

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

PRINTED: 12/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/12/2012
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NAME OF PROVIDER OR SUPPLIER BALLARD CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 820 NORTHWEST 95TH STREET SEATTLE, WA 98117
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Ballard Care and Rehabilitation Center on 12/03/12, 12/04/12, 12/05/11, 12/07/12, 12/10/11, 12/11/12 and 12/12/12. A sample of 48 residents was selected from a census of 136 which included the closed records of 1 former or discharged residents.</p> <p>The survey was conducted by:</p> <p>Katherine Ander, RN, MN, Nurse Surveyor Diane Kirse, RN, BSN Nurse Surveyor Nedra Vranish, RN, BSN, MEd, Nurse Surveyor</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Adult Services Administration Residential Care Services, District 2, Unit D 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388</p> <p>Telephone: (253) 234-6000 Fax: (253) 395-5085</p> <p><i>Lisa Rimmer</i> 12/19/12 Residential Care Services Date</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 12-29-12
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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 000 Continued From page 1

F 000

F 157 483.10(b)(11) NOTIFY OF CHANGES
SS=D (INJURY/DECLINE/ROOM, ETC)

F 157

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:

"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Ballard Care and Rehabilitation** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."

12-28-12

**F157 - D
Notify of Changes**

- 1) Resident #202's daughter was notified of change of condition on 12-7-12 by Resident Care Manager.
- 2) Recent 24 hour reports reviewed on 12-28-12 by Director of Nurses and Nurse Managers and Administrator and notification made to responsible party as identified.

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F 157	<p>Continued From page 2</p> <p>Based on observation interview & record review the facility failed to notify family of 1 of 2 sample residents (#202) reviewed for notification of change. This placed the resident at risk for unmet care needs and increased anxiety.</p> <p>Findings Include:</p> <p>Record review found that Resident #202 was admitted to the facility on [REDACTED] 12 for rehabilitation. She had some confusion, a history of high blood pressure, but no history of chest pain or any cardiac disorder.</p> <p>On 12/03/2012 at 12:30 a.m. the nursing record showed the resident developed acute chest pain. The physician was called and Resident #202 was treated with oxygen and nitroglycerine (a heart artery dilator). The record showed no attempt to contact the Resident's daughter who was the primary contact person for any change in Resident's condition. The Resident's daughter stated that she did not learn of the change in the her mother's condition until she came to visit her the next day. She stated she was concerned because her mother had never had chest pain before.</p> <p>In an interview with Staff E, RCM (Resident Care Manager) on 12/07/2012 02:50 PM, he stated that when any resident has a change in condition, the doctor, charge nurse and family are notified as soon as the change is noticed. He reviewed the documentation related to the chest pain event for Resident #202 and verified that the Resident's daughter had not been notified. He stated that acute chest pain would be considered a change in resident condition.</p>	F 157	<p>3) Licensed Nurses (including Staff E) were re-educated regarding change of condition procedures including notification of treatment related to chest pain on 12-28-12 by Staff Development Coordinator (SDC).</p> <p>4) Random reviews of the daily 24 hour reports will be conducted monthly by Director of Nurses and/or designee to ensure responsible party notifications are made related to identified residents' change of condition. Monthly Performance Improvement (PI) meetings will include a tracking/trending report from Director of Nurses regarding 24 hour report reviews and further action implemented as needed times 3 months.</p> <p>5) Director of Nurses will ensure compliance.</p> <p>6) 12-28-12</p>	

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F 250	<p>Continued From page 4</p> <p>himself in the hallway. The resident was not able to provide detailed information about his stay at the facility due to his cognitively disabling condition.</p> <p>Resident #168's record documented that the resident was admitted to the facility 06/11/12 with medically disabling conditions affecting his cognition and functional ability to care for himself. Review of Resident #168's Minimum Data Set (MDS - an assessment tool) dated 06/18/12 identified that the resident had moderate cognitive impairment and mild depression.</p> <p>Social service notes dated 06/12/12 documented that Resident #168 made specific statements to the Staff V (social worker) about ending his life and being ready for his life to end. The resident told Staff V that he thought that his neighbor who took care of him had died and he has nothing left in his life, nothing to live for. Social service notes document that 15 min checks would be done by nursing staff and the RCM (resident care manager - Staff E) was notified.</p> <p>Review of social service records found no follow up to the resident's suicidal thoughts. The only social service documentation after the initial assessment referenced a 07/18/12 care conference and a 9/18/12 quarterly note where depressive/suicidal thoughts were not identified or referenced. The 9/18/12 quarterly note documented "There are no concerns." Record review found no care plan initiated or updated related to Resident #168's suicidal thoughts, statements or gestures. See findings under F280.</p>	F 250	<p>Health Services should a resident exceed cumulative, allowable number of days out of center overnight on a Department of Social Health Services covered stay.</p> <p>4) Five random reviews of the daily 24 hour reports will be conducted by Director of Nurses and/or designee weekly to ensure reports of suicidal ideation and behavior of residents is properly care planned. Social Services Director and/or designee will conduct ten random reviews each month of Sign in/Sign out records in conjunction with census reports. Monthly Performance Improvement (PI) meetings will include a tracking/trending report from Director of Nurses regarding 24 hour report reviews and a tracking/trending report from Social Services Director regarding Sign in/Sign out and census report reconciliation and legibility and further action implemented as needed times 3 months.</p> <p>5) Director of Nurses, Business Office Manager, Social Services Director, and Administrator will ensure compliance.</p> <p>6) 12-28-12</p>	
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F 250 Continued From page 5

