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

PRINTED: 03/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505140	A. BUILDING _____ B. WING _____	03/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND CARE CENTER LLC	2400 SAMISH WAY BELLINGHAM, WA 98225

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This report is the result of an unannounced Off-Hours Quality Indicator Survey conducted at Highland Care Center on 3/17/2014, 03/18/2014, 03/19/2014, 03/20/2014, 03/21/2014 and 03/24/2014. The survey included data collection on 03/21/14 from 4:50 a.m. to 8:00 a.m. A sample of 33 residents was reviewed from a census of 42. The sample included 29 current residents and and the records of 4 former and/or discharged resident. The survey was conducted by: Michelle Scollard, R.N., B.S.N. Nedra Vranish, R.N., B.S.N., M.S.Ed Susan Harris, R.N., B.S.N. Constance Rogers, R.N., B.S.N. Claude Weedon, R.N., B.S.N, M.N. The survey team is from: Department of Social and Health Services Aging & Long Term Care Services Administration Residential Care Services 3906 172nd Street NE, Suite 100 Arlington, WA 98223-4740 Telephone: 360-651-6850 Fax: 360-651-6940 Lynne Daskee 3/28/14 Residential Care Services Date	F 000	APR 11 2014 ADSA/RCS Region 3 "This plan of correction is being submitted pursuant to the applicable federal and state regulations. Nothing contained herein shall be construed as an admission that the Facility violated any federal or state regulation or failed to follow any applicable standard of care."	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Terry Myers	Administrator	4/10/2014

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 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to obtain informed consent for use of two psychoactive medications for 1 of 5 sampled residents (10) reviewed for use of unnecessary medications. This failure deprived the resident of her right to decide whether she wished to receive those medications. Findings include: Resident 10 was admitted to the facility [redacted] 2013 with multiple medical diagnoses that included mild dementia, [redacted] and metabolic encephalopathy. The resident was alert and able to make her needs known. She was cooperative with interview. A review of the resident's February and March 2014 medication administration records (MAR's) revealed Resident 10 was receiving the [redacted] milligrams (mg) daily at bedtime when admitted to the facility on 7/8/13. Also found on the MAR's was the	F 154	**Deficiencies relating to F154** – Informed of Health Status, Care, & Treatments has been corrected as follows: The Risks and Benefits of both [redacted] and [redacted] were discussed with Resident 10 on the day the state surveyor brought the oversight to our attention and Resident 10 indicated understanding and complete agreement with the doctor's order for these medications. She signed the Informed Consent forms immediately. Upon further investigation it has been determined that this was an isolated case, but nurses have been reminded of the need for discussions regarding risks and benefits of psychoactive medications prior to administration with signed informed consent forms to document the discussions. Nurses have also been provided with an updated list of medications needing informed consents prior to administration.	

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F 154	Continued From page 2 [redacted] 25 mg daily at bedtime. The original order for [redacted] was dated 2/17/14. Both [redacted] and [redacted] were initialed on the MAR's indicating they had been given daily as ordered. The February 2014 Quarterly Psychoactive Medication Review documentation indicated the [redacted] was for sleep. [redacted] had not yet been started when the committee met.) A Social Services Progress Note dated 2/17/14 stated "use of [redacted] discussed with ARNP (nurse practitioner) to assist with sleeping - problem has been ongoing since admission." There was no documentation of informed consent for either medication in a review of the resident's clinical record. Additionally, no documentation was found in progress notes to indicate either medication had been discussed with the resident. In interview on 3/23/14, Resident 10 stated she did not know why she was taking [redacted] but had been on it for a long time. The resident said she did not think anyone in the facility had talked with her about either the [redacted] or the [redacted] The resident stated she remembered talking with someone about starting another medication for sleep (now discontinued), but not the other two medications. In an interview on 3/19/14 at 2:47 pm, Staff J, a registered nurse, was unable to locate signed informed consent records for either of the two psychoactive medications received daily by Resident 10 [redacted] Staff J stated "no consents were signed".	F 154	Going forward, the Social Services Director will audit charts for consents as she is reviewing medications and associated behaviors for the Psychoactive Medication and Behaviors Review Committee each month. Her findings will be included in her report to the Quality Assurance Performance Improvement (QAPI) Committee. If there are any concerns from her findings, the QAPI committee will initiate a Performance Improvement Project designed to reach a sustainable solution. Administrator and Director of Nursing Services will monitor for compliance. **Completion date**: 3/24/2014 gm	

