



AGING AND LONG-TERM SUPPORT ADMINISTRATION
Nursing Home Survey Report
 STATE AND CORRESPONDING FEDERAL REQUIREMENTS

1. Page <u>1</u> of <u>2</u> Pages
2. DATES OF DATA COLLECTION 10/05/16
5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Holiday
7. LICENSE NUMBER 957

3. NAME OF FACILITY Mira Vista Care Center	4. TYPE OF SURVEY <input type="checkbox"/> Full <input checked="" type="checkbox"/> Post <input type="checkbox"/> Complaint <input type="checkbox"/> Other: specify _____
6. STREET ADDRESS 300 South 18 th Street	CITY STATE ZIP CODE Mount Vernon WA 98274

NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.

8.	9. WASHINGTON ADMINISTRATIVE CODES 388-97	10. CODE OF FEDERAL REGULATION 42 CFR 483.	11. FEDERAL DATA TAG NUMBER	12. REPEAT DEFICIENCY FROM SURVEY DATED	13. NEW CITATION ON POST SURVEY	14. LICENSEE'S PLANNED DATE OF CORRECTION
<input type="checkbox"/> The requirements of the following WAC's and corresponding CFR's were not met. The text of the statements of deficiencies and the licensee's plan of correction may be read on CMS form 2567, dated: <u>08/18/16</u> . **Licensee must complete column 14. <input checked="" type="checkbox"/> The following deficiencies were determined to be corrected.	-033(1)(a)	483.10(b)(8)	F 156		<input type="checkbox"/>	
	-0640(2)(a)(b)	483.13(c)(3)	F 226		<input type="checkbox"/>	
	-0900(3)	483.15(b)	F 242		<input type="checkbox"/>	
	-580(1)(b)	483.15(e)(2)	F 247		<input type="checkbox"/>	
	-0940(1)	483.15(f)(1)	F 248		<input type="checkbox"/>	
	-0880(2)	483.15(h)(2)	F 253		<input type="checkbox"/>	
	-1000(1)(c)(i)	483.20(a)	F 272		<input type="checkbox"/>	
	-NA	483.20(i)	F 278		<input type="checkbox"/>	
	1020(1),(2)(a)(b)	483.20(k)	F 279		<input type="checkbox"/>	
	-1020(2)(f)	483.20(k)(2)	F 280		<input type="checkbox"/>	
-1620	483.20(k)(3)(ii)	F 282		<input type="checkbox"/>		
-1060(1)	483.25	F 309		<input type="checkbox"/>		

15. Surveyor's Signature(s)

SIGNATURE 	DATE 10/05/16	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

16. Licensee or Agent

SIGNATURE OF LICENSEE (OR AGENT)	TITLE	DATE
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	-1060(3)(k)(i)	483.25(I)(1)	F 329		<input type="checkbox"/>	
	-1080(1), 1090(1)	483.30(a)(1)&(2)	F 353		<input type="checkbox"/>	
	-1300(1)(b)(ii)	438.60(a)	F 425		<input type="checkbox"/>	
					<input type="checkbox"/>	
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					<input type="checkbox"/>	
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					<input type="checkbox"/>	

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SIGNATURE OF LICENSEE (OR AGENT)	TITLE	DATE

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

PRINTED: 08/31/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505315	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/18/2016
NAME OF PROVIDER OR SUPPLIER MIRA VISTA CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH 18TH STREET MOUNT VERNON, WA 98274	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey (QIS) conducted at Mira Vista Care Center on 08/09/16, 08/10/16, 08/11/16, 08/15/16, 08/16/16, 08/17/16 and 08/18/16. A sample of 34 residents was selected from a census of 76. The sample included 34 current residents and the records of 4 former and/or discharged residents.</p> <p>The following complaint was investigated: # 3253869</p> <p>The survey was conducted by:</p> <p>Cynthia Southerly MSN/Ed, RN Michelle Scollard BSN, RN Janet Beams RN Connie Phillips RN Joni Roman RN Leslie Watts RN Sarah Benjamin BSN, RN</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Disability Services Aging & Long-Term Support Administration Residential Care Services, Region 2, Unit C 3906 172nd Street NE, Suite 100 Arlington, WA 98223</p> <p>Telephone: (360) 651-6850 Fax (360) 651-6940</p> <p><i>Kathy Gold</i> 8-31-16 Residential Care Services Date</p>	F 000	<p><i>Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in statement of deficiencies. This plan of correction is prepared and executed solely because it is required for state licensure and/or for participation in the Medicare/Medicaid program.</i></p> <p>RECEIVED SEP 12 2016 ALTSAPCS ARLINGTON</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 156 SS=D	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p>	F 156	<p>F156</p> <p>Corrective action for residents found to be affected by this deficiency</p> <p>Resident rights were reviewed with Resident #47. Resident # 47 was advised of facility plan for reviewing resident rights.</p> <p>Corrective action for residents that may be affected by this deficiency</p> <p>All residents have been notified of resident rights, facility abuse policy, and location of the state hotline number. Resident rights will continue to be reviewed regularly at resident council meeting and on communication boards.</p> <p>Measures that will be put in to place to ensure this deficiency does not recur</p> <p>Residents will continue to be informed regularly of residents rights, facility abuse policy and all state contact information as required by regulation and facility policy. Staff have been re-educated on resident rights and location of abuse hotline.</p>	9/30/16	

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F 156	<p>Continued From page 2</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use</p>	F 156	<p>Measures that will be implemented to monitor the effectiveness of the corrective action taken to ensure this deficiency has been corrected and will not recur</p> <p>An audit of all residents in facility has been conducted on resident rights, facility abuse policy, and location of state hotline number. Residents have been educated on resident rights, facility abuse policy, and location of state hotline number. Five random audits will be conducted with residents to ensure knowledge of resident rights, abuse policy and location of state hotline number. Audit results will be reported to the quality assurance committee.</p> <p>Administrator will ensure compliance</p>		

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F 156	Continued From page 3 Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to periodically review resident right's and location of the State Hotline number with the residents residing in the facility. This placed residents at risk of not being informed, exercising their rights, or the ability to make anonymous phone calls to the State Hotline. In an interview on 08/10/16 at 2:34 PM, Resident 47 (Resident Council President) stated he was unaware of his resident rights. The resident stated the facility did not discuss resident rights at the resident council meeting. In an interview on 08/11/16 at 2:01 PM, Resident 95 stated resident rights were not discussed at the resident council meetings, nor did she know where the State Hotline number was located. In an interview on 08/10/16, Staff A (Activities Director) stated residents rights were not discussed at resident council meeting. Review of the resident council meeting minutes from the last 6 months found there was no documentation the resident rights or the location of the State Hotline number were discussed.	F 156			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226			

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F 226	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to recognize, investigate and report potential abuse for 2 of 5 sampled residents (102 and 34). Failure to identify potential abuse placed the resident at risk for further potential abuse along with diminished quality of life.</p> <p>Findings include:</p> <p>RESIDENT 102 Resident 102 was admitted to the facility in 2016 with diagnoses to include a [REDACTED]</p> <p>The resident's comprehensive assessment from admission through 07/29/16 revealed the Resident 102 required extensive assistance from the staff for transfers from bed to chair, wheelchair or standing.</p> <p>In an interview on 08/10/16 at 11:10, Resident 102 stated, "my roommate is crazy, she has gotten in my face and verbally threatened me, everyone knows how she is". The staff tell me my roommate, (Resident 91) "is harmless". Resident 102 was asked if this has been reported to the staff, the resident stated unsure of the staff names but had reported to the staff, "but everyone knows". The resident was asked if she knew what to do if she was abused or witnessed</p>	F 226	<p>F226</p> <p>Corrective action for residents found to be affected by this deficiency</p> <p>Resident #102 was moved to another room. Resident #91 was provided a private room. An abuse investigation was completed on August 20th following interview with facility residents, family, and staff. Abuse could not be substantiated. Resident # 34 was interviewed by Director of Nursing and Resident reported ease of bruising, related to her condition "rubbing eyes and wearing glasses." Resident # 34 had no historical concerns of abuse or neglect and denied any one hurting her throughout her stay. [REDACTED] was discontinued by physician to reduce risk of bruising.</p> <p>Corrective action for residents found to be affected by this deficiency</p> <p>Educated staff on facility abuse policies on recognizing and reporting abuse, including recognizing signs of injury of unknown origin.</p> <p>Measures that will be put in to place to ensure this deficiency does not recur</p> <p>Educated staff on facility abuse policies on recognizing and reporting abuse, including recognizing signs of injury of unknown origin.</p>	9/30/16

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F 226	<p>Continued From page 5</p> <p>a resident being abused, the resident stated she would tell someone. Resident 102 was asked if she knew about the abuse hot line number, the resident stated, "No". The resident stated the prior facility she used to live in reviewed this information frequently but they do not discuss this information here at this facility.</p> <p>In an interview on 08/15/16 at 1:34 PM, Resident 102 stated, "My roommate verbally and physically threatened me last night". The resident stated, "My roommate was standing over me holding her fist up and stated I'm going to kill someone maybe you". The resident stated, "It is scary, I told the staff at the front desk". The resident was asked the name of the staff she reported this incident to, the resident was unable to identify the staff member. Resident 102 stated the staff are aware of her but they just say "oh come on (resident's name), she is harmless, she does not know what she is doing."</p> <p>Review of Resident 91's progress notes reveals multiple incidents of aggressive behaviors:</p> <ul style="list-style-type: none"> · 08/09/16, Resident 91 stated, I don't like it here, I will kill you if you get in my way. · 07/26/16, Resident 91 stated, I just want to go, I want to kill myself. The resident was agitated, anxious pacing and wandering. · 07/28/16, Resident 91 threatened nursing staff and stated, I want my car, I may as well just kill myself. · 07/23/16, Resident 91 was found pushing another resident in a wheelchair rather quickly, the resident in the wheelchair put their feet down on the floor to stop the wheelchair, but Resident 91 continued to push the wheelchair, staff had to intervene yet again. · 07/02/16, Resident 91 was noted to have 	F 226	<p>Measures that will be implemented to monitor the effectiveness of the corrective action taken to ensure this deficiency has been corrected and will not recur</p> <p>Random audit of progress notes 4 times per week for signs of incidents, accidents, or triggers of abuse or neglect for 30 days . Following 30 days, review to occur weekly for next 2 months. Audit results will be reported to the quality assurance committee.</p> <p>Director of Nursing will ensure compliance.</p>		