On interview at 9:00 a.m. Staff J (Nursing Assistant Certified) stated that Resident #116 talks to her about dying quickly. Staff J said "When he talks about dying, he has tears in his eyes." Staff J stated that a month prior (late October 2012) the resident had a call light cord around neck like someone who wants to kill himself. Staff J stated that she told the concierge (Staff Q) about it and Staff Q talks to the resident.

On interview at 2:50 p.m. Staff E stated that he knew nothing about Resident #168's ongoing statements to Staff J about dying or the resident wrapping a cord around his neck. According to Staff E, the resident was on 15 minute checks from 06/12 to 06/18/12 after his initial depressive/suicidal thoughts and statements, but nothing since then.

On interview at 3:20 p.m. Staff Q stated that she only heard from Staff J about Resident #116 having "sad thoughts", not suicidal gestures. Staff Q stated that the sad thoughts prompted a move to a semi-private room for greater socialization.

On interview at 3:50 p.m. Staff V stated that after the initial 15 minute checks she thought that the problem was resolved. According to Staff V, a mental health referral is made if ordered by the doctor. Social services may request a mental health referral if there is a continued problem, but this did not continue to be a problem for Resident #168. Staff V said that the suicidal monitoring plan was done by nursing.

RESIDENT #84
Resident #84 was admitted to the facility [REDACTED] 0

F 250

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F 250	<p>Continued From page 6</p> <p>with diagnoses of chronic lower extremity wounds, chronic renal failure, a history of pulmonary embolism, high blood pressure and an immune disorder. Daily medication regimen included medications for immune suppression (Atripla), blood thinner (Coumadin), depression (Citalopram) and 3 heart regulating medications (Carvedilol, Digoxin, Diltiazem), diuretic and potassium supplement (Lasix & KCL).</p> <p>On 12/03/12 at 10:30 a.m. the resident's uncovered feet appeared fluid filled covered with dry scaly skin. During days of survey 12/03/12, 12/04/12, 12/05/12, 12/10/12, 12/11/12, the resident was frequently observed, when out of bed, self-propelling his wheelchair throughout the facility and outside at the front entry.</p> <p>The most recent Minimum Data Set (MDS) assessment dated 11/7/12 indicated Resident #84 was cognitively intact, required supervision from staff for bed mobility and transfer, extensive assistance for dressing and toileting and was independent with mobility once in the wheelchair. He was continent of bowel and bladder.</p> <p>The care plan for Resident #84 included behavior problems including aggression and recurrent alcohol and illicit drug use in and outside the facility. The care plan identified the resident was at risk for leaving the facility AMA (against medical advice) as he would leave the facility without signing out. The care plan listed an episode of extended period out of facility on 11/7/11. The goal was for the resident to sign out when he leaves the building and sign in when he returns to the facility.</p>	F 250		

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F 250	<p>Continued From page 7</p> <p>Each of the nursing stations in the facility had a notebook containing sign-out/sign-in forms for residents to use. The forms were entitled, "Release of Responsibility for Leave of Absence." Review of the form for Resident #84 on 12/10/12 found no reference year documented anywhere on the form. The resident signed out 11/15 at 18:00 and 11/25 at 10:35. The resident did not sign back in. There were 14 entries on the form with only 1 legible entry for date and time of sign-in. Twelve of the entries had no sign-in.</p> <p>Facility documentation showed the resident had been out of the facility a total of 12 days since 6/01/12. Resident #84 most recent absence was 12/06/12 - 12/08/12. The physician documentation from the hospital where he was taken for medical clearance stated, "Brought in for medical clearance after eloping from SNF (skilled nursing facility) and getting drunk and using cocaine."</p> <p>On interview 12/11/12 at 4:30 p.m., the administrator stated that much had been done for Resident #84 during his stay at the facility, acknowledging that during his absences, daily medications and treatment were not received. The Director of Nursing stated that Resident #84 was always sent to the hospital for medical clearance after an absence to be sure that he was safe to return to the facility.</p> <p>During interview 12/12/12 at 9:50 a.m., social workers (Staff U and Staff V) stated Resident #84's absences had not been reported to the appropriate Home and Community case manager. They said they had done so for another resident but not for Resident #84. This</p>	F 250		

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F 250 Continued From page 8
information was not conveyed to the case manager even though the resident's absences put him at risk of harm and unmet care needs.

