

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

PRINTED: 11/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/15/2012
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NAME OF PROVIDER OR SUPPLIER MERRY HAVEN CARE CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 800 10TH STREET SNOHOMISH, WA 98290
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey (QIS) conducted at Merry Haven Care Center on November 8, 9, 13, 14, and 15, 2012. A sample of 46 residents was selected from a census of 78. The sample included 32 current residents and the records of 14 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>Rick Woodrum, RN, BSN Mary Vassey, RN, BSN, MBA/HCM Louvenia Ringuette, RN, BSN Leslie Martin, BSHS</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, Region 3, Unit B 3906 172nd Street NE, Suite 100 Arlington, WA 98223</p> <p>Telephone: (360) 651-6850 Fax: (360) 651-6940</p> <p><i>Coralyn Hendley</i> 11/21/12 Residential Care Services Date</p>	F 000	<p>RECEIVED NOV 30 2012 ADSA/RCS Smokey Point</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Westland</i>	TITLE <i>Administrator</i>	(X6) DATE <i>11/29/12</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to promote care for 5 of 8 resident's (1, 58, 21,10 & 68) in a manner and in an environment which maintained or enhanced the resident's dignity and respect in full recognition of there individuality. The failure to close the resident's curtain and door, cover a Foley catheter bag, protect behavior information, and provide clothing protectors placed these residents at risk of feelings of low self-esteem.</p> <p>Findings include:</p> <p>RESIDENT 1 Resident 1 re-admitted to the facility on [REDACTED] with a diagnosis of [REDACTED]. [REDACTED] The Minimum Data Set (MDS) assessment, dated 9/16/12, indicated the resident required 2 staff members for bed mobility, and 1 staff member for personal hygiene.</p> <p>Review of the facility Plan of Care indicated the resident was non-ambulatory and required a mechanical lift to get out of bed.</p> <p>On 11/14/12, at 10:10 a.m., a licensed nurse</p>	F 241	<p>F241 SS=E 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must provide care in a manner that maintains or enhances each resident's dignity and respect. This will be evidenced by;</p> <p><u>Resident #1</u> Caregivers have been instructed on providing dignity and privacy during treatment procedures</p> <p><u>Resident #58</u> Caregivers have been instructed on proper foley cath placement</p> <p><u>Resident#21 & Resident #10</u> Will be offered a clothing protector at mealtimes</p> <p><u>Resident #68</u> The communication signs posted at bedside have removed</p>	
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F 241 Continued From page 2
(Staff B) was observed completing a dressing change to a wound on the resident's right buttock. Prior to beginning the dressing change, the door to the room was noted closed and the curtain was partially closed. There was no roommate in the room.

Staff B stated she had requested a nursing assistant (Staff C) to assist her with the dressing change. Resident 1 was found lying on her left side with her gown pushed aside exposing her back, buttocks, and legs.

As the dressing change proceeded, Staff B stated to Staff C she was out of gloves. She requested Staff C go and get her another box of gloves. Staff C left the resident's side of the bed, went through the curtains leaving them partially opened and went out of the room leaving the door open. While waiting for Staff C to return with the gloves, several staff members were observed walking past the room. They did not stop and close the door.

Staff B did not close the door or the curtain leaving the resident's backside fully exposed to residents, staff and guests to see from the hallway. Staff C returned to the room with the retrieved box of gloves and set them on the residents bedside table. Staff C was reminded by Staff B to close the door and wash his hands.

On 11/15/12, at 8:42 a.m., the resident stated she "felt dumb" when asked how she felt about her backside being exposed from the hallway while going through the dressing change. She stated she used the word "dumb" because she could not walk and or stand up. She went on to say that if

F 241

All residents have the potential to be affected. Staff will continue ongoing reminders and education regarding resident privacy and dignity

The care managers and ancillary staff will be observant during facility rounds and provide feedback to the appropriate discipline

