's initial Minimum Data Set (MDS) assessment, dated 06/23/14, documented the resident had a level II PASSAR screening was completed that identified the resident had a "serious mental illness." On 08/04/14, during an interview Resident #114 stated she was "stuck in the facility." She explained she had resided in a different facility, which closed, prior to her admission on [REDACTED] 14. She stated she had been looking for an alternate placement in a lesser care environment, but had not been able to locate any other living arrangements. She then commented "no one will take me." The resident stated she had seen a Mental Health provider in the past and they were helpful with coping strategies The clinical record also contained a referral to the "community health care center" of Snohomish County, dated 06/13/14. The referral provided a	F 406	Medical Records will audit new admits to ensure a copy of residents with a Level II PASSAR is given to Social services to follow up and ensure to coordinate Specialized mental health services is in place as needed. Social Services will be in-serviced by the Director of Nursing Services (DNS) on the need to ensure residents with a Level II PASSAR are follow up/to coordinate Specialized mental health services is in place as required. The Resident Care Manager and or designee will conduct random audits to ensure residents with a Level II PASSAR has coordinated Specialized mental health services in place as required. Findings will be given to the DNS. The DNS will bring findings to the Quality Assessment & Assurance (QA&A) Committee. The QA&A Committee will review findings and make recommendations as needed. The DNS will ensure compliance.		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505181	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/07/2014
NAME OF PROVIDER OR SUPPLIER REDMOND CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7900 WILLOWS ROAD NORTHEAST REDMOND, WA 98052		
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F 406	Continued From page 23 phone number for psychiatry access line, and instructions stating "Please call the number above. They will do a brief intake and determine a facility that bests fits your need." Review of the Social Services assessment dated 6/23/14, found no behavioral issues were documented. The assessment noted the resident was at risk for mood issues and indicated the facility staff would assist the resident to find a more appropriate placement. On 08/05/14 at 10:00 a.m. Staff N, a facility nurse, explained the Social Worker position was vacant and she filled the position for "several months." She stated the resident was admitted while she was acting Social Services. When asked about the referral dated 06/17/14, Staff D, stated she was not aware of the consult in the record, but would look into it. Not ensuring the facility coordinated mental health services for a Resident who was identified with a "serious mental illness" may have contributed to a delay in treatment and services.	F 406			
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for	F 412	F412(D) Resident #49 was seen by the dentist on 8/5/14. Resident seen by dentist on 8/22/14 for tooth extraction and resident adamantly refused to have teeth pulled, thus remains with same oral status. Family and physician notified. Resident's daughter will be at the facility on 8/27/2014 to meet with Social		

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F 412	<p>Continued From page 24</p> <p>transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to provide dental services for two of two Residents (#s 48 & 49) reviewed in Stage II for dental services. Failure to ensure residents received routine dental care in a timely manner placed them at risk for poor oral hygiene, pain and less than adequate nutritional intake.</p> <p>Findings include:</p> <p>RESIDENT #49</p> <p>According to the Minimum Data Set Assessment (MDS) dated 01/27/14, Resident #49 had no evidence of dental caries, broken or missing teeth.</p> <p>A review of the nursing assessment done by the facility dated 01/27/14 revealed, the resident had both dental caries and missing teeth however, the facility's "LN-Nutrition/Hydration Risk Evaluation" dated 01/30/14 indicated the resident's teeth were in good condition.</p> <p>Resident #49's dental consultation on 08/05/14 revealed missing teeth on both upper and lower; in addition the report also indicates the resident's gums were irritated and red with heavy tarter.</p> <p>In an interview on 08/05/14 at 11:01 A.M., Staff B stated information regarding the conditions of</p>	F 412	<p>Services and obtain a list of dentist's in the Redmond/Bellevue area (daughter's request) so she can make an appointment for resident. Daughter will accompany resident to dentist appointment. Resident has been observed by staff eating meals with no c/o pain or discomfort. Pain assessment was completed, resident denied any pain r/t oral status. Documentation is in the medical record. MDS has been corrected to reflect residents current oral status and resident's care plan has been updated. A new LN-Nutrition/Hydration Risk Evaluation was completed on 8/22/14.</p> <p>Resident #48 was seen by the dentist on 2/11/14. An oral assessment was completed on 8/25/14. Resident denies any pain or discomfort associated with her current oral status. The MDS has been corrected to reflect residents' current oral status and residents' care plan updated.</p> <p>Oral assessments will be conducted on current residents by Resident Care Manager and or designee, and those needing dental services will be put on a list and given to Social Services.</p> <p>Social Services will ensure residents needing dental services are seen by our dental consultant, Dr. Sherris and or by dentist of choice. Social Services will ensure referrals have been initiated and documented on a timely manner.</p>	
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F 412	<p>Continued From page 25</p> <p>Resident #49's teeth should have been collected on the initial assessment and included on the MDS. Staff B stated she was unaware if residents are routinely informed about dental services when they are admitted. However, Staff B stated licensed nurses should have assessed the condition of the resident's teeth and made a referral for dental services for evaluation and treatment.</p> <p>An observation of the resident's teeth on 07/31/14 at 2:10 P.M. revealed several missing and broken teeth. According to the resident, she mentioned the condition of her teeth and her desire to have her teeth repaired and replaced when she entered the facility on [REDACTED] 14, however she was not seen by a dentist until 08/05/14.</p> <p>RESIDENT #48</p> <p>Resident #48 was readmitted from an acute care facility on [REDACTED] 13, with multiple medical diagnoses. Review of the most recent annual MDS assessment dated, 02/05/14, noted the resident had broken and or loose teeth.</p> <p>On 07/31/2014 at 9:30 a.m., the resident was interviewed. When asked the questions about oral health status the resident reported " my teeth are falling out." She stated she had not seen a dentist in years and reported the staff was aware of the need for dental services. She stated</p>	F 412	<p>The Director of Staff Development and or designee will in-service licensed nursing staff to ensure resident conduct an initial evaluation of the resident's dentals needs on admit. Make referrals to the Social Services to have residents be seen by dental consultant as needed. Daily dental and oral hygiene is provided by nursing and report/referrals of any dental issues as required</p> <p>The Resident Care Manager and or designee will conduct random audits to ensure resident routine dental care needs are being met. Findings will be given to the Director of Nursing Services (DNS).</p> <p>The DNS will bring findings to the Quality Assessment & Assurance (QA&A) Committee. The QA&A Committee will make recommendations as needed.</p> <p>The DNS will ensure compliance.</p>	<p>9/15/14</p>