F 250

F 272 483.20(b)(1) COMPREHENSIVE ASSESSMENTS
SS=D

F 272

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:

- Identification and demographic information;
- Customary routine;
- Cognitive patterns;
- Communication;
- Vision;
- Mood and behavior patterns;
- Psychosocial well-being;
- Physical functioning and structural problems;
- Continence;
- Disease diagnosis and health conditions;
- Dental and nutritional status;
- Skin conditions;
- Activity pursuit;
- Medications;
- Special treatments and procedures;
- Discharge potential;
- Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and

F272 - D

Comprehensive Assessments

1) A device evaluation was completed on 12-26-12 by Resident Care Manager (RCM) after reviewing a recent rehabilitation evaluation to assess use of side rails to include entrapment risk and alternatives to side rail use. Resident #62's left 1/2 side rail has been removed. Resident #36 discharged on [REDACTED] 12 and survey findings were from review of a closed record.

2) Device assessments were conducted by the Therapy and Licensed Nursing staff for residents with existing side rails in use on 12-16-12. These assessments included review of entrapment risk and consideration of alternatives to side rail use. Residents with existing excoriated skin issues have been identified by Licensed Nurses on 12-14-12 through 12-21-12. Skin records reviewed by Nurse Managers and updated with further detail as needed 12-14-12 through 12-21-12.

3) Therapy staff were re-educated on 12-28-12 by Therapy Program Manager (TPM) regarding need for therapy involvement in side rail use, entrapment risk, and alternatives to side rail use. Licensed Nurses (LNs) were re-educated on 12-14-12 through 12-28-12 by Staff Development Coordinator regarding need for therapy involvement in side rail use, entrapment risk, and alternatives to side rail use. Resident Care Managers and

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F 272 Continued From page 9
Documentation of participation in assessment.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to accurately assess entrapment risk or alternatives to side rail use for 1 of 2 sampled residents (#62) who had half side rails in use. This placed the resident at risk for injury from entrapment between the air mattress and the bed rail. The facility failed upon admission and ongoing, to comprehensively assess the skin condition for 1 of 5 sample residents (#36) reviewed for skin conditions. This placed the residents at risk for unmet care needs and deterioration in skin condition.

Findings Include:

RESIDENT #62:
Record review found that Resident #62 was admitted to the facility on [REDACTED] 11 with a CVA (stroke), seizure disorder, and [REDACTED] rendering him [REDACTED] side. The MDS (Minimum Data Set- an assessment tool) dated 10/14/2012 identified the resident required extensive assist for care and activities.

Records documented use of side rails for Resident #62: Physician order dated 11/05/2011 "Bilateral side rails for safety to avoid injury during

F 272 other Licensed Nurses were re-educated on 12-14-12 through 12-28-12 by Staff Development Coordinator regarding the use of the 'non-pressure wound and skin condition documentation form' and details required related to skin excoriation.

4) Director of Nurses and/or designee will conduct five random reviews each month of device assessments/evaluations and skin records and findings will be tracked/trended as necessary and included in monthly Performance Improvement (PI) meetings and further action taken as needed times 3 months.

5) Director of Nurses will ensure compliance.

6) 12-28-12

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F 272	<p>Continued From page 10</p> <p>seizure activity." Side rail consent dated 05/12/2012 listed the reason for use as "Increased mobility when in bed." Identified risks of side rail use included "accident and injuries, loss of mobility, decreased independence, and death." Nursing assessment dated 10/24/2012 by Staff B identified side rails were to assist with mobility and prevent injury during seizures.</p> <p>Review of clinical records from June 2012-December 1, 2012 showed no falls or seizure events for this Resident. Medical record review found no evaluation or recommendations by the therapy department for the use of side rails.</p> <p>On 12/05/2012 at 9:30 AM, Resident #62 was observed lying on an air mattress with half side rails present on both sides of his bed, extending from the top of the bed to the middle. The resident was leaning slightly onto the left rail. The rails were found to be slightly loose and there was approximately a 1-2 inch gap between the rail and the mattress on the right side. The side rails were not padded.</p> <p>On interview at 9:30 a.m. Resident #62 stated the side rails were placed on his bed when he arrived to the facility because he had suffered a fall and he could not move his left side. Resident #62 said the staff use the rails when they turn him.</p> <p>On interview 12/10/2012 at 3:25 p.m. the Director of Nursing (DNS) stated Resident #62's side rails were being used for bed mobility and fall prevention. She stated that if a resident was at risk for an "actual seizure" the side rails would be padded. The DNS then stated that Resident #62 was "not really a fall risk because he has had no</p>	F 272		
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F 272	<p>Continued From page 11</p> <p>fails." When asked what alternatives could be used to prevent falls, she stated they might do a bed alarm, scoop mattress, bed in low position, and mats at the bedside. When asked if an assessment of entrapment risk had been performed, she stated "My policy is that therapy will evaluate them for side rails."</p> <p>On interview 12/10/2012 at 3:30 p.m. Staff DD (Occupational Therapy Program Manager) stated "If we see side rails, it is not an automatic evaluation." She stated they do evaluations only if asked to do so. She stated "We will only do the evaluation if it is our recommendation to place side rails." She stated that OT (occupational therapy) had never worked with this Resident.</p> <p>RESIDENT #36: Resident #36 was admitted [REDACTED] 12 with multiple diagnoses including heart failure, peripheral vascular disease and anemia. Her admission nursing assessment [REDACTED] 12 revealed "excoriated skin" over the coccyx area, indicated by a small circle drawn on the back side of a figure, included on the admission form. The assessment did not include a description or measurement of the area involved. Nursing documentation on the same date stated the resident's skin was grossly intact with excoriated bottom and some bruising on the left upper extremity.</p> <p>Further review of the clinical record revealed nursing documentation, dated 10/20/12, which stated an old scab on left bottom came off; no bleeding. This was the first documentation referring to a scab on the bottom of Resident #36. The last documentation in the clinical record</p>	F 272		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/21/2012
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/12/2012
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NAME OF PROVIDER OR SUPPLIER BALLARD CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 820 NORTHWEST 95TH STREET SEATTLE, WA 98117
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F 272 Continued From page 12 related to the skin of Resident #36 was dated 10/25/12 and written by Staff Y. It stated skin check had been completed with old scab/excoriation in between buttock cheeks. The resident was transferred to another skilled nursing facility on [REDACTED] 12.