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F 154	Continued From page 3 In an interview on 3/20/14, Staff I, the Director of Nursing, stated the facility process for a resident receiving, or about to begin a psychoactive medication(s) included a discussion of risks and benefits associated with use of the specific medication(s) and obtaining signed informed consent from the resident, if able, or from the resident's representative (if the resident was unable to give consent). In an interview on 3/24/14 at 9:48 a.m., Staff I looked for progress notes indicating one or both medications had been discussed with the resident. Staff I stated she did not find any progress notes addressing the [redacted] or [redacted] In an interview on 3/24/14 at 10:13 a.m., a Mental Health Consultant stated she visited the facility every two weeks and had seen Resident 10 only once. The consultant stated Resident 10 had reported to her that she took [redacted] for some problems that were "not as bad as [redacted] The consultant said the resident's reported information told her the resident needed to be on the [redacted]	F 154		
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	F 315		

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F 315	Continued From page 4 function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide the necessary care and services for 1 of 2 sampled residents (29) reviewed for urinary incontinence. This failed practice placed Resident 29 at risk of not achieving and/or maintaining his optimal urinary functional level. Findings include: Resident 29 was admitted [redacted] 2013 with a diagnosis of urinary incontinence. The nursing admission assessment, dated 10/2/13, stated the resident denies urinary pain "discomfort, urgency, frequency .... " The admission Minimum Data Set (MDS), an assessment tool, dated 10/9/13, identified the resident as continent of his bladder. The Care Area Assessment, dated 10/9/13, stated the resident was continent of urine and was able to make his toileting needs known. The quarterly MDS assessment, dated 1/2/14, identified the resident as frequently incontinent of bladder and there was no trial of a toileting program. The resident had short term memory loss. The Nursing Quarterly Summary, dated 1/2/14, identified the resident as being frequently incontinent of urine, and required assist with toileting. The assessor stated "no changes" in his urinary elimination and toileting. A Bladder Incontinence History assessment was	F 315	**Deficiency relating to F315** – No Catheter, Prevent UTI, Restore Bladder has been corrected as follows: A Bladder Incontinence History assessment was done on Resident 29 on 1/2/14. A subsequent 3 day bladder diary has been completed and it has been determined that his continence / incontinence has not changed. It appears as incontinence when he uses or empties his urinal and spills. CNAs (Certified Nursing Aides) have been in-serviced to check and empty his urinal more frequently to decrease spillage. They have also been in-serviced to alert nursing through the Stop and Watch system if any changes are noted in Resident's continence pattern. Incontinence questions have been added to the admission flow sheets for consistent admission assessments. Residents will continue to be assessed upon admission and will have a care plan developed to meet their needs. Assessments will continue to be done TM	

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F 315	Continued From page 5 completed on 1/2/14. The assessment identified the resident had been incontinent of urine prior to admission and had "functional" urinary incontinence. The resident required extensive assist of two people for toileting needs. The plan was to toilet the resident every 2-3 hours and when requested. The current care plan goal was to maintain his skin integrity over the next quarter. The resident was to be toileted every 1 - 2 hours and when requested. On several days of the survey, the resident was observed sitting in his wheelchair or in a reclining chair in his room with a urinal on the over bed table and within his reach. In an interview on 3/21/14 at 10:45 a.m. the Director of Nursing Services (DNS) was interviewed regarding the facility's procedure for evaluating a resident's urinary status. The DNS stated each resident was assessed upon admission and quarterly regarding their urinary status using the "Bladder Incontinence History" assessment form. The DNS was asked what the expectation was when a resident exhibited a decline in their urinary function. The DNS stated there should be an assessment of why there was a change. On 3/21/14 at 1:39 p.m., Staff C, Resident Care Manager (RCM) was interviewed regarding Resident 29's decline in urinary continence and if there was a Bladder Incontinence History assessment done on admission. Staff C replied there had been no assessment done on admission and there had been no further plan to regain the resident's urinary continence.	F 315	with any significant changes and at least quarterly with any necessary changes being made to the care plan. The Resident Care Manager will document changes found in the assessments and/or made in the care plan in the Residents' medical charts. The Director of Nursing Services (DNS) will review resident care plans and documentation regarding changes as Minimum Data Set (MDS) changes are made. Her findings will be included in her report to the Quality Assurance Performance Improvement (QAPI) Committee. If there are any concerns from her findings, the QAPI committee will initiate a Performance Improvement Project designed to reach a sustainable solution. Administrator and Director of Nursing Services will monitor for compliance. **Completion date:** 4/15/2014	