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F 412	<p>Continued From page 26</p> <p>the last time the facility staff talked to her about the issue was several months ago.</p> <p>Review of the clinical record found a dental exam was completed on 2/11/14. The consult indicated the resident needed tooth extractions and noted nine broken teeth. A hand written notation on the side of consult stated " has her own dentist for ext (extractions.)"</p> <p>On 08/04/14 at 11:35 a.m., a Social Services Assistant, Staff K, was interviewed about the coordination of dental services. She reported the nursing staff was responsible for reporting the need for dental services and stated the Receptionist maintained a list of the residents who were referred.</p> <p>On 8/4/14 at 12:55 p.m., Staff M, the Receptionist was interviewed. Staff M reported she maintained a list of residents in need of dental care. She explained the nurses provided the names of the residents who needed services and then they are placed on the list. When asked Staff M, reported the last referral for Resident #48 was in December 2013.</p> <p>On 08/05/14 at 1:05 p.m., Staff L, a Nurse was interviewed about the resident care needs. She stated she was not aware the resident needed any dental treatment. Not ensuring the facility coordinated dental services for Resident #48, placed the resident at risk for health complications associated with untreated dental caries.</p>	F 412			
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431			

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F 431 SS=D	Continued From page 27 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 facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	F431 (D) No Residents noted to be affected by F431 citation. The Resident Care Manager and/or designee will conduct an inspections of facility medication carts and the medication refrigerator in the medication room to ensure a) Medications that are expired are removed and disposed of as required. b) Medications prescribed for residents no longer in the facility are returned to the pharmacy and or disposed as required. The Director of Staff Development and or designee will conduct an in-service for licensed nurses to ensure there is proper disposition of expired medications as required. This includes disposition of medications for discharged residents. The Director of Staff Development will conduct random audits of the medication carts and the refrigerator in the medication room to ensure there are no expired medications stored in these areas. Findings will be given to the Director of Nursing Services (DNS) for review and follow up. The DNS will bring findings to the Quality Assessment and Assurance (QA&A) Committee. The QA&A Committee will review findings and make recommendations as needed.		
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record		The DNS will ensure compliance.	9/15/14	

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F 431	Continued From page 28 review, it was determined the facility failed to label and destroy out dated medications as indicated. Findings include: Facility Policy The Facility's Drug Storage Policy dated November 2007 indicated the Facility should follow both state and federal regulations, and ensure that all medication and biological's should have an expiration date and would be properly labeled additionally, unused medication will be returned to pharmacy. In an observation of the "B wing's medication cart" on 07/30/14, a box of Melatonin 3 milligrams (mg) tablets with an expiration date of 01/19/14, also a box of children's Allegra with an expiration date of 06/2014. According to Staff O in an interview on the same day, the Allegra belonged to a former resident. In an observation of the "C wing's medication cart" on 07/30/14 a bottle containing hydrocodone tablets, (a narcotic) were found with an expiration date of 02/01/12. In an observation of the facility's "medication room refrigerator" on 07/30/14 revealed five boxes of influenza vaccine with an expiration date of June 2014, in addition a vial of antibiotics with an open date of 07/22/14 was observed in the refrigerator. According to Staff I antibiotics should be disposed of 24 hours after opening them.	F 431			
F 441	483.65 INFECTION CONTROL, PREVENT	F 441			