The facility utilized a form entitled "Non-pressure wound and skin condition documentation form." The back of the form listed 15 categories of wound type to be assessed. Number 14 on the list was "excoriation." Documentation of ongoing skin assessment was completed by staff on this form for other residents reviewed. However, the clinical record for Resident #36 did not include this form.

On 12/10/12 at 11:00 a.m. the Director of Nursing Service (DNS) was interviewed regarding the assessment of the wound for Resident #36. She indicated she was not really familiar with this resident. Staff Y was interviewed by telephone on 12/10/12 at 1:55 p.m. She said she could not remember in detail the condition of the skin for Resident #36 on the date observed, 10/20/12, but could say with certainty that the resident's coccyx area still had excoriation present. Staff Y was asked if she knew when the scab was first observed. She said, to the best of her knowledge, the resident had the scab on her bottom from the time of admission and the excoriation was present and being treated when assessed on 10/25/12.

F 272

F 280 483.20(d)(6), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP
SS=D

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F 280	<p>Continued From page 13</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to revise the careplan for 1 of 1 residents (#168) who expressed suicidal thoughts and behavior. This placed the resident at risk for harm and unmet care needs.</p> <p>Findings include:</p> <p>Observations and interviews were conducted 12/07/12.</p> <p>Observation on 12/07/12 at 8:50 a.m., 9:07 a.m. and 10:40 a.m. found Resident #168 seated in a wheelchair, clean, alert with out odor. The</p>	F 280	<p>F280 - D Right to Participate Planning Care- Revise CP</p> <p>1) Resident #168's care plan was updated on 12-10-12 by Social Services Director (SSD) to include information about suicidal ideation and behavior.</p> <p>2) Other residents were reviewed on 12-28-12 by IDT for history of and/or current episodes of suicidal ideation or behavior and further assessment and care planning completed by Social Services as needed.</p> <p>3) Social Services team (including Staff V) re-educated on 12-28-12 by Staff Development Coordinator regarding care planning needs related to suicidal ideation and behavior. Staff (including Staff E, Staff J, and Staff Q) re-educated on process of reporting signs and symptoms of suicidal ideation and behavior of residents to include a referral to the Social Services team.</p> <p>4) Five random reviews of the daily 24 hour reports will be conducted by Director of Nurses and/or designee weekly to ensure reports of suicidal ideation and behavior of residents is properly care planned. Monthly Performance Improvement (PI) meetings will include a tracking/trending report from Director of Nurses regarding 24 hour report audits and further action implemented as needed times 3 months.</p> <p>5) Director of Nurses and Social Services Director will ensure compliance.</p>	
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F 280 Continued From page 14
resident was conversant but could not provide detailed information about his stay at the facility due to his cognitively disabling condition.

Resident #168's record documented that the resident was admitted to the facility [REDACTED] 12 with medically disabling conditions affecting his cognition and functional ability to care for himself. Review of Resident #168's Minimum Data Set (MDS - an assessment tool) dated 06/18/12 identified that the resident had moderate cognitive impairment and mild depression.

Resident #168's social service record documented that on admission [REDACTED] 12, Resident #168 made statements to Staff V (social worker) about ending his life and that he was ready for it it end. Resident #168 said that he had nothing left in his life, nothing to live for. Staff V notified Staff E (resident care manager) and documented that nursing staff started 15 minute checks.

Documentation in Resident #168's record showed that from 06/12/12 to 06/18/12 care staff monitoring Resident #168 for suicidal ideation every 15 minutes.

Resident #168's care plan reviewed 12/7/12 identified no interventions for suicidal thoughts, statements or gestures.

On interview at 9:00 a.m. Staff J (Nursing Assistant Certified) stated that a month prior (late October 2012) the resident had a call light cord around neck like someone who wants to kill himself. Staff J stated that Resident #168 talked to her about dying with "tears in his eyes."

F 280 6) 12-28-12

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F 280 Continued From page 15
According to Staff J, she communicated this information to Staff Q (concierge).

On interview at 2:50 p.m. Staff E stated that the resident's care plan was written by the interdisciplinary team and Social Services should have written the plan of care for Resident #168's suicidal gestures and sad thoughts. "Social Services should have addressed this." (See findings under F250).