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F 315	Continued From page 6 The facility failed to provide the necessary care and services in an attempt to assist the resident in overcoming the obstacles preventing continence, such as assessing why there may have been a decline in urinary continence, a trial toileting program, or other measures appropriate to the resident's assessed physical needs.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure 1 of 3 sampled residents (22) identified with limited range of motion received restorative and/or rehabilitative services to prevent further functional decline. Findings include: Resident 22 was admitted [redacted] 2013 with diagnosis of [redacted] The resident required extensive assist of one person for dressing, eating, toileting and personal	F 318	**Deficiency relating to F318 –** Increase/prevent decrease in range of motion has been corrected as follows: Resident #22 did admit with orders from previous facility for a Palm Guard and Resting Hand Splint as well as directions for the washcloth / hand roll in his left hand. When queried about the whereabouts of the palm guard and hand splint, staff at the previous facility stated he had always refused to wear them and they did not know where they were. Documentation on our treatment administration records (TARs) shows clearly resident's refusals to wear / use the washcloth hand roll in his hand from [redacted]13 (date of admit) through 12/9/13 when it was d/cd for non-use.	

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F 318	Continued From page 7 hygiene. In an interview on 3/17/14 at 11:14 a.m., Staff I, Director of Nursing Services stated the resident had contractures (a contracture is defined as a condition of fixed high resistance to passive stretch of a muscle) in both of his hands and in his toes. The resident was not on any range of motion (ROM) program for his hands and toes, nor did he have a splint in place. Staff I stated the resident refused to wear any type of splint or device to assist with his contractures. In an interview on 3/17/14 at 3:00 p.m., Resident 22 was observed to have [redacted] of [redacted] position and he was not able to straighten them out. The resident demonstrated limited range of motion in his hands. Resident 22 stated both of his ankles "turn inward," but he was "able to still walk." The admission orders referred staff to see "splint schedule attached." The splint schedule directed staff to apply a washcloth hand roll in his left hand. The washcloth was to be on for 6 hours and the off for 6 hours around the clock. The Licensed Nurse was responsible for the applying and removing the hand roll. This was documented on the monthly Treatment Administration Records (TARs). Upon review of the December 2013 TARs, the left hand roll was discontinued on 12/9/13. The restorative nursing progress notes were reviewed. There was no evidence of why the hand roll was removed or that there was a hand roll in place upon admit. The resident received a	F 318	Resident was assessed in January by Occupational Therapy for adaptive equipment for eating, and refused treatment or equipment. Resident has consistently refused therapy assessments for contractures &/or adaptive equipment. Resident has also refused Restorative programs for Range of Motion (ROM) including general non-compliance with the neck ROM program. Resident 22's Primary Care Physician has provided care for him for years and is well aware of his refusals and consequential discontinuation of washcloth hand roll. Staff has been reminded of the importance of documenting such conversations / refusals of care. Facility will continue to assess and offer contracture treatment to Resident 22 at least quarterly. Residents will continue to be assessed upon admission and will have a care plan developed to meet their needs. Assessments will continue to be done with any significant changes and at least quarterly with any necessary	