The Director of Nursing will be responsible for lasting compliance

Plan of correction date
11/27/2012 & ongoing

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F 241	<p>Continued From page 3</p> <p>she could have gotten out of bed she would have closed the curtain and the door. "I can't. I need help".</p> <p>RESIDENT 58 Resident 58 admitted to the facility on [REDACTED] with the diagnosis of [REDACTED]. A review of the MDS assessment dated 10/8/12, indicated the resident had a Foley catheter placed to assist in the drainage of urine from the bladder.</p> <p>Review of the facility plan of care indicated staff were to provide Foley catheter care each shift per the facility policy and were to keep the urinary drainage bag covered at all times - dignity issue.</p> <p>On 11/8/12 at 2:24 p.m., the resident was noted sleeping. The catheter bag was uncovered and was lying flat on the floor adjacent to the residents bed.</p> <p>On 11/13/12 at 11:04 the catheter drainage bag was noted on the floor uncovered and visible from the hallway for other residents, guest and staff to see. The same day at 12:54 p.m., the catheter bag was found covered in a blue case while the tubing remained on the floor.</p> <p>On 11/14/12, at 8:08 a.m., the Foiey catheter drainage bag was observed lying flat on the floor, tubing on the floor with the drainage bag uncovered.</p> <p>On 11/14/12, at 8:15 a.m., nursing assistant (Staff A) stated she was responsible for emptying and disposing the urine from the bag. She went onto say there were blue colored bags used to cover</p>	F 241		
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F 241	<p>Continued From page 4</p> <p>over the drainage bags. She stated that the drainage bags were covered for resident dignity.</p> <p>On 11/14/12, at 8:31 a.m., the Resident Care Manager stated, her expectations were for staff to cover the drainage bag and keep the bag and tubing up off the floor.</p> <p>RESIDENT 10 On 11/9/12, at 10:25 a.m., Resident 10 was observed receiving a meal tray in her room. She stated she used an apron as a clothing protector because no one had ever offered her a clothing protector with her meal. She further stated, she used a pillow case as a clothing protector.</p> <p>Resident 10 was observed during several meals to have a pillow case on her lap during meals. On 11/15/12, during the breakfast room tray delivery, three different staff were observed. No staff members were observed to offer residents dining in their rooms clothing protectors. None of the carts coming from the kitchen had clothing protectors on them for the staff to offer to protect their clothing from spills.</p> <p>RESIDENT 21 Resident 21 was observed sitting beside her bed in a wheel chair with her breakfast tray in front of her. She had a napkin opened across her lap. The napkin had several spots of cereal on it. "We are never offered a clothing protector". When asked if she wanted a clothing protector stated, "It would be nice".</p> <p>Continued observations found residents who dined in their rooms were not provided and were not observed wearing clothing protectors.</p>	F 241		
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F 241	<p>Continued From page 5</p> <p>On 11/15/12, at 8:15 a.m., nursing assistant (Staff F) stated the clothing protectors were kept in the dining room. "We don't usually give the residents in their room a clothing protector. Those that eat in their room aren't that messy."</p> <p>On 11/15/12, at 8:50 a.m., the Director of Nursing Services (DNS) stated, clothing protectors are in the dining room. She would expect staff to offer a clothing protector to all residents. She was unaware residents in the rooms were not being offered clothing protectors to keep their clothing clean.</p> <p>RESIDENT 68 Resident 68 admitted to the facility on [REDACTED] with a diagnosis of [REDACTED] which had resulted in the resident's inability to move part of the body and affected her ability to verbally communicate. The MDS assessment, dated 10/10/12, indicated the resident was unclear in her speech but did respond adequately to simple, direct communication.</p> <p>On 11/13/12, at 12:59 p.m., during room observations, a Communication Guidelines form was noted posted on the wall of Resident 68's room. The guideline which had an "X" mark in front of them, indicated a specific method staff could use to communicate with Resident 68. For example, there was an "X" marked in front of "Encourage patient to use communication board/book/device". A note next to this strategy stated the communication board could be found on the door of the bathroom. On the bottom of this sheet was a note which stated that "Her pointing yes or no was not reliable".</p>	F 241		
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F 241

Continued From page 6

F 241

Also posted above the bedside was Behavior Management non-medical interventions. They were as follows:

1. Please encourage resident to attend out of room activities and take her to them.
2. Alert SS (Social Services) & LN (Licensed Nurse) of any mood/behavior changes.