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F 226	<p>Continued From page 6</p> <p>nocturnal agitated aggressive behaviors with statements of harming self and others.</p> <p>Despite the facility's knowledge of Resident 91's aggressive behaviors the facility failed to recognize the behaviors were abusive to Resident 91's roommate, Resident 102. This caused diminished quality of life for Resident 102.</p> <p>RESIDENT 34 Resident 34 was a long term care resident with diagnosis to include [REDACTED]</p> <p>Review of the care plan revealed the resident was at risk for self-inflicted injuries to vulnerable areas of her extremities due to [REDACTED]. The Licensed Nurse (LN) was to assess vulnerable areas of the body (upper and lower extremities) for new or changes in bruising every shift.</p> <p>Review of a progress note, dated 05/18/16, revealed the resident had a bruise to the [REDACTED] eye. The resident was not able to state how the bruise occurred. There was no further assessment in the medical record indicating how the resident obtained the bruise.</p> <p>Review of the Treatment Administration Record from May to August 17th revealed the LN monitored the resident's upper and lower extremities every shift for new or changes in bruising. The LN performed weekly skin assessments. There was no documentation regarding the [REDACTED] eye bruise.</p> <p>Review of the state reporting log revealed no entry regarding the bruise.</p>	F 226			

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F 226	Continued From page 7	F 226			
F 242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to actively include 1 of 3 residents (248) regarding the resident's preference to choose when to awaken daily and what type of bath the resident would prefer. This failed practice placed the resident at risk for diminished quality of life.</p> <p>Resident 248 was admitted to the facility in 2016 with diagnoses to include [REDACTED]</p> <p>In an interview on 08/09/16 at 11:22 AM, the resident stated no, he /she had to get up for</p>	F 242	<p>F242</p> <p>Corrective action for residents found to be affected by this deficiency</p> <p>Resident #248 discharged on August 22nd to home with son and daughter-in-law.</p> <p>Corrective action for residents found to be affected by this deficiency</p> <p>All resident care plans have been reviewed and revised to include residents activities and schedules. Upon completion of RAI activity assessment, preferences will be individualized on care plan.</p>	9/30/16	

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F 242	<p>Continued From page 8</p> <p>breakfast but would rather get up later maybe around 10:00 AM. The resident stated he/she had "to take a shower, would prefer a bathtub, but we do not have a bathtub."</p> <p>In an interview on 08/10/16 at 1:57 PM, Staff (P) Licensed Nurse stated, "It's not a room we've used for a long time, the tub is not working. It hasn't been working for at least a year."</p> <p>In an interview on 08/10/16 at 1:59 PM, Staff (Q) Nurse Aide Certified, stated there was no tub in the facility.</p> <p>In an interview on 8/15/16 at 9:00 AM, the DNS stated the tub does work and they do not have anyone right now requesting a tub bath.</p> <p>In an interview on 08/15/16 at 10:03 AM, the resident stated he/she had to get up by 7:30 AM for breakfast or "you do not get breakfast." In addition, the resident stated he/she would like to sleep in until at least 9:00 AM. If the resident sleep in until 9:00 AM he/she could not get breakfast after they woke up.</p> <p>In an interview on 08/15/16 at 3:53 PM, Staff (E) Social Services (SS) stated SS does not discuss specific resident choices, SS only works on choices with residents when working on discharge planning.</p> <p>In an interview on 08/15/16 at 2:47 PM, Staff A, Activities Director stated that the minimum data set (MDS) assessment goes through 16 choice items and the information is coded on the MDS based on the resident's response. Staff A stated they also have an extra level of individual interest assessment. Staff A stated the extra level of</p>	F 242	<p>Measures that will be put in to place to ensure this deficiency does not recur</p> <p>Trained activity personnel on cross over of RAI assessment to care plan. Staff trained on bathing and waking preferences, including the location and operation of all bathing equipment.</p> <p>Measures that will be implemented to monitor the effectiveness of the corrective action taken to ensure this deficiency has been corrected and will not recur</p> <p>All residents in facility were audited for bathing and waking preferences to determine that all preferences were care planned. Resident preferences and choices will be completed during our admission assessment audit one time per week times 4 weeks, and then twice a month for 2 months. Audit results will be reported to the quality assurance committee.</p> <p>Administrator will ensure compliance</p>		

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F 242	Continued From page 9 individual interest assessment did not include when the residents would like to get up in the morning. Staff A stated the information is not automatically placed on the resident's care plan and Staff A did not think this information was placed on the Kardex. Review of Resident 248's MDS dated 08/03/16 Section F0400 C asked how important is it to you to choose between a tub bath, shower, bed bath, or sponge bath, the resident's response was coded 1 = very important. Review of the resident's care plan, revealed an intervention for bathing directing staff to utilize one person in bathing assistance and the resident preferred to have a shower after breakfast. No intervention was noted in the care plan as to when the resident would prefer to awaken in the morning.	F 242			
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 3 of 5 residents (110,174 and 250) reviewed for notification of room or roommate changes received appropriate, timely notification. This failed practice placed residents at risk for diminished quality of life.	F 247	F247 Corrective action for residents found to be affected by this deficiency Resident #250 discharged on [REDACTED] 2016 and returned on [REDACTED] in [REDACTED] room with spouse. Residents #110 and 174 were interviewed and were satisfied with room and roommates.	9/30/16	

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F 247	Continued From page 10 Findings include: RESIDENT 110 Review of the medical record for Resident 110 revealed she was moved to a different room on 08/06/16. The form used by the facility for room transfers did not indicate the resident or family was agreeable to the transfer. RESIDENT 250 Review of the medical record for Resident 250 revealed no documentation in the record for the room change done on 08/06/16. RESIDENT 174 In an interview on 08/17/16 at 10:56 AM, Resident 174 stated she had recently moved from a different room, and did not know why she was moved. She also stated she only received 10 minutes notice before she was moved. Review of the medical record for Resident 174 revealed there was no documentation of the room change done on 08/04/16. In an interview on 08/17/16 at 9:37 AM, Staff D, Social Services Director stated he informs a resident and family when they are getting a roommate, he does not document in the clinical record that they were informed. In an interview on 08/17/16 at 9:55 AM, Staff E, Social Services Assistant stated there was a checklist form used for room transfers and when the form was completed, the form was then scanned into the resident's electronic record. Social service staff uses this form for all room transfers and informs the current resident in the	F 247	Corrective action for residents found to be affected by this deficiency Facility has revised room change form to indicate notification of roommate change and agreement of existing resident. Social service designee will document in resident record appropriate and timely notification of new roommate. Measures that will be put in to place to ensure this deficiency does not recur Staff was trained on proper completion of revised checklist for internal transfers form so residents are notified appropriately and timely. Measures that will be implemented to monitor the effectiveness of the corrective action taken to ensure this deficiency has been corrected and will not recur All room changes will be audited for appropriateness and timeliness one time per week for 4 weeks, and then every other week for 2 months. Audit results will be reported to the quality assurance committee. Director of Nursing to ensure compliance		

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F 247	Continued From page 11 room of the transfer. "We do not document in the clinical record when the current resident in the room has been informed. We only document in the clinical record of the resident being moved". In an interview on 08/17/16 at 10:32 AM, Staff F, Admission Assistant stated when a resident is admitted to the facility they verbally tell the current resident in the room they are getting a roommate. They do not document in the medical record that the resident has been informed.	F 247			
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide meaningful activities for extended periods for 2 of 3 sample residents (1 and 39) reviewed for activities. Failure to consistently provide individualized, meaningful activities placed residents at risk for a lack of stimulation and created the potential for a diminished quality of life. Findings include: RESIDENT 1 Resident 1 was a long term care resident with a	F 248	F248 Corrective action for residents found to be affected by this deficiency Resident #1 has an updated assessment and plan of care to include new strategies of optimal therapeutic interventions. Resident #1 will participate in meaningful activities per preferences as tolerated. Resident #39 has an updated assessment and plan of care to include new strategies of optimal therapeutic interventions. Resident #39 will participate in meaningful activities per preferences as tolerated.	9/30/16	