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F 318	Continued From page 8 ROM program for his neck. The current care plan stated the resident had [redacted] The goal was to have no decline in his ROM. There were no interventions in place on his care plan to direct staff to help prevent a further decline in ROM. In an interview on 3/20/14 at 3:00 p.m., Staff H, Restorative Aid, stated Resident 22 was currently on a ROM program for his neck. Staff H stated she never had a ROM program for his hands or feet. In an interview on 3/21/14 at 9:25 a.m., Staff C, Restorative Nurse, was asked about the discontinuation of the left hand roll. Staff C replied the hand roll was discontinued by one of the floor nurses on 12/9/13. Staff C reviewed the resident's record and could not find a rationale for why the hand roll was discontinued or what the facility implemented to maintain the resident's ROM to his left hand. There was no justification of why the hand roll was discontinued, or what the facility attempted to do to prevent potential decline in the resident's limited range of motion to his left hand. The primary physician was not notified of the discontinuation of the hand roll.	F 318	changes being made to the care plan. Physicians will continue to be notified of any changes in condition noted in their residents. The Resident Care Manager will document changes found in the assessments and/or made in the care plan in the Residents' medical charts. The Director of Nursing Services (DNS) will review resident care plans and documentation regarding changes as Minimum Data Set (MDS) changes are made. Her findings will be included in her report to the Quality Assurance Performance Improvement (QAPI) Committee. If there are any concerns from her findings, the QAPI committee will initiate a Performance Improvement Project designed to reach a sustainable solution. Administrator and Director of Nursing Services will monitor for compliance. **Completion date**: 3/24/2014	
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on	F 356		

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F 356	Continued From page 9 a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to properly maintain all required components for a daily posting of staff working in the facility. This failure placed residents and visitors at risk of not being accurately informed of the daily staffing levels.	F 356	**Deficiency relating to F356** – Posted Nurse Staffing Information has been corrected as follows: The night shift nurses were in-serviced to change the staffing information posted at midnight each night and update any changes in actual hours worked each shift. Administrator and Director of Nursing Services will monitor for compliance. **Completion date**: 3/24/2014	gm

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F 356	Continued From page 10 Findings include: On 3/17/14 at 9:00 a.m., the daily staffing posted was for 3/14/14. On 3/18/19, 3/19/14, 3/20/14 and 3/21/14, the daily staffing posted was for the prior day. The facility shifts were scheduled as follows: Night shift started at 10:00 p.m., a.m. shift started at 6:00 a.m. and p.m. shift started at 2:00 p.m. The daily staffing was not updated until after 9:15 a.m. The daily staffing posted only reflected the predicted staffing hours and not the actual staffing hours. In an interview on 3/21/14 at 11:15 a.m., the Director of Nursing Services (DNS) stated medical records personnel updated the daily staffing when "she comes in." The DNS was informed the daily staffing had not been updated until after 9 a.m. each day of the survey and did not accurately reflect the daily staffing. On 3/24/14 at 8:45 a.m., the daily staffing posted was for 3/21/14.	F 356		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371		TM

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F 371	Continued From page 11 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure food was distributed and served under sanitary conditions in 1 of 1 dining rooms. This placed residents at risk for potential food borne illnesses Findings include: On 3/20/14 at 8:00 a.m., the breakfast meal was being served. Staff A, Nursing Assistant Certified (NAC), was holding Resident 3's hand in both of her hands prior to the meal being served. Staff A, got up and started to assist with meal delivery without washing her hands. Staff A delivered a breakfast tray to resident 27. While removing the items from the tray, Staff A touched the rims of each beverage with her bare hands. Staff A, then went into the kitchen to obtain some honey for a resident, then retrieved another breakfast tray and left the dining room. Staff A then came back into the dining room and washed her hands. At 8:06 a.m., Staff A was observed delivering a tray to Resident 54. Staff A grabbed two cups at the same time with her bare right hand and placed them on the table. Staff A then removed the last cup by the rim and placed it on the table. Staff A was observed to touch her pants with her bare hands as she obtained a breakfast tray for Resident 34. With now contaminated hands, Staff A removed each beverage cup, with her	F 371	**Deficiency relating to F371** – Food Procure, Store/Prepare/Serve – Sanitary has been corrected as follows: Staff have been re-in-serviced on hand washing technique and frequency, and on the sanitary serving of food and beverages. An additional sanitizer station has also been installed in the dining room next to where staff line up to retrieve trays to serve meals to residents. Staff is encouraged to re-sanitize hands frequently during meal service in addition to washing when knowingly contaminated. Additionally, the Dining Services personnel are removing all lids from beverages in order to simplify meal service for staff delivering the food and beverages. The Staff Development Coordinator / Infection Control Nurse will monitor meal service with frequent, random observations. She will report her findings to the Quality Assurance Performance Improvement (QAPI) gm	