A communication board was found on the outside of the closet door. This sheet depicted a person performing individual activities. The sheet had 11 blocks with pictures. Captioned underneath each picture were the following words: eat, wash, lie down, drink, dress, wear, sleep, bathroom, give, get, pain and up high.

The Communication and Behavior Guidelines were visible not only for staff to see but other residents and visitors entering the room could also read these guidelines. The paperwork remained above the bed and on the bathroom door throughout the survey period.

On 11/13/12 at 2:30 p.m., Resident 68 was observed repeating the word "OK" over and over again when the surveyor attempted to talk to her about the posted care directives at her bedside.

On 11/13/12, at 3:40 p.m., a licensed nurse (Staff J) stated that the resident used the word "Ok" to indicate both "yes" and "no". When the word "OK" was repeated over and over again meant the staff member was not doing what she wanted them to do.

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F 241	Continued From page 7	F 241		
F 252 SS=E	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a home like environment in two of three dining rooms. This failure had the potential to diminish the resident's quality of life.</p> <p>Findings include:</p> <p>MAIN DINING ROOM Observations on 11/8/12 at 12:14 p.m., revealed 16 residents seated at various tables. Six tables could accommodate 4 residents each and two oblong tables placed together could accommodate 12 residents. An additional 6 residents were brought into the dining room within 10 minutes of the start of the observation. The dining room appeared crowded.</p> <p>The first cart with lunch trays was delivered from the kitchen, adjacent to the dining room at 12:25 p.m. Staff retrieved the trays and brought them to the residents. Items were removed from the trays</p>	F 252		

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F 252	<p>Continued From page 8 and placed restaurant style, in front of the residents.</p> <p>During the distribution of the lunch trays, not all residents seated at the same tables were served at the same time. At several tables, there was a 10 minute period before everyone had their lunch served to them. An unidentified resident was overheard to say to three residents eating their lunch at his table, "I hope I get my lunch before it's dinner time"! The last trays were served at 12:38 p.m.</p> <p>Throughout the dining experience, there was little conversation or interaction between residents and, or, staff. Although there was a radio located on the wall, no music was playing. At 12:40 p.m., a male resident in a wheel chair was brought into the dining room. In a loud voice, Staff A, a nursing assistant, stated to another assistant across the room, "Take this table because I'm going to stick him at another table"! While several residents were eating, she asked them to stop. The two residents were pushed away from the table in their wheel chairs, and the newly arriving resident in a wheel chair was pushed through. Several times, the resident was pushed into the sides of other wheel chairs, jarring those residents while eating.</p> <p>On 11/15/12 at 7:30 a.m., the radio was on and playing rock music. During a previous interview on 11/8/12 at 2:35 p.m., the Director of Nursing Services (DNS) stated the radio was to be on each meal period and soft music was to be played. Additionally, she related several tables had been removed to be refurbished, and would be placed into service shortly. When asked, the</p>	F 252	<p>Safe/Clean/Comfortable/Homelike Environment</p> <p>Meal carts arranged for a systematic meal tray distribution according to resident table assignment to ensure tablemates receive meal trays at the same time.</p> <p>55YOF resident will turn on radio and select rock music.</p> <p>Staff in-serviced on meal service to include:</p> <ul style="list-style-type: none"> • Background music or television will be on during meals. • Meal trays to be distributed according to resident table assignments. • Staff will not request residents stop eating and move residents To accommodate late arrivals. • Staff will communicate with residents during meals. <p>All dining room tables have been refurbished and placed in dining rooms For spacious resident seating during meal time.</p> <p>Administrator/DNS/RCM/Dietary Manager to monitor meal service during routine rounds.</p> <p>Administrator/DNS/Dietary Manager to review at monthly QA Meeting.</p>	<p>11/16/12</p> <p>12/7/12</p> <p>12/7/12</p> <p>On going</p> <p>On going</p>

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F 252	Continued From page 9 DNS stated staff was to talk and encourage conversation with the residents. RAMBLING VINE DINING ROOM During observations of this dining room on 11/14/12 at 8:12 a.m. until 8:35 a.m., 11 residents and two staff members were sitting at tables with breakfast trays on them. A large TV was attached to a wall, but it was not on. The staff members were feeding two residents. The only sound was when an assistant asked, "Do you want another bite"? The remaining residents sat at their tables, staring at their food.	F 252		
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;	F 272		