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F 248	<p>Continued From page 12</p> <p>diagnosis to include [REDACTED] According to the Minimum Data Set assessment, dated 06/12/16, Resident 1 enjoyed to listen to music, being involved with pets and spending time outdoors. The Care Area Assessment (CAA) stated the resident's activity participation was not possible at this time, but there were some 1:1 activities the resident may be able to engage in. The CAA did not state what these 1:1 activities were.</p> <p>Review of the activity care plan had a goal to maintain or improve Resident 1's mood through leisure intervention. The care plan directed staff to provide socialization and/or sensory stimulation/reality orientation pre-meal, invite/escort to pre-meal activities and music and to provide comfort by offering relaxing music on cable TV or one of her stuffed animals.</p> <p>Review of the activity flow sheets from May to August 16th revealed the following: the resident attended the pre-meal activity 13 out of 31 days in May, 14 out of 30 days in June, 16 out of 31 days in July and 8 out of 16 days in August. Additionally, the Nursing Assistant's (NA) documented Resident 1 was involved in an activity (Snack hour, exercise, bingo or arts and craft) 11 out of 31 days in May, 14 out of 30 days in June, 17 out of 31 days in July and 10 out of 16 days in August.</p> <p>In multiple observations on 08/09/16 at 11:20 AM, 12:15 PM, 1:12 PM, 2:38 PM and 3:40 PM, the resident was observed in her room. The [REDACTED] was running. There was no sensory stimulation observed for Resident 1.</p> <p>In multiple observations on 08/10/16 at 8:00 AM, 9:45 AM, 10:30 AM, 11:30 AM, 12:15 PM, 1:10</p>	F 248	<p>Corrective action for residents found to be affected by this deficiency</p> <p>Activity staff completed education on how to extend invitation to residents, RAI analysis, and care plan process.</p> <p>Measures that will be put in to place to ensure this deficiency does not recur</p> <p>Educated Activity Director on providing meaningful activities for extended periods, active vs. passive activities, and offering individual leisure interventions to maximize quality of life.</p> <p>Measures that will be implemented to monitor the effectiveness of the corrective action taken to ensure this deficiency has been corrected and will not recur</p> <p>Invitation observation audit of intentional strategies to encourage participation in activities will be conducted 5 times per week times 8 weeks. Audit results to be reported to the quality assurance committee.</p> <p>Administrator to ensure compliance</p>	

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F 248	<p>Continued From page 13</p> <p>PM, and 2:00 PM the resident was not observed engaged in any activity. There was no pre-meal activity observed for lunch between 11:30 AM and 12:15 PM. The resident was observed in her room not holding her stuffed animals and no music playing.</p> <p>Similar observations were noted on 08/11/16, 08/15/16 and 08/16/16.</p> <p>In an interview on 08/16/16 at 12:05 PM, Staff A, Activities, stated the only activity the resident attends was the pre-meal activity. Staff A stated the NA's were to ensure there was music playing in the residents room had her hold her stuffed animals. Staff A stated the facility was working on activities directed towards sensory stimulation.</p> <p>At 12:57 PM, the Director of Nursing Services (DNS) was mad aware of the lack of activities for Resident 1. The DNS was not able to provide any additional information.</p> <p>RESIDENT 39 Resident 39 was admitted to the facility in [REDACTED] 2016 with diagnoses to include [REDACTED]. [REDACTED] She was unable to ambulate independently and used a wheelchair for mobility.</p> <p>Review of the resident's Minimum Data Set (MDS) assessment, dated 05/12/16, revealed it was very important for the resident to: 1) listen to music you like, 2) be around animals such as pets 3) keep up with the news 4) do things with groups of people, 3) go outside to get fresh air when the weather was good, 4) to participate in</p>	F 248		

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F 248	<p>Continued From page 14 religious services or activities.</p> <p>Review of the resident's Kardex (special instructions for caregivers on how to care for resident) stated 1) on pet therapy list 2) has an audiobook 3) used to do art 4) enjoys dancing</p> <p>Review of the Activities Participation Record - Annual, revealed from 05/01/16 - 08/15/16 (107 days):</p> <ol style="list-style-type: none"> 72 days with no documented activity. 5 shifts with music activity documented No documented trips outside to enjoy the weather. No documented church services No documented pet therapy <p>On 15 separate observations from 08/09/16 - 08/16/16, the resident was observed to be sitting in her wheelchair or lying in bed by herself, not listening to audio books or engaged in any activity. There were no observations of music or television being on in his room or of staff members attempting to engage the resident in any activities. She ate meals in her room. The resident was not observed out of her room on any occasion during resurvey.</p> <p>In an interview with the resident about activity attendance on 08/15/16 at 12:03 PM, she stated "I didn't know there were any, maybe if my roommate goes, maybe she could invite me."</p> <p>In an interview on 08/16/16 at 07:24 AM, Staff B, NAC was asked about the multiple observations where the resident was observed to be sitting alone not engaged in audiobooks or involved in any activities. She stated that the only time resident goes out of her room is for showers and</p>	F 248			

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F 248	<p>Continued From page 15</p> <p>when her daughter visits on Wednesdays. Staff B stated the resident is encouraged to attend activities but when she assists the resident up she declines to attend</p> <p>In an interview on 08/16/16 at 12:05 PM, Staff A, Activity Director, stated the resident was "not really interested in group activities" Staff A stated the activities staff does try to work with her, but she didn't know how much. Staff A stated that nurse's aides (NAC's) were encouraged to help assist her to activities.</p> <p>In an interview on 08/16/16 at 07:24 AM, Staff B, NAC was asked about the multiple observations where the resident was observed to be sitting alone not engaged in audio books and not involved in any activities. She stated that the only time resident goes out of her room is for showers and when her daughter visits on Wednesdays. Staff B stated the resident is encouraged to attend activities but when she assists the resident up she declines to attend.</p> <p>Review of the Care Plan (CP) dated 07/11/16 identified focus as "maintaining quality of life. The goal stated "resident will be invited to attend arts and crafts; she will choose whether or not to participate. She will find entertainment and comfort through audio books. Interventions stated "On pet therapy list, has an audiobook, used to do art, enjoys dancing." There were no interventions about keeping the resident informed of the activities offered, assisting with transport, assisting with audio book player/headphones, offering individual in room activities as tolerated, or to encourage involvement in Sunday Worship.</p>	F 248		

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F 248	Continued From page 16	F 248			
F 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to identify and provide necessary maintenance and housekeeping services in rooms throughout the building in 3 of 3 hallways. These failures placed residents at risk for decreased quality of life, compromised dignity, and potential infection control issues.</p> <p>Findings include:</p> <p>On 08/15/16 at 8:45 AM, the following observations were conducted:</p> <p>On the 100 hall, multiple rooms (116, 114, 112, 110, 106 and 102) had gouges in the walls down to drywall, patches on some walls were not painted. There were holes in the walls and missing floor transition strips from the hall way into room and the hall carpet has large stains.</p> <p>On the 200 hall, multiple rooms (207, 206, 209, 213 and 208) had cracks and gouges in the walls, broken formica on front of a sink exposing bare wood, and missing floor transition strips from the hall way into rooms and the hall carpet has large stains.</p>	F 253	<p>F253</p> <p>Corrective action for residents found to be affected by this deficiency</p> <p>Rooms 102,106, 110, 112, 114, 116, 206, 207, 208, 209, 213, 302, 309, and 311 repairs were completed, and thresholds were replaced if indicated.</p> <p>Corrective action for residents found to be affected by this deficiency</p> <p>All other resident rooms not identified were reviewed for maintenance and repaired to meet compliance. There are no stains on the hall carpets. However, fluid spills were cleaned up timely and carpet cleaning schedule is twice per week and as needed.</p> <p>Measures that will be put in to place to ensure this deficiency does not recur</p> <p>Educated maintenance and environmental staff on how to identify and provide necessary maintenance and housekeeping services in rooms throughout the facility.</p>	9/30/16	

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F 253	Continued From page 17 On the 300 hall rooms 302, 309, and 311 had cracked wall patching, water damaged ceiling tiles, broken or missing floor transition strips, and a black substance on the wall behind a toilet with peeling wall covering exposing the drywall. In an interview on 08/16/16 at 7:42 AM Staff K, Maintenance Supervisor acknowledged that rooms are in need of repair and stated when a wall is patched they try to paint the patched area the next day. "If the resident is in the room we do not work in the room. The new room transitions have been purchased and we are in the process of replacing the missing transitions".	F 253	Measures that will be implemented to monitor the effectiveness of the corrective action taken to ensure this deficiency has been corrected and will not recur Environmental room audits will be completed weekly for 8 weeks. Audit results will be reported to the quality assurance committee. Administrator to ensure compliance		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Contenance;	F 272			

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F 272	<p>Continued From page 18</p> <p>Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to conduct an accurate comprehensive assessment for 1 of 1 resident (46) sampled for restraints. This failure to accurately assess and identify a restraint prevented the facility from developing an accurate care plan with individual specific interventions and placed the resident at risk of injury.</p> <p>Per the State Operations Manual, Appendix PP and the Minimum Data Set 3.0 assessment manual describes physical restraints as: Any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body.</p>	F 272	<p>F272</p> <p>Corrective action for residents found to be affected by this deficiency</p> <p>Resident # 46 was re-assessed. IDT attempted alternative interventions. After IDT review and resident input, it was determined that the [REDACTED] are an appropriate device for positioning and is not considered a restraint. Assessment form and analysis is documented in the resident record. The care plan is consistent with the assessment and resident's wishes.</p>	9/30/16	