On interview at 3:50 p.m. Staff V stated that after the initial 15 minute checks she thought that the problem was resolved. Staff V said that the suicidal monitoring plan was done by nursing.

On interview at 4:20 p.m. the administrator stated that Resident #168 should have had a care plan to address his suicidal statements and behavior.

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.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to provide adequate supervision and monitoring to ensure that

F 280

**F323 - D
Free of Accident
Hazards/Supervision/Devices**

1) Residents #53, #69, and #97 have been re-educated on smoking rules by Resident Care Manager on 12-20-12.

2) Other residents who smoke have been re-educated on smoking rules by Resident Care Managers on 12-12-12 through 12-28-12.

3) Staff (to include Staff K, Staff H, and Staff G) re-educated on 12-14-12 through 12-28-12 by Staff Development Coordinator regarding smoking rules and provision of supervision and monitoring to consistently enforce smoking rules

4) Five random reviews will be conducted weekly times 4 weeks, then monthly times 2 months by Administrator and/or designee and results tracked and trended for review in monthly PI meeting and further action taken as needed times 3 months.

5) Administrator and Director Of Nurses will ensure compliance.

6) 12-28-12

F 323

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DBHCS/ADSA/IFCS Kent

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F 323	<p>Continued From page 16</p> <p>residents followed smoking rules and failed to respond consistently to violations of smoking policy. The failure to ensure that residents consistently followed safe smoking practices placed Residents #53, #69 and #97, as well as the other 34 identified smoking residents residing in the facility at risk for injury from fire.</p> <p>Findings include: Facility records show that 136 residents resided at the facility. On 12/03/12 the facility identified 17 residents as Dependent smokers and 17 current residents as Independent smokers. Facility smoking policy included the following: -Noncombustible ash tray and metal self-closing container for cigarette disposal is in proximity of the designated smoking area. -The Interdisciplinary Team ensures a Safe Smoking Evaluation. Residents deemed not safe may be restricted from smoking. Interventions are entered onto the resident's care plan. -"Smoking materials will be stored with the Licensed Nurse."</p> <p>Facility smoking evaluation included 11 items for review. If any of the items were circled "No", the resident was considered an unsafe smoker and the Interdisciplinary Team must proceed to the Care Plan as the resident may not smoke unsupervised.</p> <p>All residents who smoked signed the "Smoking Rules" form which included agreement: -All smoking materials would be extinguished in the proper receptacle(s) - i.e., smoking urn. -Smoking was permitted only in designated smoking area. -All smoking materials would be kept at the</p>	F 323		
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DASHADSAIRCO Kam

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F 323 Continued From page 17
nursing station - Licensed nurses were required to check OUT and check IN all smoking materials - failure to return smoking materials to the Licensed Nurse immediately after smoking would result in a 'supervised smoking' status. -If assessed as needing a smoking apron, you would need to wear one when smoking.

The facility position description for smoking supervision included general maintenance duties, not a specific description of how smoking supervision was conducted, or that staff must be knowledgeable of each resident's smoking status and smoking care plan.

Observation of the facility's designated smoking area on 12/03/12 found a courtyard with a wooden Gazebo structure. Attached wooden benches were on the inside of the Gazebo. Dark black spots/areas were scattered over most surfaces of the wooden bench. There were 3 metal smoking urns for proper extinguishing of smoking materials. No ashtrays were observed in the designated smoking area.

Initial general observations on 12/03/12 at 11:45 a.m. 12:06 p.m., 12:29 p.m. and 12:40 a.m. found 2-7 residents present at identified points in time, with no or one staff member present. At 12:40 p.m. one resident said he had control of his smoking materials. The other two said they get their smoking materials from the nurses prior to coming outside. Facility smoking policy requires all residents to have smoking materials held by the licensed nurse.

On 12/03/12 Staff K was the assigned staff person supervising the residents. At 12:43 p.m.