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F 272 Continued From page 10
 Psychosocial well-being;
 Physical functioning and structural problems;
 Continence;
 Disease diagnosis and health conditions;
 Dental and nutritional status;
 Skin conditions;
 Activity pursuit;
 Medications;
 Special treatments and procedures;
 Discharge potential;
 Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and
 Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:
 The facility failed to comprehensively assess 2 of 6 sample residents (68 & 54) reviewed for assessments. The failure to accurately assess restorative needs for Resident 68 placed the resident at risk for a preventable decline in her right hand range of motion. The failure to accurately assess behaviors for Resident 54 placed the resident at risk for unidentified and/or unmet needs.

Findings include:

RESIDENT 68
 Resident 68 was admitted to the facility on

F 272

F272 SS=D
 483.20 (B) (1)
 COMPREHENSIVE ASSESSMENTS

The facility will conduct initially and periodically a comprehensive assessment of the resident's functional capacity.
 This will be evidenced by;

Resident #68
 The MDS has been modified to indicate a restorative program is in place.
 Therapy clarified the hours for the splint application 2hr on 2 hr off.
 The restorative aides will be Responsible for application of the splint.
 The Restorative care plan has been updated.

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F 272	<p>Continued From page 11</p> <p>██████████ with a diagnosis that included ██████████. The resident began rehabilitation services with physical, occupational and speech therapy upon her admission to the facility. A right palm protector splint was ordered for the resident prior to her discharge from therapy services. On 8/4/12 the occupational therapist (O.T.) discharged the resident to the restorative care program for continued passive range of motion of the resident's right hand.</p> <p>According to the resident's Minimum Data Set (MDS) assessment, dated 10/10/12, the resident had a splint for her right hand and was dependent on staff assistance for her dressing and mobility needs. The MDS did not indicate the resident was in the restorative program.</p> <p>Observations made on 11/9/12 at 1:20 p.m. and on 11/13/12 at 10:58 a.m., revealed the resident was in her wheel chair in the hallway without the splint on her right hand. On 11/13/12 at 12:59 p.m., the resident was out of her room and her splint was lying on her bedside table. At 2:30 p.m., the resident was in bed, her splint remained on the bedside table. On 11/14/12 at 9:15 a.m., the resident was observed without her splint.</p> <p>According to the Restorative Care Program developed by the O.T. on 8/3/12, the goal for the resident's right hand was for her to maintain current passive range of motion of her right hand fingers. One approach listed to meet that goal was for staff to apply the right palm guard splint.</p> <p>According to documentation on the Restorative Nursing Summary Note, dated 8/4/12, the</p>	F 272		
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Continued From page 12

Director of Nursing Services (DNS), who oversaw the restorative program for the facility, had reviewed the resident's recommended restorative program. The DNS made no revisions to the 8/3/12 plan.

A review of the resident's clinical record revealed no evidence that a comprehensive assessment was performed by the DNS upon the residents transfer to the restorative program.

The lack of the assessment resulted in a undefined treatment plan. The treatment plan did not address how many days a week, or how many hours the resident should wear her splint to maintain her current function. The resident's care directive posted in her room read "right hand splint everyday". No further guidance was provided.

On 11/14/12 at 9:19 a.m., the restorative aide, Staff G stated the resident received restorative services 4 to 6 times a week. As for her splint, Staff G stated Resident 68 only wore the splint as much as she wanted to, and that she refused to wear it often. On 11/14/12 at 3:15 p.m., nursing assistant, Staff H stated that Resident 68 usually only wore her splint during the day. Staff H further stated she would remove the splint for the resident at night if it was on.

On 11/15/12 at 10:40 a.m., the DNS was asked about the resident's assessment and treatment plan for the use of the right hand splint. The DNS stated "I made the restorative aides responsible for it." She continued, the splint should have been worn daily." When made aware of the missing information on the resident's treatment

F 272

Resident #54
Social Service has conducted a current assessment and has identified resident specific behaviors. behavior monitoring sheets have been provided for LN documentation

All resident have the potential to be affected
If assessments are not completed accurately or timely therefore we will continue to complete the required assessments on admission, quarterly and upon significant changes in condition. Others will be per the MDS schedule.