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F 272	<p>Continued From page 19 Findings include:</p> <p>Resident 46 was admitted in [REDACTED] 2015 with diagnoses to include [REDACTED]</p> <p>Review of the most recent Minimum Data Set (MDS) assessment dated 3/16/16 revealed there were no restraints identified on the assessment. Resident 46 required 2 person assist with bed mobility and transfers and 1 person assist for all other activities of daily living and an extensive assist of one person for dressing.</p> <p>In an observation on 08/16/16 at 1:39 PM, Resident 46 was sitting in his wheel chair with two [REDACTED]. There was a [REDACTED] secured around [REDACTED] one at the [REDACTED] area, and one around [REDACTED] holding his [REDACTED] to the [REDACTED].</p> <p>Review of the clinical record revealed there was no documented assessment for the [REDACTED] to determine if they were classified as restraints or if the resident was able to reach, manipulate the clasps, or able to easily remove both or either [REDACTED].</p> <p>In an interview on 08/16/16 at 2:19 PM, Resident 46 stated he has been using the [REDACTED] for two years. "When I recline in my wheel chair it keeps my [REDACTED] from coming off of the [REDACTED]."</p> <p>In an interview on 08/16/16 at 2:38 PM Staff N acknowledged the use of the [REDACTED] to residents [REDACTED] were not identified on the care plan or kardex, and no physical therapy evaluation</p>	F 272	<p>Corrective action for residents found to be affected by this deficiency</p> <p>All residents with adaptive aides and restraints were reviewed to ensure comprehensive assessments for adaptive devices are in place and reflect resident plan of care and preference.</p> <p>Measures that will be put in to place to ensure this deficiency does not recur</p> <p>Licensed staff were educated on restraint policy and procedure.</p> <p>Measures that will be implemented to monitor the effectiveness of the corrective action taken to ensure this deficiency has been corrected and will not recur</p> <p>Audit completed on all residents with adaptive aides and restraints to ensure assessment, consent and plan of care are accurate. Audit completed weekly times 3 months on any new residents assessed to have adaptive aides and/or restraints, and results will be reported to the quality assurance committee.</p> <p>Director of Nursing to ensure compliance</p>	
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NAME OF PROVIDER OR SUPPLIER MIRA VISTA CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH 18TH STREET MOUNT VERNON, WA 98274	
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F 272	Continued From page 20 was done.	F 272		
F 278 SS=D	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure accuracy of the</p>	F 278		

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F 278	<p>Continued From page 21</p> <p>Minimum Data Set (MDS) assessment for 2 of 3 residents (39 and 174) for oral/dental status, and 1 of 4 sampled residents (102) reviewed for pain assessment and management. Failure to accurately code the MDS placed residents at risk for decreased quality of life and unmet care needs.</p> <p>Findings include:</p> <p>RESIDENT 39 Resident 39 was admitted in [REDACTED] 2016 with diagnoses to include [REDACTED]</p> <p>Resident 39's MDS dated 05/07/16, documented the resident had moderate cognitive impairment, was able to make her needs known, and required extensive assistance of one person with brushing her teeth. The MDS assessment revealed Resident 39 had upper dentures and no problems with her lower natural teeth.</p> <p>On 08/09/16 at 2:14 PM, the resident was observed to have missing teeth noticeably her [REDACTED] bottom front tooth. She indicated she needed assistance with brushing her teeth.</p> <p>According to the nursing admission assessment dated 04/30/16, the resident was noted to have no cavities or dental concerns.</p> <p>The admission MDS assessment dated 05/12/16 indicated no oral/dental issues, consequently the Care Area Assessment (CAA) did not trigger (a CAA is to help nursing facilities apply assessment data collected on the MDS, Care Area Assessments are triggered responses to items</p>	F 278	<p>F278</p> <p>Corrective action for residents found to be affected by this deficiency</p> <p>Resident # 39 , #102 and # 174 dental and pain Care Areas Analysis were completed and care plan was revised.</p> <p>Corrective action for residents found to be affected by this deficiency</p> <p>All resident admission MDS assessments for oral care and pain have been audited to ensure care area for oral care has been developed on the plan of care.</p> <p>Measures that will be put in to place to ensure this deficiency does not recur</p> <p>MDS Coordinator was trained on completing RAI process.</p> <p>Measures that will be implemented to monitor the effectiveness of the corrective action taken to ensure this deficiency has been corrected and will not recur</p> <p>Ten Random audits to be completed for dental and pain MDS accuracy every week times 8 weeks, and then 10 random audits monthly for 2 months. Audit results to be reported to the quality assurance committee.</p> <p>Director of Nursing to ensure compliance</p>	9/30/16

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F 278	<p>Continued From page 22</p> <p>coded on the MDS specific to a resident's possible problems, needs or strengths), and a care plan problem was not initiated for oral/dental issues.</p> <p>Review of the nursing care plan identified alteration in self care ability. The care plan stated Resident 39 had a top denture and lower natural teeth with some missing teeth, staff to assist the resident to clean her teeth after meals and at bedtime.</p> <p>In an interview on 08/15/16 at 10:29 AM the Director of Nursing Services (DNS) stated the resident's dental status should have been coded on her admission MDS, triggered on the CAA and addressed on her care plan.</p> <p>RESIDENT 174 Resident 174 was admitted in [REDACTED] 2016 with diagnoses to include [REDACTED]</p> <p>The MDS dated 08/06/16, revealed the resident had no cognitive impairment, was able to make her needs known, and required extensive assistance of one person with brushing her teeth.</p> <p>On 08/10/16 at 2:50 PM the resident was observed to have upper dentures and natural lower teeth with [REDACTED] and [REDACTED] was [REDACTED]. The resident reported [REDACTED] is [REDACTED] as well. The resident indicated she needed assistance with cleaning her upper dentures and brushing her teeth related to her [REDACTED]. She indicated staff had only assisted her on 3 to 4 times since admission.</p>	F 278		

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F 278	<p>Continued From page 23</p> <p>According to the nursing admission assessment dated 07/05/16, the resident was noted to have broken teeth and poorly fitting dentures.</p> <p>The admission MDS assessment dated 07/15/16 indicated no oral/dental issues, consequently the Care Area Assessment (CAA) did not trigger (a CAA is to help nursing facilities apply assessment data collected on the MDS, Care Area Assessments are triggered responses to items coded on the MDS specific to a resident's possible problems, needs or strengths), and a care plan problem was not initiated for oral/dental issues.</p> <p>The MDS's dated 07/15/16 and 08/11/16 revealed Resident 174 had no dental issues.</p> <p>Review of the care plan dated 07/05/16 revealed no mention of loose fitting denture or any special care or dental follow up the resident needed for her broken teeth.</p> <p>Review of the Registered Dietician note on 07/13/16 indicated the resident had upper and lower dentures and there were no concerns.</p> <p>In an interview on 08/15/16 at 10:29 AM, the DNS stated the resident's loose fitting dentures and missing teeth should have been coded on her admission MDS, triggered on the CAA and addressed on her care plan.</p> <p>RESIDENT 102 Resident 102 was admitted to the facility in 2016 with diagnoses to include _____</p>	F 278			

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F 278	Continued From page 24  In an interview on 08/10/16 at 11:18 AM, Resident 102 was asked if you have any discomfort now or have you been having discomfort such as pain, heaviness, burning, or hurting with no relief. The resident stated, "My shoulder hurts, I have migraine headaches and have had an ear ache." "They don't always give me anything." Review of the resident's MDS dated 03/10/16 revealed the resident was able to be understood and understands others, able to communicate fully. On the MDS section to determine if a pain assessment interview should be conducted with the resident, the MDS was coded no, indicating the resident is rarely or never understands others or is understood. Review of the resident's MDS section on resident pain assessment interview from 03/10/16 through 06/02/16 revealed all 6 MDS's were coded to not interview the resident. In an interview on 08/15/16 at 12:42 PM, Staff (R) Licensed Nurse, MDS Coordinator stated she completed all MDS's at the facility. Staff (R) was asked to review the process when completing a resident pain assessment interview on the MDS. Staff (R) stated the pain assessment interview is dependent on resident caseload, she might go and complete a resident pain assessment interview but it was not the MDS Coordinator's role. The resident's case mangers now complete a different type of pain assessment. Staff (R) was asked about Resident 102 MDS pain assessment interview, Staff (R) stated if the case manager did not complete a pain assessment	F 278			

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F 278	Continued From page 25 then the pain assessment interview on the MDS was not completed. In an interview on 08/16/16 at 1:58 PM, the Director of Nursing Services (DNS) was asked why a resident who can be interviewed does not have a completed pain assessment interview on the MDS. The DNS stated it is the expectation that the resident receive a pain assessment interview if the resident is able be understood and is understand. The DNS stated a MDS class is being provided for the MDS Coordinator.	F 278			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279			

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F 279	<p>Continued From page 26</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain accurate, updated care plans for 1 of 4 sample residents (145) reviewed for care plan accuracy. This failed practice had the potential for residents to have unmet care needs and a diminished quality of life.</p> <p>Findings include:</p> <p>Resident 145 was re-admitted to the facility in 2016 with a diagnosis of [REDACTED]</p> <p>Review of the physician orders dated 06/10/16; stated resident goes to [REDACTED] 3 times a week. The orders also had detailed instructions on [REDACTED] care between [REDACTED] treatments and daily care instructions after her [REDACTED] treatment. Also, Resident 145 was on 1000 ml (milliliters) fluid restriction per day due to [REDACTED]</p> <p>FLUID RESTRICTION In an observation on 08/15/16 at 9:05 AM, Resident 145 had a large cup of fluids on her bed side stand along with her breakfast tray that contained a cup of coffee, small glass of juice, small glass of milk and small glass of water.</p> <p>In an interview on 08/15/16 at 8:50 AM, Staff L Dietary Manager, stated he was not aware Resident 145 was on a fluid restriction. "I get a slip regarding diet changes, from he dietitian, nursing or therapy. Currently the resident is receiving 240 ml's of fluid on each meal tray from the kitchen".</p>	F 279	<p>F279</p> <p>Corrective action for residents found to be affected by this deficiency</p> <p>Resident # 145 plan of care was updated.</p> <p>Corrective action for residents found to be affected by this deficiency</p> <p>Dietary recommendation policy and procedure was revised. All resident diet orders and Tray Card information was cross matched to ensure there were no discrepancies. All [REDACTED] patient and [REDACTED] care plans were reviewed and cross matched with orders to ensure all components of the plan of care matched specific resident care plan needs. RD will input orders into plan of care.</p> <p>Measures that will be put in to place to ensure this deficiency does not recur</p> <p>Staff were educated on new dietary recommendation policy and procedure.</p> <p>Measures that will be implemented to monitor the effectiveness of the corrective action taken to ensure this deficiency has been corrected and will not recur</p> <p>Will complete random audits one time per week for 4 weeks, then once a month for 2 months. Audit results to be reported to quality assurance committee.</p> <p>Director of Nursing to ensure compliance</p>	9/30/16