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F 441 SS=F	Continued From page 29 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F441(F) There were no residents noted to be affected by F441. Staff G was given 1:1 training by the Director of Staff Development and or designee on hand hygiene, sanitizing, and cross contamination related to proper wearing of protective clothing. The Plant manager will conduct an audit to ensure that the staff is wearing the proper protective clothing, washing or sanitizing their hands, and properly storing the dirty linen. The plant manager will post a temperature log on the washing machines and an in-service will be conducted to teach the laundry staff how to read the temperature of the water in the washing machine and document it on the log. Random audits will be conducted by the Plant Manager and or designee to ensure the proper protective clothing is being worn and the temperatures are being recorded correctly The results will be reported to the Quality Assessment & Assurance Committee (QA&A). Staff P was given 1:1 training by the Director of Staff Development and or designee on hand hygiene, sanitizing, and cross contamination related to proper medication administration.	

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F 441	<p>Continued From page 30</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to establish a system to ensure effective sanitization of linen and personal clothing in the laundry to prevent spread of infection. Additionally, the facility failed to implement appropriate infection control practices related to hand washing and use of protective clothing in the laundry. This failure placed the residents at risk for exposure to infectious diseases.</p> <p>Findings include:</p> <p>Review of the Laundry Inspection report under sub-heading recommendations read, "Chlorine for all bleachable linen. 140 degrees -15 minutes contact time and 160 degrees-5-minutes contact time."</p> <p>On 08/05/14 at about 8:35 a.m., during the initial tour of the facility's laundry, Staff G the laundry manager was observed loading soiled linen in the washing machine without any protective clothing or gloves. In an interview when Staff G was asked, she stated she had forgotten to wear an apron and gloves before loading the washing machine with soiled linen.</p> <p>On 08/05/14 at about 8:40 a.m., bags of unsorted soiled linen from isolation rooms were observed on the floor next the washing machines in the clean area of the laundry. When asked, Staff G acknowledged and stated, "These bags are supposed to be in the soiled linen sorting room, but there was not enough room."</p>	F 441	<p>Training also included that plastic trays will no longer be available for the use of medication administration.</p> <p>The Director of Staff Development and or designee conducted in-services for licensed nursing staff on hand hygiene, sanitizing, and cross contamination related to proper medication administration. This will ensure appropriate infection control practices.</p> <p>The Director of Staff Development and or designee will conduct random audits to ensure license staff are practicing appropriate hand hygiene, sanitizing, and cross contamination related to proper medication administration. Findings will be given to the Director of Nursing Services (DNS) for review and follow up.</p> <p>The DNS and Plant manager will bring findings to the Quality Assessment and Assurance (QA&A) Committee. The QA&A Committee will review findings and make recommendations as needed.</p> <p>The Administrator will ensure compliance.</p>	9/15/14
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F 441	<p>Continued From page 31</p> <p>On 08/05/14 at about 9:00 a.m., Staff G the Laundry Manager and Staff H the Laundry Aide were unable to demonstrate how they checked temperatures for the washing machines. Staff G stated "I don't know how to check temperatures, because I have never done it before" Staff G also stated that the facility did not maintain a temperature log since she has worked in the laundry room at least 3 years.</p> <p>On 08/06/14 at 9:10 a.m., in an interview, Staff F, the Laundry Director acknowledged and confirmed the facility did not maintain evidence of temperatures for sanitization for the washing machines.</p> <p>Handwashing</p> <p>Staff P was observed on 08/01/14 at 5:00 A.M., threading tubing through an intravenous machine. Following the procedure, Staff P exited the room without conducting hand-washing or using hand sanitizer.</p> <p>Staff P returned to the "D wing" medication cart and without washing her hands or using hand sanitizer began to prepare medications. Staff P used a pink plastic tray to deliver medication to a residents room. She sat the tray on the resident's beside table. After administering medications, Staff P returned to the medication cart and without cleaning the pink plastic tray she placed it on the medication cart.</p> <p>Staff P continued to administer medications using the same plastic pink tray to transport medications to a resident whom she identified as having C-Difficile (a contagious gastrointestinal infection which cause diarrhea). Staff P failed to</p>	F 441		
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F 441	Continued From page 32 conduct hand washing or using hand sanitizer. Additionally, she transported the pink plastic tray back to her medication cart. In an interview on 08/01/14 at 08:00 A.M., with Staff P stated her normal practice was to clean the tray after each use.	F 441		
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