Social Service will review resident specific behaviors in conjunction with the monthly IDT psychotropic meeting.

The Social Service Director will be responsible For lasting compliance

The Director of Nursing Services will conduct Quarterly reviews of the restorative programs.

- Therapy will clarify splint application Times and the responsible discipline

Care plans will be revised as indicated

The Director of Nursing Services will be responsible For lasting compliance

Plan of correction date
11/27/2012 & ongoing

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F 272	<p>Continued From page 13 plan, the DNS stated the resident should have been assessed to determine her individual needs regarding the use of the splint.</p> <p>RESIDENT 54 Resident 54 admitted on [REDACTED] with a diagnosis of [REDACTED]. To assist the resident with the behaviors which accompany this diagnosis, the physician ordered the resident to be given an anti-psychotic medication on a routine basis.</p> <p>Review of the residents Minimum Data Set (MDS) assessment dated for 6/15/12 and for 9/4/12 indicated the resident had experienced no mood and behavior issues through both assessment time frames.</p> <p>Review of the facility Behavior Monitoring flowcharts completed by nursing for the month of November indicated nursing was assessing Resident 54 for the following behaviors:</p> <ol style="list-style-type: none"> 1. combative with care 2. combative and or aggressive towards other residents 3. paranoia <p>From 11/1 -11/5/12 there was no documented evidence found indicating nurses assessed the resident for behaviors.</p> <p>On 11/16/12 at 1:32 p.m., a review of the nursing documentation indicated that on 11/5/12 at 11:00 p.m., Resident 54 declined all medications. She also refused to allow the nurse to instill her eye drops. Further review of the medical record found other indications the resident declined her</p>	F 272		
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F 272	Continued From page 14 medications, raised her voice, and spoke negatively. A nursing, dated 7/27/12 at 12:25 p.m., documented that redirection was "not effective". On 11/16/12, at approximately 2:00 p.m., the Social Services Director (SSD) stated she was the one responsible for listing the behaviors which nursing assessed the residents for monthly. She stated she just wrote down the behaviors listed above for nursing to monitor during the month of November. She stated she was aware they did not accurately reflect the behaviors of the resident. Consequently, there was no accurate assessment made by nursing to reflect the behaviors Resident 54 presented with. The Social Services Director stated she should have provided nursing with an accurate assessment for nursing to document. Because there was no accurate assessment completed the behavior monitoring completed by nursing did not reflect the actual behavior of the resident.	F 272			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323			

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F 323	<p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review the facility failed to ensure medications were kept in a secure manner for 2 of 2 sample resident's (10, 13). The failure placed these residents at risk for harm by potentially ingesting medications not intended for ingesting and/or using medications in ways not intended and without proper monitoring.</p> <p>Findings Include:</p> <p>RESIDENT 13 During a routine medication observation on 11/15/12 at 6:22 a.m., Resident 13 was observed to have a container of miconazole powder sitting on her over-the-bed table.</p> <p>When the surveyor asked Staff D, a licensed nurse (LN), about the medication sitting on the over-the-bed table the LN stated the medication was a prescribed medication used for skin redness. She then picked up the container and stated "Is it not to be kept in the resident's room?" When told to follow the facility policy, the LN placed the powder container into the resident's bedside table drawer.</p> <p>On 11/15/12 at 8:40 a.m., the Director of Nursing Services (DNS) stated the miconazole powder was considered a treatment, and should have been stored in the treatment cart not in the resident's room.</p> <p>RESIDENT 10</p>	F 323	<p>Free of Accident Hazards/ Supervision/Devices</p> <p>Resident 13 miconazole powder stored in the treatment cart. Staff D educated on proper storage of resident's treatment supplies.</p> <p>Resident 10 assessed for self-medication program, informed to notify nursing staff of new medications, physician order obtained for medications at bedside and Resident 10 provided with a locked container.</p> <p>Nursing staff in-serviced on resident self-medication programs, need for physician orders and a locked container for all medications stored at bedside.</p> <p>Nursing staff to be in-serviced upon hire, annually and PRN on the facility's resident self-medication program.</p> <p>DNS/RCMs to monitor for medications at bedside during routine rounds.</p> <p>Administrator/DNS to review at Monthly QA meeting</p>	<p>11/15/12</p> <p>11/15/12</p> <p>12/7/12</p> <p>On going</p> <p>On going</p> <p>On going</p>
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F 323	<p>Continued From page 16</p> <p>On 11/15/12 at 8:25 a.m., during an interview with Resident 10 regarding an unrelated concern a bottle of Systain eye drops were observed sitting on the resident's over-the-bed table.</p> <p>Additionally when the surveyor looked down while standing at the resident's bedside the resident's second drawer to her bed side table was observed open approximately 5 inches. Observed in the front of the drawer was a box of laxatives. When the resident observed the surveyor looking at the box sitting in her open drawer, the resident closed the drawer and stated "I do not like nosey people."</p> <p>At 8:40 a.m., the DNS was notified of the medications in the resident rooms. She stated all medications stored in a resident room should be stored in a locked container.</p>	F 323		
F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;</p>	F 441		