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F 279	<p>Continued From page 27</p> <p>Review of the registered dietician assessment dated 02/09/16 recommended a low fat, low cholesterol, no added salt, [REDACTED] with regular thin liquids and 1000 ml fluid restriction.</p> <p>In an interview on 08/15/16 at 9:48 AM, Resident 145 stated staff had just informed her that she was on a fluid restriction. "They took my large cup away from me. I never knew I was on fluid restriction before today. They keep telling me to drink water".</p> <p>Review of the nursing care plan dated 07/14/16 and the kardex (directions for nursing assistant staff), revealed directions to "encourage fluid intake throughout the day with drinks of choice".</p> <p>Review of the fluid intake reports dated 06/15/16 through 08/14/16 revealed Resident 145 had consumed greater than 1000 ml of fluid on 23 days.</p> <p>[REDACTED] CARE PLAN A review of the care plan and kardex dated 06/02/16 revealed there were no [REDACTED] care interventions listed.</p> <p>Review of the physician orders dated 06/10/16 and medication administration record for August 2016 revealed detailed instructions for monitoring resident after [REDACTED] treatments and between treatments.</p> <p>In an interview on 08/11/16 at 1:44 PM, Staff I, Licensed Nurse acknowledged the information was not on the care plan or the kardex.</p>	F 279		

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F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure 1 of 3 sample residents (102) the opportunity to participate in decision-making in their treatment and care planning. Failure to ask the resident for input during care planning placed the resident at risk for diminished quality of life.</p> <p>Resident 102 was admitted to the facility in 2016 with diagnoses to include a [REDACTED]</p>	F 280	<p>F280</p> <p>Corrective action for residents found to be affected by this deficiency</p> <p>Resident # 102, family, and/or legal representative were included in a Care Plan Conference and provided the opportunity to participate in decision making toward plan of care.</p> <p>Corrective action for residents found to be affected by this deficiency</p> <p>All resident records were audited to ensure care plan conferences have been held and provided each resident, family, and/or legal representative the opportunity to participate in decision making toward plan of care.</p> <p>Measures that will be put in to place to ensure this deficiency does not recur</p> <p>Social Services was re-educated on following the RAI calendar for scheduling care conferences with residents and family members.</p>	9/30/16

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F 280	Continued From page 29 [REDACTED] In an interview on 08/10/16 at 11:09 AM, the resident was asked if the staff included the resident in decisions about your medicine, therapy or other treatments. The resident stated, "They make all the decisions, they do not talk to me about them." The resident stated, "I wish they would include me, there are things that I would like to discuss." Review of the resident's medical record revealed no documentation of the resident's involvement in the care plan process. In an interview on 08/15/16 at 3:50 PM, Staff (E) Social Services was asked if the resident's participation or attendance to the resident's care plan would be documented in the resident's medical record. Staff (E) stated ideally the resident's participation or attendance to the care plan meetings would be documented in the resident's medical record. Staff (E) stated a prior social service staff member who no longer worked at the facility was assigned to Resident 102. Staff (E) did not provide any further comments or documentation.	F 280	Measures that will be implemented to monitor the effectiveness of the corrective action taken to ensure this deficiency has been corrected and will not recur Care planning conference random audit to be completed in conjunction with RAI audit 4 times per week for one month. Audit results will be reported to the quality assurance committee. Administrator to ensure compliance		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282			

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F 282	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide care and services in accordance with each resident's written plan of care for 2 of 10 sample residents (1 and 174) reviewed for care plan implementation. This failure placed Resident 1 at risk for injury related to bilateral landing mats not in placed on either side of the bed and potential for skin breakdown related to feet and legs not being elevated. Additionally, this failure resulted in Resident 174 not receiving routine oral care and put him at risk for dental and dental related complications. Findings include: RESIDENT 1 Resident 1 was a long term care resident with diagnoses to include [REDACTED] [REDACTED] According to the Minimum Data Set (MDS) assessment, dated 06/12/16, Resident 1 was dependent on two staff members for bed mobility and transfers. Resident 1 had short and long term memory deficits. Review of the care plan directed staff to elevate the resident's legs and float her heels (position the heels off of the surface of the bed) when in bed and to turn the resident every 2 hours. Additionally, Resident 1 was at risk for falls. Staff was directed to have two landing mats on the floor on either side of the bed. In multiple observations on 08/09/16 at 11:20 AM, 12:15 PM and 1:12 PM, the resident was observed to be lying on her back in bed, her feet	F 282	F282 Corrective action for residents found to be affected by this deficiency Resident #1, #79 and #174 care plans were updated. Resident #79 treatment was revised by physician. Corrective action for residents found to be affected by this deficiency Randomly audit kardex to determine if staff are following care plan instructions 3 times per week for 8 weeks. All resident care plans for wound prevention and skin care were audited. Measures that will be put in to place to ensure this deficiency does not recur Licensed staff were educated on following care plans and facility skin policy and procedure.	9/30/16

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F 282	<p>Continued From page 31</p> <p>were flat on the surface of the bed and no landing mats were present.</p> <p>At 2:38 PM and 3:40 PM, the resident was observed to be lying slightly to the right side, with her feet directly on the surface of the bed and no landing mats in place.</p> <p>In multiple observations on 08/10/16 at 8:00 AM, 9:45 AM and 10:30 AM, the resident was observed to be lying on her back in bed, her feet not elevated/floated off of the bed and no landing mats in place.</p> <p>At 11:30 AM, the resident was observed to be up in her wheelchair next to her bed.</p> <p>At 12:15 PM, 1:10 PM, and 2:00 PM the resident was observed lying on her back, feet/lower extremities were lying flat on the mattress and there were no landing mats in place.</p> <p>Similar observations were noted on 08/11/16, 08/15/16 and 08/16/16.</p> <p>In an interview on 08/16/16 at 6:30 AM, Staff U, Nursing Assistant, (NA), stated Resident 1 was turned and repositioned every two hours. The resident's feet were to be elevated. Staff U stated the resident did not have any landing mats in place.</p> <p>At 6:57 AM, Staff S, NA, stated Resident 1 does not try to get out of bed and did not have any landing mats in place. Staff S stated Resident 1 was on a standard every two hour turning and repositioning program.</p> <p>At 1:07 PM, the Director of Nursing Services</p>	F 282	<p>Measures that will be implemented to monitor the effectiveness of the corrective action taken to ensure this deficiency has been corrected and will not recur</p> <p>Facility will audit high risk patients for skin breakdown using the Braden scale including NAC interview and observation 3 times per week for 8 weeks. Randomly audit residents for oral care completion 3 times per week for 8 weeks. Audit results to be reported to the quality assurance committee.</p> <p>Assistant Director of Nursing to ensure compliance</p>	
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F 282	<p>Continued From page 32</p> <p>(DNS) stated the care plan was not updated to reflect the resident no longer required bilateral landing mats. The DNS stated the resident was to be repositioned every two hours and her feet should be elevated per the directions on the care plan. The DNS was made aware this did not occur for this resident.</p> <p>RESIDENT 79 Resident 79 was a long term care resident with a diagnosis to include [REDACTED]. According to the MDS assessment, dated 07/06/16, the resident had severe cognitive impairment and required extensive assistance of two people for bed mobility.</p> <p>Review of the care plan directed the NA to apply [REDACTED] ointment and [REDACTED] after each incontinent episode. The NA was to notify the Licensed Nurse (LN) if there were any open areas to the resident's buttocks/coccyx.</p> <p>Review of a nursing progress note, dated 08/12/16, revealed the resident had moisture associated contact [REDACTED] on her [REDACTED]. The area measured 15 centimeter (cm) by 10 cm.</p> <p>In an interview on 08/16/16 at 6:25 AM, Staff U, NA stated the resident has an open area on her [REDACTED] right now that was "real bad."</p> <p>At 6:45 AM, Staff S and Staff T, NA's, were observed to provide incontinent care to Resident 79. The resident was turned onto her left side. The resident's buttocks was exposed and observed to have thick white cream on her buttocks. The cream was coming off in some areas. Staff S applied lotion to the resident's buttocks and then wiped the lotion and cream off</p>	F 282		

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F 282	<p>Continued From page 33</p> <p>of her buttocks with a wet washcloth. When the thick cream was removed, there was [REDACTED] of the resident's buttocks) of [REDACTED]. The skin was [REDACTED] and [REDACTED] areas were observed. After Staff S cleaned the resident's buttocks, Staff S then applied [REDACTED] ointment directly onto the resident skin and applied a [REDACTED] to each side of the resident's buttock.</p> <p>At 12:50 PM, the DNS stated the facility's policy was the NA could apply the [REDACTED] ointment and [REDACTED] to the resident's buttocks as a preventative skin intervention. The NA was to apply the [REDACTED] ointment directly onto the [REDACTED] and then place it onto the resident skin. The NA was not to apply the preventive intervention to any resident whose skin was not intact. The DNS was made aware Staff S applied the intervention incorrectly onto the resident's wound.</p> <p>RESIDENT 174 Resident 174 was admitted in [REDACTED] with diagnoses to include [REDACTED]</p> <p>The MDS dated 08/06/16, documented the resident had no cognitive impairment, was able to make her needs known, and required extensive assistance of one person with brushing her teeth.</p> <p>In an interview on 08/10/16 at 2:50 PM the resident indicated she needed assistance with cleaning her upper dentures and brushing her teeth on the bottom related to her [REDACTED] and [REDACTED]. She indicated staff had only assisted her on 3 to 4 occasions since admission. She stated her teeth were cleaned yesterday and that was the only time all weekend they were</p>	F 282		