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	505140		03/24/2014

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F 371	Continued From page 12 bare hands, by their rim and placed them on the table. At 8:07 a.m. Staff B, NAC, was observed touching her pants as she obtained a tray for Resident 2. Staff B removed the cups from the tray by grabbing their rims and placing them on the table. In an interview on 3/20/14 at 11:50 a.m., Staff D, Staff Development Coordinator, was asked regarding the handling of cup rims when placing them on the table. Staff D stated staff were not to touch the cup rims with their bare hands. In an interview on 3/20/14 at 1:00 p.m., Staff A was asked about how she delivered the breakfast trays and handled the rims of four different residents cups while placing them on the table. Staff A acknowledged she did not deliver they trays correctly.	F 371	Committee. If there are any concerns, the QAPI committee will initiate a Performance Improvement Project designed to reach a sustainable solution. Administrator and Director of Nursing Services will monitor for compliance. **Completion date**: 3/27/2014	
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.	F 411		

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F 411	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to arrange dental services for 1 of 4 residents (22) reviewed for dental needs. This failed practice placed the resident at nutritional risk and had the potential to affect psychosocial well-being. Findings include: The facility's policy and procedure titled "Dental Care" stated Social Service was responsible to review dental care needs with the resident and/or responsible party when admitted, quarterly and at care conferences. Resident 22 was admitted to the facility [redacted] 2013. The admission Minimum Data Set (MDS), an assessment tool, dated 11/4/13, and the quarterly MDS, dated 1/27/14, identified the resident as alert and oriented, able to make his needs known, and had no dental concerns. The quarterly nursing summary, dated 1/27/14, stated the resident had full upper and lower dentures. In an interview on 3/17/14 at 2:56 p.m., Resident 22 stated his dentures did not fit and he was unable to wear them. When asked if he had told the facility of his dentures not fitting properly, Resident 22 replied he had told several staff members. During several observations throughout the survey, Resident 22 did not have his dentures in place. They were sitting in a denture container on the sink.	F 411	**Deficiency relating to F411** – Routine/Emergency Dental Services in SNFs has been corrected as follows: Resident 22 has been set up with a dental appointment and will have his denture needs addressed as quickly as possible. No other residents were identified as having similar issues. This was an isolated event. Residents will continue to be assessed upon admission and with any significant changes and quarterly for dental needs. Care with the appropriate dental professional will be arranged as needed. Additionally the Interact Stop and Watch program has been initiated so that any changes noted in any resident by any person will be noted on a duplicate form. The original of the Stop and Watch form is given to the resident's charge nurse and the duplicate is given to either the DNS or	

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F 411	Continued From page 14 The resident's current care plan and Nursing Assistant flow sheets stated the resident had full upper and lower dentures and needed assist to care for them. The resident received a mechanically altered diet. In an interview on 3/20/14 at 1:15 p.m., Staff D, Nursing Assistant Certified (NAC), stated she was aware the resident used dentures and they did not fit properly. When asked what the process was when a resident was experiencing dental concerns, Staff D replied she was to notify the Licensed Nurse (LN). In an interview on 3/20/14 at 1:30 p.m., Staff F, LN, was asked about Resident 22's dentures. Staff F stated she was aware his dentures did not fit and she notified the Social Service Director (SSD). In an interview on 3/20/14 at 1:40 p.m., Staff E, SSD, stated she was not aware of any concerns with Resident 22's dentures. Staff E was new to the position and stated the normal process was for the staff to notify the SSD of any dental concerns and the SSD would initiate obtaining a dentist for the resident. Staff E looked through the resident medical record and could find no evidence there had been a discussion with the resident regarding obtaining dental services. In an interview on 3/20/14 at 3:15 p.m. with Staff G, NAC, he stated the resident's dentures did not fit and the resident did not like to wear them. Staff G stated he alerted the LN of Resident 22's dentures not fitting.	F 411	the Administrator. The nurse then gives the original to the DNS / Administrator when the matter is followed up appropriately. The Stop and Watch forms are compiled by the Administrator for a report to the QAPI committee. The Social Services Director will also be reporting to the QAPI Committee on ancillary services – tracking, trending, and provided. If there are any concerns from either the Administrator's report or the Social Services Director's report the QAPI committee will initiate a Performance Improvement Project designed to reach a sustainable solution. Administrator and Director of Nursing Services will monitor for compliance. **Completion date**: 3/24/2014 gm	