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F 441	<p>Continued From page 17</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement and monitor it's infection control policy. The failure to monitor temperatures in a lab specimen refrigerator, employees touching resident food with their bare hands, and improper hand hygiene, placed residents at risk for delays in receiving accurate diagnostic lab reports and contracting foodborne illness.</p>	F 441		

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F 441	<p>Continued From page 18</p> <p>Findings include, but are not limited to:</p> <p>LABORATORY REFRIGERATOR Observations on 11/8/12 at 10:00 a.m. and 11:23 a.m., revealed a small refrigerator labeled "lab specimens" located on a counter in a dirty utility room. Upon inspection, a thermometer inside read 60 degrees. The surveyor placed a thermometer inside and read the temperature an hour later. The same reading of 60 degrees was noted.</p> <p>During observations on 11/9/12 at 1:15 p.m., a reading of 60 degrees inside the refrigerator was read. Observations on 11/13/12 at 7:30 a.m., revealed several lab specimens and a temperature of 61 degrees. When interviewed on 11/13/12 at 1:15 p.m., the Director of Nursing Services provided a policy which showed the temperatures of keeping specimens in a viable state should be between 35 and 46 degrees. When asked if 60 degrees was too warm, she replied "Yes".</p> <p>MAIN DINING ROOM During observations on 11/15/12 at 7:55 a.m., Staff L, a nursing assistant was helping a resident eat her breakfast. On three occasions, the staff member was observed to rake her hands through her long hair. She proceeded to handle the resident's utensils and pick up her toast.</p> <p>At 8:07 a.m. during the same observation, Staff A, a nursing assistant, picked up the toast for Resident 104 using her bare hands. She placed the toast on the palm of her hand and used the other hand to apply jelly with a knife. The employee was observed to repeat this action with</p>	F 441	<p>Infection Control, Prevent Spreads Linens</p> <p>Laboratory refrigerator replaced. Laboratory refrigerator temperature within acceptable range of 35-45 degrees.</p> <p>Staff in-serviced on infection control practices:</p> <ul style="list-style-type: none"> • Do not touch hair and handle resident's utensils and food. • Staff demonstration on how to use utensils to apply condiments. <p>Garbage cans replaced with step-pedal lid opening trash cans.</p> <p>Staff/new hires to be in-serviced upon hire/annually/PRN on proper infection control practices related to food handling and hand washing.</p> <p>Nursing staff to monitor laboratory refrigerator temperature daily for acceptable range of 35-45 degrees.</p> <p>Administrator/DNS/RCM/Charge Nurse/Dietary Manager to monitor daily during routine rounds.</p> <p>Administrator/DNS to review at monthly QA Meeting.</p>	<p>11/14/12</p> <p>12/7/12</p> <p>12/7/12</p> <p>On going</p> <p>On going</p> <p>On going</p> <p>On going</p>