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F 282	<p>Continued From page 34</p> <p>cleaned. She stated that her daughter assists her with oral care when she visits every 3 days. The resident stated "it is probably my fault I don't get help because I don't ask for it. My daughter says the same thing."</p> <p>Review of resident's Kardex and related care plan dated 07/05/16 both stated "oral care-upper dentures lower teeth are natural-1 EA (extensive assist) with oral care". There was no documentation of the oral care being provided since admission.</p> <p>Review of the oral care policy and procedure stated oral care will be offered and assisted with as need is identified through nursing assessments or by any resident requesting assistance with this function. Oral care will be provided routinely throughout the day & evening as allowed & tolerated by resident or as requested by a resident. Purpose is to provide cleanliness and comfort to the resident, to minimize dental issues and provide opportunity for oral assessment and identify need for further care.</p> <p>In an interview on 08/15/16 at 10:29 AM the DNS stated the resident's dental needs should have been on the Kardex for nurse's aides to document oral care when given.</p> <p>On 08/16/16 at 07:10 AM, Staff B, a NAC (Nursing Assistant Certified) stated she asked the resident a few days ago if she wanted to brush her teeth at the bed or at the sink and the resident stated "I would love to go to the sink; you are the first person who asked me. I helped her to the sink and she did wonderful."</p>	F 282		
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F 282	Continued From page 35 In an interview on 08/16/16 at 2:44 PM the DNS stated that it is her expectation oral is care is given in the morning and at bedtime. Residents with a history of pocketing food receive oral care after each meal.	F 282			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review 1 of 3 sampled residents (102), the facility failed to implement interventions to address pain. Failure to provide the care and services necessary placed the resident at risk for uncontrolled pain and a diminished quality of life. Additionally, the facility failed to attain or maintain the highest practicable level of physical well being for 1 of 3 residents (110) reviewed for Activities of Daily Living. Failure to promote Resident 110's ability to self feed placed her at risk for a diminished quality of life. Findings include:	F 309	F309 Corrective action for residents found to be affected by this deficiency Resident # 102 was re-evaluated by primary care physician with orders to help manage pain. Resident # 110 was reassessed by Nurse Manager and plan of care revised.	9/30/16	

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F 309	<p>Continued From page 36</p> <p>PAIN RESIDENT 102 Resident 102 was admitted to the facility in [REDACTED] 2016 with diagnoses to include a [REDACTED]</p> <p>Review of the orthopedic note dated 06/29/16, revealed the resident had good reduction with good position of plates and screws to [REDACTED] on immediate postoperative film however, on 06/01/16 the x-ray revealed lost reduction with failure of the screw fixation and at least 2 screws protruding outside of the [REDACTED]. The resident had refused further x-ray or surgery.</p> <p>Review of the resident's current pain management regime revealed routine [REDACTED] 50 mg [REDACTED] (pain reliever) five times daily with [REDACTED] 500 mg or 1000 mg every six hours as needed.</p> <p>Review of the progress note dated 08/03/16 by Staff C, Licensed Nurse (LN), revealed the resident experienced pain to the [REDACTED] which is often rated at an 8 out of 10-pain scale while on routine [REDACTED]. The progress note continues to focus on the resident's lack of [REDACTED] behaviors requesting a change in [REDACTED] medication; no requests were mentioned to address the resident's continued severe pain.</p> <p>In an interview on 08/09/16 at 3:53 PM, Resident 102 declined a full interview and stated, "I have a lot of pain."</p> <p>In an interview on 08/10/16 at 11:18 AM, Resident 102 was asked if she experienced pain without relief. The resident stated, "My [REDACTED] hurts, frequently have migraine headaches and I'm</p>	F 309	<p>Corrective action for residents found to be affected by this deficiency</p> <p>All residents with pain were re-assessed for pain management. All residents requiring assistance with meals were re-assessed to ensure therapeutic strategies were in place.</p> <p>Measures that will be put in to place to ensure this deficiency does not recur</p> <p>Licensed staff were re-educated on policy and procedure for pain assessment and pain management. Licensed staff were re-educated on therapeutic dining approaches.</p> <p>Measures that will be implemented to monitor the effectiveness of the corrective action taken to ensure this deficiency has been corrected and will not recur</p> <p>Ten Random audits to be completed for pain assessment accuracy every week times 8 weeks, and then 10 random audits monthly for 2 months. Randomly audit 5 high risk residents for pain management weekly for 8 weeks. Therapeutic dining room audit to be completed weekly times 8 weeks. Audit results to be reported to the quality assurance committee.</p> <p>Director of Nursing to ensure compliance</p>	
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F 309	<p>Continued From page 37</p> <p>having an earache". Resident 102 stated, "They don't always give me anything".</p> <p>In an interview on 08/15/16 at 12:25 PM, Staff I, LN Case Manager was asked about Resident 102's pain management regime and the resident's pain assessment. Staff I reviewed the resident's Comprehensive Pain Management Form documenting the resident's pain rating to be at an 8 out of 10. Staff I stated the resident does not visibly appear to be in pain at the level she rates her pain.</p> <p>In an interview with the resident on 08/15/16 at 1:42 PM, the resident stated the staff tell me "Oh it doesn't hurt, the nurse gives me some pain pills but it is not enough to control my pain, I am hurting right now".</p> <p>In an interview on 08/15/16 at 3:30 PM, Staff H, MD was asked if Resident 102's pain was controlled, Staff H stated the resident's "pain is reasonably controlled but unsure if it is sufficiently controlled". Staff H stated "would like to avoid narcotics to treat Resident 102's pain related to the uncertainty of the resident's [REDACTED] health".</p> <p>In an observation and interview on 08/16/16 at 7:41 AM, Resident 102 was sitting in her wheelchair at the nurse's station. Staff C, LN asked the resident to rate her pain on a 0 to 10 pain scale with 0 being no pain and 10 being the worse pain experienced. The resident stated her pain was at an 8 out 10 rating to her [REDACTED] back and ear.</p> <p>Review of the resident's documented dayshift pain scale on the Medication Administration Record (MAR) on 08/16/16, revealed Staff C</p>	F 309			

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F 309	<p>Continued From page 38</p> <p>documented the resident's pain level at a 5 out of 10.</p> <p>In an interview on 08/16/16 at 1:24 PM, Staff C was asked how the resident's pain rating is determined on the daily MAR pain assessment. Staff C stated the resident is asked to rate her pain on a 0 to 10 pain scale. Staff C stated Resident 102 was asked about pain around 7:00 AM during the morning medication pass while the resident was sitting at the nurses station. Staff C stated the resident typically rates her pain at 5 and that a pain scale of 5 is the resident's standard pain scale.</p> <p>In an interview on 08/16/16 at 2:05 PM, Staff C was asked about the discrepancy in pain rating from the observation at 7:41 AM, Staff C stated "... she typically rates her pain at a 5."</p> <p>Review of the resident's MAR documented pain scale revealed Staff C documented the resident's pain to be a 5 out of 10 on every entry Staff C documented for the months of July and August 2016.</p> <p>In an interview on 08/16/16 at 1:47 PM, the resident was asked to rate her usual pain relief with her current pain regiment. Resident 102 stated her medication helps a little usually reduces her pain to a 6 or a 7 out of 10.</p> <p>In an interview on 08/16/16 at 1:52 PM, Staff G, Nursing Aide Assistant (NAC) stated the resident "complains of pain sometimes, if she wants something, she complains of pain and she wants attention all the time". Staff G was asked what approaches are on the care plan for the NAC's in regards to the resident's pain; Staff G stated</p>	F 309			

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F 309	<p>Continued From page 39</p> <p>there are no interventions for the NAC's on the Kardex from the Care Plan.</p> <p>Review of the resident's care plan revealed the resident has a problem titled "alteration in comfort due to the resident's surgical repair of [REDACTED]". The only interventions related to the resident's pain are to offer distraction with walks, coffee and snacks and to offer a warm blanket to the [REDACTED] when the resident complains.</p> <p>In an interview on 08/18/16 at 3:30 PM, the Director of Nursing Services stated the facility was reluctant to treat the resident's pain with stronger pain management related to the resident's past [REDACTED] and concerns with the resident's [REDACTED] status related to the resident's [REDACTED].</p> <p>HIGHEST LEVEL OF WELL-BEING RESIDENT 110</p> <p>Resident 110 was admitted to the facility in [REDACTED] 2015 with diagnosis to include a [REDACTED].</p> <p>[REDACTED] According to the Minimum Data Set assessment, dated 04/27/16, the resident required extensive assistance of one for eating.</p> <p>Review of the care plan revealed the resident required 1 to 1 assistance and was to sit upright (at 90 degrees) for all meals.</p> <p>On 08/09/16 at 12:38 PM, Resident 110 was served yogurt prior to the lunch meal being delivered. The resident was not sitting upright in her wheelchair and staff was not present. Resident 110 was observed to eat the yogurt independently.</p>	F 309			