F 323

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OSHS/ADSA/RCS Katt

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F 323	<p>Continued From page 18</p> <p>Staff K came out to the smoking area. Staff K said residents are supervised with smoking 24 hours per day 7 days per week. Staff K did not know which residents required a smoking apron. He said he just asks residents whether they would like to wear a smoking apron or not.</p> <p>Observation on two separate occasions found unsafe smoking by independent residents in the smoking area. No staff was present or intervened in response to unsafe smoking. On 12/04/12 at 8:30 a.m. Resident #53 was observed with an extinguished cigarette butt lying on the clothing protector on her lap. After smoking, Resident #53 dropped a still burning butt in a coffee cup and proceeded to enter the facility. On 12/05/12 at 1:45 p.m. Resident #69 was observed flicking ashes on the ground around her, and flicking ashes directly over the papers in her walker basket. There was a cigarette butt lying on the bench of the gazebo and another lying on the ground. Residents #53 and #69 were assessed by the facility as independent, yet engaged in unsafe smoking practice in violation of policy without knowledge or intervention by the facility.</p> <p>Observation on 12/04/12 at 10:15 a.m. found 4 residents smoking cigarettes in the smoking area. Staff H was standing inside the door. Staff H said he it was too cold to stand outside all the time so he watched from inside. Staff H said he puts the smoking aprons on those residents designated as dependent smokers.</p> <p>Observation on 12/05/12 at 1:15 p.m. found Resident #97 in her electric wheelchair sitting at an intersection approximately 4 blocks from the facility, smoking a cigarette. Smoking evaluation</p>	F 323		
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F 323	<p>Continued From page 19</p> <p>completed 10/01/12 designated Resident #97 as an unsafe smoker. Staff documented the resident could not light, hold and extinguish smoking materials, personal belongings were not free from evidence of burn holes and she had history of smoking related incidents. The resident's care plan dated 11/13/12 stated that Hospice staff would spot check the resident's top locked drawer to ensure cigarettes were not stored there. Documentation for 12/07/12 revealed visiting Hospice social workers found the resident with a cigarette lighter and the resident refused to give it up. It was reported to facility staff.</p> <p>Observation of the designated smoking area 12/07/12 at 9:00 a.m. found 4 residents and Staff G present. A large trash container with an attached metal ash tray on top was observed in the Gazebo. One resident stated staff brought it out yesterday. One of the residents was using the metal ashtray to flick ashes; the other three were flicking their ashes on the ground. Staff G stated he was filling in for the person who normally supervises smokers. Staff G said it was his responsibility to supervise dependent as well as independent smokers, but said nothing to residents about flicking ashes.</p> <p>On 12/07/12 at 11:10 a.m. Resident #97 was observed proceeding to the smoking area in her electric wheelchair, accompanied by a Hospice NAC (Nursing Assistant Certified). Staff G attempted to put a smoking apron on Resident #97 but she refused.</p> <p>On interview 12/05/12 at 1:45 p.m. Resident #69 stated that people who are supposed to be</p>	F 323		
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F 323 Continued From page 20
dependent smokers sneak out to the smoking area. "We're really not supposed to (share cigarettes). It's the policy but ..."

On interview 12/07/12 at 3:15 p.m., the Director of Nursing Service (DNS) stated the smoking supervisor position (for which there was no specific identified job description for smoking supervision) was primarily meant to supervise the dependent smokers. She was aware that the independent smokers did not always follow the smoking rules. There was a process to address one resident giving smoking material to another if the facility was aware. According to the DNS, there were so many problems with smoking that the facility was considering changing to a non-smoking status.

F 364 SS=E 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP

Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to meet acceptable food temperature palatability for 12 of 28 sample residents interviewed (#193, #71, #201, #117, #31, #135, #97, #89, #148, #106, #140, #147). This potentially affected resident quality of life.

F 323 F364 - E
Nutritive Value/Appear, Palatable/Prefer Temp

1) All residents identified as expressing food temperature palatability issues during 12-12-12 annual survey who are still currently residing in the Center are receiving food at more preferred temperatures. Plate warmer equipment has been repaired by Maintenance on 12-24-12.

2) Residents are receiving food at more preferred temperatures. Plate warmer equipment has been repaired by Maintenance on 12-24-12.

3) All staff (including Staff BB and Staff S) re-educated by Staff Development Coordinator on 12-17-12 through 12-28-12 regarding tray passing procedure as it relates to Interdisciplinary Team participation and speed of delivery.

4) Five random reviews of tray temperatures and customer satisfaction surveys will be conducted weekly times 4 weeks, then monthly times 2 months by the Nutrition Services Director (NSD) and/or designee and results tracked and trended and reviewed monthly in the PI Meeting and further action taken as needed times 3 months.

5) Nutrition Services Director and Administrator will ensure compliance.

6) 12-28-12

F 364

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10/10/ADSA/RCS/Kem

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F 364	<p>Continued From page 21</p> <p>Findings include:</p> <p>On interview during Stage I survey, 12 of 28 residents interviewed made negative comments about food temperature:</p> <p>Resident #193 12/03/12 3:21 p.m. "Food is below temp - it can't be right, the cart sits for 20 min before being served, other floors longer."</p> <p>Resident #71 12/03/12 3:50 p.m. "Could be hotter. No meal different than another."</p> <p>Resident #201 (and family member) 12/03/12 at 3:26 p.m. "Hot foods are not hot. Breakfasts especially are on the cold side, if eggs/bacon/toast are served it is luke-warm." Both reported that soup can be cold or cool.</p> <p>Resident #117 12/04/12 9:00 a.m. Food is not served at the proper temperature "quite a bit, several times/week. Could be breakfast, lunch or dinner - it varies. A couple of people came in and talked about it - independent audit; they took advice but didn't do anything about it."</p> <p>Resident #31 12/04/12 9:28 a.m. "Breakfast is good but usually cold. Staff is too busy to heat items up."</p> <p>Resident #135 12/04/12 10:02 a.m. Food is not served at the proper temperature. Food is "always cold." Resident eats in her room for all meals.</p> <p>Resident #97 12/04/12 11:42 a.m. Food is not served at the proper temperature. (Eats meals in</p>	F 364		
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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER BALLARD CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 820 NORTHWEST 95TH STREET SEATTLE, WA 98117		
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F 364	<p>Continued From page 22 dining room)</p> <p>Resident #89 12/04/12 3:15 p.m. "Depends on who is working in the kitchen." When served in resident's room food tends to be consistently not at appropriate temp for palatability.</p> <p>Resident #148 12/05/12 10:51 a.m. Food is not served at the proper temperature "Cold food - at (the hospital) food is hot - this place is pathetic. It needs to be worked out."</p> <p>Resident #106 12/05/12 11:59 a.m. Food is not served at the proper temperature. Food is "Typically cold."</p> <p>Resident #140 12/05/12 11:59 a.m. "Lately there has been more of a problem with hot foods, such as pancakes being on cold side." (Resident eats meals in his room)</p> <p>Resident #147 12/05/12 3:36 P.M. Food is not served at the proper temperature. "Food is cold."</p> <p>TEST TRAY: 12/07/12 11:49 a.m., the third of three meal carts for 500 hall arrived on the unit. Staff started delivering trays to residents. During meal service one staff (BB) delivered meals from the cart, stopping to assist residents in meal set up and/or positioning. Staff BB had to return to the kitchen for condiments like butter or extra tartar sauce with each individual resident request. The last tray delivered was at 12:11 p.m. Fahrenheit temperatures of food on the test tray was: Rice 135 degrees; Fish 123 degrees; vegetables 122 degrees.</p>	F 364		