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F 464 SS=D	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure 1 of 1 dining rooms was adequately furnished and had sufficient space to accommodate the physical and social needs of residents during the dining experience. Findings include: On 3/17/14 at 11:59 a.m., Resident 69 was served his noon meal. Resident 69 was observed in a wheelchair, the height of the table top was so low he was observed having difficulty bringing the food to his mouth without spilling it down his front. A substantial amount of food never made it to his mouth. Resident 69 was observed spilling some of the food down the front of his body as he was lifting the spoon to his mouth. Staff was observed walking by and not offering assistance. At 12:12 p.m., Staff H, Nursing Assistant Certified (NAC), sat down and assisted him with his meal. On 3/20/14 at 7:45 a.m., Staff D, License Practical Nurse (LPN), brought Resident 69 into the dining room. Staff D stated the table for Resident 69 is "almost too low for him."	F 464	**Deficiencies relating to F464** – Requirements for Dining and Activity Rooms have been corrected as follows: A new table with adjustable height has been ordered to meet the needs of Resident 69 and future tall residents. While we await the arrival of the new table, staff has been in-serviced to insure that he is moved as close as possible to his food – and to assist as necessary and as allowed with his meals. Staff has also been reminded to assist residents as they move about tight quarters and to insure that residents who may be disrupted by the movements are also assisted back to comfortable eating positions. gm	

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F 464	Continued From page 16 At 8:10 a.m., Resident 69 was served breakfast. During the breakfast observation Resident 69 was having difficulty reaching the eggs and oatmeal on his plate and feeding himself. As Resident 69 was bringing the spoonful of food to his mouth, it was falling off of the spoon and onto the front of his clothing protector. At 8:23 a.m., Resident 69 started to cough. Staff D, NAC, came over and asked him if he was okay. Resident 69 replied "I can't do it." Staff D, asked him what he could not do, and Resident 69 stated "eat." Staff D asked him if he wanted assistance with his meal, and the resident replied "yes." At 8:35 a.m., Resident 12 pushed back from the table and started to self-propel himself out of the dining room. Resident 12 was propelling his wheelchair between two tables. Resident 1 was sitting at one of the tables, eating her breakfast with her right hand, and there was a regular chair positioned at the seat next to her. As Resident 12 was propelling his wheelchair forward, he was trying to move the chair in front of him out of the way with his feet so he could get through. As Resident 12 was trying to move the chair, he was pushing Resident 1's wheelchair forward and slightly to the right. Resident 1's left side and abdomen was being pushed into the edge of the table as she was trying to eat her meal. At approximately 8:39 a.m., Staff B, NAC, assisted Resident 12 through the area and out of the dining room. Resident 1 was left positioned sideways to the table, and unable to adequately reach her meal. In an interview at 8:40 a.m., Staff D was asked about how Resident 69 was positioned in the dining room and it appeared the table was not	F 464	The Staff Development Coordinator / Infection Control Nurse will monitor meal service with frequent, random observations. She will report her findings to the Quality Assurance Performance Improvement (QAPI) Committee. If there are any concerns, the QAPI committee will initiate a Performance Improvement Project designed to reach a sustainable solution. Administrator and Director of Nursing Services will monitor for compliance. **Completion date**: 3/24/2014 gm	

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F 464	Continued From page 17 high enough to meet his needs and he was spilling his food trying to feed himself. Staff D stated she was aware of the situation and would be assessing him for the proper table height.	F 464		

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