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F 309	<p>Continued From page 40</p> <p>At 12:55 PM, Resident 110 was served the lunch meal. An unidentified staff member repositioned the resident's wheelchair (w/c) in an upright position. Resident 110 then began to feed herself her meal.</p> <p>At 1:08 PM, Staff V, Nursing Assistant (NA), sat down next to Resident 110, removed the spoon from the resident's hand and began to feed the resident. At no time did Staff V allow or encourage Resident 110 to assist with feeding herself.</p> <p>In an interview on 08/11/16 at 2:09 PM, Resident 110 stated she could feed herself. The resident stated she needed assistance in cutting certain foods up but "didn't want to go backwards" and "liked feeding myself."</p> <p>In an observation on 08/16/16 at 8:25 AM, Resident 110 was served breakfast by a dietary staff member. Resident 110's w/c was leaning back at an approximated 120 degree angle. The resident grabbed her spoon and quickly began to feed herself her meal.</p> <p>At 8:30 AM, Staff W, NA, placed the resident upright and sat down next to the resident. Staff W verbally cued the resident to slow down between bites of food and encouraged her to drink her fluids.</p> <p>In an interview at 1:26 PM, Staff W stated Resident 110 was able to feed herself. Staff W stated the resident required verbal cueing to slow down and to take sips of fluids.</p> <p>At 1:35 PM, Staff I, Resident Care Manager, stated 1 to 1 assistance with meals meant staff</p>	F 309			

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F 309	Continued From page 41 were next to the resident or in view of the resident during the resident's meals. Staff I was made aware of the above observations and resident interview. Staff I stated she would educate staff and re-assess the resident's care plan to ensure she was maintained at her highest level of independence.	F 309			
F 323 SS=E	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 safely secure hazardous liquids, ensure hazardous liquids were safely secured for 3 of 3 hallways, failed to store wheel chair foot rests off the floor and out of the residents direct path and failed to ensure the appropriately positioning devise was used for 1 of 1 resident (46) observed for possible restraints. This failure had the potential to allow a confused resident access to caustic poisons, to safely secure hazardous agents, properly store wheel chair foot rests, and provide an appropriate positioning devise placed residents at risk for an unsafe environment. Findings include:	F 323			

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F 323	<p>Continued From page 42</p> <p>CHEMICALS During initial rounds of the facility on 08/09/16, observations revealed unlocked doors allowing access of residents to chemicals.</p> <p>At 9:30 AM the tub room on the 200 hall was unlocked, with gallon containers of shampoo/body wash stored on the floor. There was an unlocked cabinet with gallon containers of whirlpool cleaning solution and disinfectant.</p> <p>At 9:45 AM the shower room on the 300 hall was unlocked and contained a gallon container of shampoo/body wash.</p> <p>During environmental rounds on 08/15/16 and 08/16/15 perineal (peri) cleaning solution were observed in resident rooms 105, 106, 114, 116, 208, 304, 315, 316 and 312.</p> <p>In an interview on 08/16/16 at 8:33 AM the Director of Nursing Services (DNS), stated independent residents can keep there personal care items at the sink. Peri wash is kept in the residents top drawer "most of the time", out of reach of the residents.</p> <p>WHEEL CHAIR FOOT RESTS During environmental rounds on 08/15/16 wheel chair foots rests were observed lying on the floor next to the resident's bed in room 213, and under the residents' sink in rooms 115, 203, and 204.</p> <p>In an interview on 08/16/16 at 8:26 AM the DNS, stated wheel chair foot rests should be placed in the residents closet or on the wheel chair seat when not in use. "My expectation would be a clutter free environment".</p>	F 323	<p>F323</p> <p>Corrective action for residents found to be affected by this deficiency</p> <p>Tub room on 200 hall and shower room on the 300 hall were locked and hazardous materials secured. [REDACTED] and [REDACTED] were secured in resident 93's room. [REDACTED] was secured in rooms 105, 106, 114, 116, 208, 304, 315, 316, and 312. Wheel chair foot rests were secured in room 213, 203, 115 and 204. Resident # 46 was re-assessed for adaptive aides and restraints. IDT attempted alternative interventions. After IDT review and resident input, it was determined that the [REDACTED] are an appropriate device for positioning and is not considered a restraint. Assessment form and analysis is documented in the resident record. The care plan is consistent with the assessment, resident's wishes, and facility restraint policy and procedure. Resident #93 self-medication assessment & plan of care was completed to manage [REDACTED] in a safe manner that promoted resident's autonomy.</p>	9/30/16	

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F 323	<p>Continued From page 43</p> <p>RESIDENT 46 Resident 46 was admitted in [REDACTED] 2015 with diagnoses to include [REDACTED]</p> <p>In an observation on 08/16/16 at 1:39 PM, Resident 46 was sitting in his wheel chair with a [REDACTED] around both [REDACTED] holding them together at the [REDACTED] area. There was another [REDACTED] around both [REDACTED] and the metal [REDACTED] holding his [REDACTED] on the [REDACTED]</p> <p>Review of the clinical record revealed there was no assessment by physical therapy, for the use of [REDACTED] for positioning. There was no care plan or kardex interventions identified for [REDACTED] use.</p> <p>In an interview on 08/16/16 at 2:19 PM, the resident stated he has been using the [REDACTED] for two years. "When I recline in my wheel chair it keeps my [REDACTED] from coming off of the [REDACTED]"</p> <p>In an interview on 08/16/16 at 2:38 PM, Staff N, Registered Nurse acknowledged the use of the [REDACTED] to residents [REDACTED] were not identified on the care plan or kardex, and no physical therapy evaluation was done.</p> <p>HAZARDOUS LIQUIDS During multiple observations on 08/10/16, 08/11/16 and 08/16/16, [REDACTED] and [REDACTED] were observed on the nightstand of Resident 93. The [REDACTED] and [REDACTED] were labeled "keep out of reach of children".</p> <p>In an interview with the DNS on 08/16/16 at 2:41 PM, she indicated that staff were securing</p>	F 323	<p>Corrective action for residents found to be affected by this deficiency</p> <p>Environmental Rounds were completed with all hazardous liquids secured. All residents with adaptive aides and restraints were reviewed to ensure comprehensive assessments for adaptive devices are in place and reflect resident plan of care and preference.</p> <p>Measures that will be put in to place to ensure this deficiency does not recur</p> <p>Staff were educated on how to secure and lock the cabinets for hazardous liquids in the tub and shower rooms, and on keeping hazardous liquids secure. Staff were educated on how to store wheel chair foot rests off the floor and out of residents direct path. Licensed staff were educated on restraint policy and procedure.</p> <p>Measures that will be implemented to monitor the effectiveness of the corrective action taken to ensure this deficiency has been corrected and will not recur</p> <p>Environmental audits will be conducted to inspect locked cabinets and doors in shower and tub rooms 5 times per week times 8 weeks. Audit completed on all residents with adaptive aides and restraints to ensure assessment, consent and plan of care are accurate. Audit completed 1 time per week times 3 months on any new residents assessed to have adaptive aides and/or restraints, and results will be reported to the quality assurance committee.</p>		

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F 323	Continued From page 44 chemicals and Resident 93 was being assessed for a self-medication program. There was no additional information.	F 323	Assistant Director of Nursing to ensure compliance		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 3 of 5 residents (42, 5 and 102) were free of unnecessary medications related to	F 329			

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F 329	<p>Continued From page 45</p> <p>adequate indications for use, use of non-pharmacological interventions prior to the use of an as needed [REDACTED] medication and consistent monitoring of the effectiveness of the medication. This failure placed residents at risk for receiving unnecessary medications and related complications.</p> <p>Findings include:</p> <p>RESIDENT 42 Resident 42 was a long term care resident with diagnoses to include [REDACTED] and [REDACTED]. Resident 42 was re-admitted to the facility after a hospital stay on [REDACTED] 16 with a new diagnosis of [REDACTED].</p> <p>[REDACTED] According to the Minimum Data Set (MDS) assessment, dated 07/22/16, Resident 42 had moderate cognitive impairment.</p> <p>Review of the care plan revealed it was not individualized to meet the resident's [REDACTED] or cognitive needs.</p> <p>Review of the re-admission physician orders, dated 04/14/16, included an order for [REDACTED] 0.25 milligrams (mg) twice daily for [REDACTED] with [REDACTED] and [REDACTED] 0.25 mg every three hours as needed for [REDACTED].</p> <p>Review of the Medication Administration Record (MAR) from May 1st to 24th revealed the resident received as needed [REDACTED] five times.</p> <p>Review of the May behavior flow sheets revealed supportive documentation 1 time for the use of the as needed [REDACTED].</p>	F 329	<p>F329</p> <p>Corrective action for residents found to be affected by this deficiency</p> <p>Resident #42 [REDACTED] orders were reviewed by the primary care physician and re-assessed by the pharmacist with orders and diagnoses clarified. [REDACTED] review committee reviewed all [REDACTED] medications and completed resident care plans. Resident #5 and # 102 consent forms completed. Pharmacist reviewed and clarified orders & diagnosis.</p> <p>Corrective action for residents found to be affected by this deficiency</p> <p>All residents with [REDACTED] medications were audited & verified to have consent in place.</p> <p>Measures that will be put in to place to ensure this deficiency does not recur</p> <p>Educated members of [REDACTED] review committee on completing a [REDACTED] medication review to avoid unnecessary medications.</p>	9/30/16