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F 364	Continued From page 23 On interview, Staff S (Dietary manager) stated that food temperatures should be 130 degrees at the lowest. On tasting, Staff S stated "food could be warmer. " Staff S thought that the food temperature was low because there was only one person delivering trays off the cart, as the other staff was busy finishing a resident shower. On interview 12/11/12 Staff CC (Regional Dietician) identified that 106 of 136 residents are served meals in their rooms. The facilities system for keeping hot foods hot during delivery was to use an insulated plastic cover on a heated plate. Observation 12/11/12 at 11:30 a.m. noted an unused plate warmer device behind the tray line, a second covered plate warmer device was plugged in behind the server. Staff S stated staff found that the 1st plate warmer was not working 3-4 days prior.	F 364	F371 - D Food Procure, Store/Prepare/Serve - Sanitary 1) Staff are properly cleaning hands in between passing trays to individual residents/resident rooms as needed. Dietary Staff are observing infection control procedures as it relates to clean and dirty interchange. Kitchen and service halls are maintained for cleanliness. 2) Staff are properly cleaning hand in between passing trays to individual resident/resident rooms as needed. Dietary Staff are observing infection control procedures as it relates to clean and dirty interchange. Kitchen and service halls are maintained for cleanliness 3) All staff (including Staff AA, Staff BB, and Staff S) re-educated by Staff Development Coordinator on 12-17-12 through 12-27-12 regarding tray passing procedure to include infection control as it relates to hand washing during resident meal tray pass, and clean/dirty surfaces interchange. Housekeeping team re-educated by Housekeeping Director on 12-17-12 through 12-27-12 regarding cleaning procedures and schedules for kitchen and service halls. 4) Staff Development Coordinator will conduct random hand washing audits weekly times 4 weeks, then monthly times 2 months during hall tray passes and Housekeeping Supervisor will conduct five random kitchen/service hall	
F 371 SS=D	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 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 371		

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F 371	<p>Continued From page 24</p> <p>review the facility failed to prepare, distribute and serve food under sanitary conditions. This placed residents at potential risk for food borne illness.</p> <p>Findings include:</p> <p>12/5/12 from 8:15 to 8:25 a.m. Staff AA delivered breakfast trays from room to room on the 300 hall. Staff AA brought meals to 3 different residents, preparing food and /or fluids for two of the residents. At no time did Staff AA wash hands or use sanitizer. On interview Staff AA said that she is supposed to use hand sanitizer or wash between residents but did not do this today. According to Staff AA, she usually carries hand sanitizer in pocket, but not today.</p> <p>12/7/12 from 12:00 to 12:10 p.m. Staff BB delivered trays on the 500 hall. Staff BB brought meals to three different residents, preparing foods and/or fluids for three residents, including assisting to arrange clothing protectors. Staff BB did not wash or use hand sanitizer between residents. Staff BB said that she forgot to wash during lunch service as "I was rushing."</p> <p>12/11/12 11:10 a.m. Kitchen inspection noted that the kitchen floor in food preparation areas was dirty along the perimeter. At 11:28 a.m. kitchen staff rolled a cart with trays of hot prepared food from the kitchen to the tray line room. The passage floor between the kitchen and tray line was dirty. The door to the tray line room was dirty and doorknob sticky on both sides. During transport, a book containing dietary information fell onto the passage floor. The kitchen staff person picked up the book from the floor and placed it on top of the clean cold food service</p>	F 371	<p>cleanliness audits weekly times 4 weeks, then monthly times 2 months. Results will be tracked and trended and reviewed in the monthly PI Meeting and further action taken as needed times 3 months.</p> <p>5) Staff Development Coordinator and Housekeeping Supervisor will ensure compliance.</p> <p>6) 12-28-12</p>	