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F 441	Continued From page 19 four more residents. Staff D, a nurse, was observed doing the same procedure with the toast belonging to Resident 56. KITCHEN During observations on 11/14/12 at 11:05 a.m., a hand washing sink was located to the side of the tray line table. A garbage can with a lid was located next to the sink. As there was no foot pedal, the only way to open the trash can was to reach down and pull up on the lid. When asked by the surveyor, the kitchen manager stated "You have to just open it". On 11/14/12 at 11:40 a.m., Staff N, a cook, was observed to wash and dry her hands. She picked up the lid of the garbage can with her bare hands to throw away the wet hand towel before returning to place food into the steam table to serve. At approximately 11:30 a.m., Staff O washed his hands at the same sink and dried them with a paper towel. He was observed to lift the garbage lid with bare hands and place the wet towels inside.	F 441			
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.	F 463			

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F 463	<p>Continued From page 20</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure 2 of 40 residents (109 and 1) had a functioning means to alert caregivers help was needed. Failure to have a functioning communication system for Resident 109 and failure to ensure Resident 1 was able to access her call light placed the residents at risk for not having their needs met.</p> <p>Findings include:</p> <p>RESIDENT 109 This resident was admitted to the facility on [REDACTED] with diagnosis to include [REDACTED]. The resident was alert and oriented. Observations on 11/14/12 at approximately 2:30 p.m., revealed the resident's daughter standing outside the resident's bedroom door. She was visibly upset and stated her mother had to use the restroom and no one was coming to assist her. Upon approaching the room, it was observed that the call light above the door was not on. When asked if the call light had been turned on, the resident's daughter stated, "Yes, it's on but we have been waiting about 20 minutes."</p> <p>After being notified of the resident's need for assistance and that the call light was not working properly, a nursing assistant walked into the restroom and moved the restroom call light switch from the middle position to off (up position). Upon doing so, the light above the door lit up. The assistant stated if the switch from the call light in</p>	F 463	<p>Resident Call System-Rooms/Toilet/Bath</p> <p>Maintenance Department tested resident call light system to ensure nurse's station received resident calls from resident rooms; and toilet and bathing facilities.</p> <p>Bathroom call light switch with a visible on/off switch position.</p> <p>Staff in-serviced on need to place call light switch in designated on/off position.</p> <p>Staff in-serviced on need to place resident's call light within easy reach at all times while in bed or wheelchair.</p> <p>Staff/new hires to be in-serviced upon hire/ annually/PRN on need to place resident bathroom call light switch in designated on/off position and proper placement of the resident's call light for easy access.</p> <p>Administrator/DNS/RCM/Charge Nurse to monitor call light system to ensure proper functioning and call light placement daily during routine rounds.</p> <p>Administrator/DNS to review at monthly QA Meeting.</p>	<p>11/30/12</p> <p>11/30/12</p> <p>12/7/12</p> <p>On going</p> <p>On going</p> <p>On going</p>

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F 463	<p>Continued From page 21</p> <p>the restroom was left in the middle position and was not pushed all the way up, the light above the door would not light up if the call light was pushed at the bed side. The resident's daughter stated, " My mother is immobile, she relies on the call light next to her. "</p> <p>RESIDENT 1 This resident re-admitted to the facility on [REDACTED] with a diagnosis of [REDACTED]. [REDACTED] The Minimum Data Set (MDS) assessment, dated 9/16/12, indicated the resident required 2 staff members for bed mobility, and 1 staff member for personal hygiene.</p> <p>Review of the facility Plan of Care indicated the resident was non-ambulatory and required a mechanical lift to get out of bed.</p> <p>On 11/14/12, at 2:43 p.m., the resident was observed lying in her bed. She stated she was in pain and needed the nurse to bring her pain medication. She attempted to turn herself towards the right side of the bed to look for the call light to summon the nurse. She turned to the surveyor and asked where the call light was. After noting the call light was not visible to either the surveyor or resident, a Licensed Nurse (Staff B) was requested to assist in finding the call light. Staff B found the call light partially tucked under the mattress and wrapped around the bottom of the 1/4 side rail on the right side of the bed.</p> <p>Staff B stated the resident should have had the call light within easy reach especially since she was dependent on staff for care and could not</p>	F 463			

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F 463	Continued From page 22 move herself.	F 463		
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