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F 371	Continued From page 25 shelf. On interview, Staff S (food service manager) and Staff CC (Regional Dietician) acknowledged that the floor and door were dirty and stated that kitchen staff should have wiped down the book or put it aside until it could be wiped off before placing the book on the clean food service shelf.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the 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	F 431	F431 - D Drug Records, Label/Store Drugs & Biologicals 1) Central Supply storage cabinet has been repaired by Maintenance on 12/12/12. 500 and 600 Hall medications rooms - medication/prosthetics storage, fridge, and staff personal items storage issues have been resolved by Resident Care Managers on 12-11-12 through 12-14-12. 2) Central Supply storage cabinet has been repaired. All other medication rooms - medication/prosthetics storage, fridge, and staff personal items storage issues have been resolved. 3) Nursing Staff and Central Supply Clerk were re-educated (to include Staff A) by Staff Development Coordinator on 12-17-12 through 12-24-12 regarding system for proper storage, dating, labeling, and return of medications to include personal medications and prosthetics, and cleanliness of fridges and storage of staff personal items in medication rooms. 4) Staff Development Coordinator and/or designee will conduct 3 random monthly audits of med rooms and Central Supply over the counter med storage. Results tracked and trended and reviewed in the monthly PI Meeting and further action taken as needed times 3 months.	

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F 431	<p>Continued From page 26</p> <p>Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that one of three medication storage areas was locked and limited access to authorized personnel. The facility failed to date vials of medications when opened. The facility also failed to establish a system to store, account for and return personal medications and prosthesis brought into the facility by residents. This placed residents at risk for receiving medications or biologicals that are ineffective or outdated and/or not having personal medications and prosthesis returned after discharge.</p> <p>Findings include:</p> <p>CENTRAL SUPPLY MEDICATION STORAGE: On 12/7/12 at 8:10 a.m. the room used for central supply was observed with Staff T (central supply specialist). Staff T said she had been in her current position for about 8 years, having been a nursing assistant and restorative aide prior to that. Staff T had no specific training or education from pharmacy staff.</p> <p>Central supply included an unlocked 8 shelf medication cabinet used for storage of multiple</p>	F 431	<p>5) Staff Development Coordinator and Director Of Nurses will ensure compliance.</p> <p>6) 12-28-12</p>

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F 431	<p>Continued From page 27</p> <p>over-the-counter medications. There was apparatus on the doors to the cabinet that, if used, would allow the cabinet to be locked. Staff T said the lock had broken years ago and never been fixed or replaced.</p> <p>On 12/7/12 at 12:00 p.m. Staff X (Pharmacy Consulting Nurse) stated that only licensed nurses should have access to the medications.</p> <p>500 HALLWAY MEDICATION ROOM: On 12/07/2012 at 8:45 AM observation of the 500 hall medication storage area found multiple bags and bottles of personal medications including medications of four residents who had been discharged and two unlabeled Medi Sets (containers to organize home medications). There was no way to determine what medications were in the Medi Sets or to whom they belonged.</p> <p>In addition to resident medications, a storage bin contained an upper dental plate and a full set of dentures with no resident identification label. A prosthetic eye was also found without resident identification.</p> <p>In addition to resident medications and unlabeled dentures and eye prosthesis, further inspection found the following: five syringes of heparin flush (used to keep IV lines open) expiration date 04/2011; one Biopatch antimicrobial dressing expiration date 12/2009; twenty two blood collection tubes expiration dates between 2009 and early 2012.</p> <p>An inspection of the refrigerator revealed two vials of flu vaccine. One vial was open without a date and one expired on 11/10/2012. The bottom</p>	F 431		
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F 431	<p>Continued From page 28 of the freezer portion of the refrigerator was soiled with a brown substance.</p> <p>Three syringes of Lovenox (a blood thinning agent) were found to be expired on 11/2011. A box of 80 Gluco-Chlor cleaner towlets used for cleaning the glucose testing devices were found to have expired on 04/2011. In a bottom cabinet, a purse along with a large white bag of food and drink items, belonging to a staff member, were stored on top of isolation gowns.</p> <p>On interview Staff Z confirmed all noted observations. Staff Z identified that the personal medications were brought from resident's homes. Staff Z stated these medications are supposed to be sent with the resident when they are discharged or transferred. He stated that when the resident expires, the medications are returned to the family or the guardian if they want them. Staff Z stated that those medications are considered to be their property.</p> <p>600 HALLWAY MEDICATION ROOM: On 12/07/2012 at 10:15 AM inspection of the 600 hallway medication room refrigerator found three vials of Tubersol (used for TB skin testing) vials that were opened and expired. The room contained a Biopatch dressing expiration date 01/2012. In a box labeled "Special Order Dressings", five vials of eye medications for four different residents were found. Staff A, RN, RCM confirmed all noted observations.</p> <p>A review of October 2012 pharmacy report recommended that the facility "keep flu vaccine dated" and "Tubersol, three open, two undated." The report goes on to say "please date the flu</p>	F 431		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/21/2012
FORM APPROVED
OMB NO. 0938-0391

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F 431	Continued From page 29 vaccine, once open good for 28 days." On 12/07/2012 at 11:50 AM, on interview Staff X stated that flu vaccines expire 28 days after opening and Tubersol expires within 30 days. She stated she does an audit of the facility every other month. Staff X verified that the facility does not have a system in place to account for the medications residents bring in from home.	F 431		

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