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F 329	<p>Continued From page 46</p> <p>On 05/24/16, the as needed [REDACTED] was discontinued per the April pharmacist recommendation.</p> <p>Review of the May pharmacist recommendation revealed the following: if the resident's agitation continued, to consider scheduling [REDACTED] 0.25 mg at bedtime for agitation or to consider starting [REDACTED] 250 mg twice daily. On 06/02/16, the Physician responded back (to the faxed pharmacist recommendations) to start [REDACTED] 0.25 mg every 3 hours as needed for agitation.</p> <p>On 06/01/16, the LN faxed the physician again clarifying the as needed [REDACTED] was discontinued on 05/24/16. The LN requested the pharmacist recommendation again to add a bedtime dose of [REDACTED] if the resident continued to be agitated or to consider [REDACTED] twice daily. On 06/03/16, the physician ordered "ok to change [REDACTED] order to 0.25 mg at bedtime for agitation."</p> <p>Review of the behavior flow sheets and nursing progress notes from May 1st to June 2nd revealed the resident exhibited behaviors on 5/11 and 6/1. The addition of the bedtime [REDACTED] was not clinically justified.</p> <p>Review of the medical record revealed no further communication / clarification to the physician regarding the confusing [REDACTED] orders.</p> <p>Review of the June MAR from 06/03/16, revealed, the resident received [REDACTED] 0.25 mg 8:00 AM, 5:00 PM and 8:30 PM.</p> <p>Review of the July MAR revealed on 07/15/16 the</p>	F 329	<p>Measures that will be implemented to monitor the effectiveness of the corrective action taken to ensure this deficiency has been corrected and will not recur</p> <p>[REDACTED] Review Committee and pharmacist will audit all [REDACTED] medication orders, consents, diagnosis and plan of care. An audit will be conducted on the psych reviews weekly times 8 weeks. Audit results to be reported to the quality assurance committee.</p> <p>Assistant Director of Nursing to ensure compliance</p>	

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F 329	<p>Continued From page 47</p> <p>resident's 8 AM and 5 PM [REDACTED] was discontinued and [REDACTED] 0.25 mg every three hours as needed for agitation was added. There was no physician order or nursing progress noted found in the resident's medical record reflecting this change.</p> <p>In multiple observations on all days of the survey, Resident 42 was alert and oriented to person, place and time. Resident 42 did not exhibit any signs of [REDACTED] or behaviors.</p> <p>On 08/16/16, the physician was faxed regarding the as needed [REDACTED] initiated on 07/15/16). The LN stated the pharmacist recommended discontinuing the as needed medication on 04/19/16 and 05/31/16. The resident had not used the as needed [REDACTED] since it was re-instated on 07/15/16. The physician responded back on 08/17/16, stating, "What is going on? On both 5/24/16 + 6/2/16 I requested/agreed that the prn (as needed) [REDACTED] be stopped. Please make it happen (again)."</p> <p>In an interview on 08/16/16 at 5:40 AM, Staff X, NA, stated the resident was cooperative with care and was not aware of any behaviors.</p> <p>At 6:15 AM, Staff Y, LN, stated the resident was cooperative with care and had no recent behaviors. Staff Y stated prior to administering any as needed [REDACTED] medication she would attempt a non-pharmalogical interventions.</p> <p>In an interview on 08/17/16 at 12:24 PM, Staff N, LN Resident Care Manager, was asked the following: - A) Why the resident continued to receive</p>	F 329		

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F 329	<p>Continued From page 48</p> <p>██████████ from April 14th to July 15th for ██████████ status does not last for 3 months without significant intervention from the physician)</p> <ul style="list-style-type: none"> - B) Why the resident received as needed ██████████ without clinical justification or the use of nonpharmacological interventions - C) Why the resident had the addition of a bed time dose of ██████████ without clinical justification - D) Why the resident's 8 AM and 5 PM ██████████ was discontinued without evidence of a physician's order - E) Why the resident's care plan was not individualized <p>Staff N stated she had to follow up on the questions asked.</p> <p>At 12:47 PM, Staff N stated the physician discontinued the as needed ██████████ Staff N was not able to provide any additional information regarding the above questions.</p> <p>RESIDENT 5 Resident 5 was admitted ██████████ 2015 with multiple diagnoses which included ██████████</p> <p>Reviews of the physician orders dated: 05/23/16, ██████████ usage was related to disorientation</p> <p>08/03/16 ██████████ 7.5 mg (milligrams) every night for ██████████ persistent ██████████ and assess for behavioral changes</p> <p>08/03/16 ██████████ dosage was</p>	F 329		

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F 329	<p>Continued From page 49 changed to 6.25 mg at bedtime.</p> <p>Review of a progress note dated 08/03/16 revealed a request to the physician to change the diagnosis for [REDACTED] use to [REDACTED] with behavioral disturbances. There was no follow up on the recommendation noted in the clinical record.</p> <p>Review of the [REDACTED] Medication consent form revealed no consent in the clinical record for [REDACTED] use. The consent for [REDACTED] dated 05/23/16 did not indicate a diagnosis for its usage.</p> <p>In an interview on 08/16/16 at 9:00 AM, Staff N, LN acknowledged there was no consent in the medical record for [REDACTED]</p> <p>In an interview on 08/16/16 at 11:26 AM, the Director of Nursing Services acknowledged the diagnosis for the use of [REDACTED] required clarification. RESIDENT 102 Resident 102 was admitted to the facility in [REDACTED] 2016 with diagnoses to include a [REDACTED]</p> <p>Review of the resident's clinical record revealed no resident consent for the use of [REDACTED] or [REDACTED]</p> <p>Review of a progress note dated 04/24/16, Staff (D) Social Service Director revealed the resident</p>	F 329		

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F 329	<p>Continued From page 50</p> <p>declined a [REDACTED] evaluation. The resident stated, "does not believe" ...experiencing ..."any [REDACTED] issues and refused to consent" ... to [REDACTED] services.</p> <p>Review of a progress note dated 08/03/16 revealed the resident was having some lip smacking and pill rolling, potential side effects of an [REDACTED] medication.</p> <p>Review of a physician progress note dated 08/09/16 revealed an order for a gradual dose reduction of [REDACTED] for a diagnosis of [REDACTED]</p> <p>Review of the resident's medication administration record revealed [REDACTED] was given for several different diagnoses of which none had sufficient documentation to support the usage of an [REDACTED] medication. Diagnoses included major [REDACTED] disorder on two separate entries and a diagnosis of [REDACTED] with [REDACTED] on one entry and another diagnosis of [REDACTED] on another entry.</p> <p>In an interview on 08/15/16 at 12:25 AM, Staff (I) stated the resident's was on [REDACTED] for major [REDACTED] and had demonstrated [REDACTED] when the resident was first admitted. Staff (I) confirmed there was no consent for [REDACTED] or [REDACTED]. Staff (I) stated unsure why it was not completed.</p> <p>In an interview on 08/15/16 at 3:30 PM Staff (H) MD stated the resident "was admitted to the facility with [REDACTED] problems". Staff (H) was asked about the use of [REDACTED] for a diagnosis of [REDACTED]. Staff (H) stated the</p>	F 329		
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F 329	Continued From page 51 resident "did not have a specific diagnosis for usage of _____ on admission, there was a diagnosis for _____ with _____ but _____ is not an indication for the usage of _____	F 329			
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure sufficient staff was available to provide necessary care and services to meet	F 353			

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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	
F 353	<p>Continued From page 52</p> <p>residents needs in a timely manner for 13 of 34 sampled residents (248, 42, 141, 27, 24, 56, 249, 213, 93, 244, 102, 250 and 174) reviewed for sufficient nurse staffing. Failure to ensure residents received assistance with basic activities of daily living, requested assistance to meet their need in a reasonable amount of time, as well as failure to ensure staff were supervised in a manner that enabled them to meet resident's needs placed residents at risk for diminished quality of life and unmet care needs.</p> <p>Findings include:</p> <p>In an interview on 08/09/16 at 11:46 AM, Resident 248 stated when she put her call light on she had to wait a long time for assistance. Resident 248 pointed to a sign in her room that stated "stop, press your call button wait for assistance". Resident 248 stated she was incontinent at times because staff did not respond to her needs and that mad her feel uncomfortable.</p> <p>At 11:52 AM, Resident 42 stated the facility was understaffed. Resident 42 stated he could not get up on his own and had to wait for staff assistance. Resident 42 stated he would get a "little perturbed" at times when he had to wait.</p> <p>At 11:56 AM, Resident 141 stated she had to wait a long time to have her call light answered on the evening shift. Resident 141 stated it was embarrassing when staff would not answer her call light timely and she urinated in her bed or chair.</p> <p>At 12:02 PM, Resident 27 stated there was not enough staff to meet his needs during meal time or in the middle of the night. The resident stated</p>	F 353	<p>F353</p> <p>Corrective action for residents found to be affected by this deficiency</p> <p>Quality of life interview completed on residents 248, 42, 141, 27, 24, 56, 249, 213, 93, 244, 102, 250, and 174. Care plans were reviewed and revised as necessary to provide optimal care delivery.</p> <p>Corrective action for residents found to be affected by this deficiency</p> <p>Root cause analysis was completed to identify interventions necessary to meet our residents needs. Quality assurance sub committee was created and a performance improvement project (PIP) was started.</p> <p>Measures that will be put in to place to ensure this deficiency does not recur</p> <p>Staff were educated on appropriate call light response times.</p> <p>Measures that will be implemented to monitor the effectiveness of the corrective action taken to ensure this deficiency has been corrected and will not recur</p> <p>Call light audit will be conducted at random weekly 5 days per week times 8 weeks and to include all shifts. Quality of life audit to be completed 3 times per week for 8 weeks. Audit results to be reported to the quality assurance committee.</p> <p>Administrator to ensure compliance</p>	.30/16	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505315	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/18/2016
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F 353	<p>Continued From page 53</p> <p>he had to wait up to 45 minutes when he put his call light on.</p> <p>At 2:50 PM, Resident 24 stated when she put on her call light she could wait up to 45 minutes for it to be answered. Resident 24 stated she had come to "live with it" because that was just the way it was. Resident 24 felt the recent staff was not very experienced. The resident stated that the staff would come in, tell her they will notify her NA, turn the call light off and leave the room. Resident 24 stated the NA would not come and she would have to put her call light on again. Resident 24 stated she needed assistance with her personal care needs.</p> <p>At 2:53 PM, Resident 56's family member stated the resident had to wait to be changed or if she needed something heated up. The family member stated staff would come into the room and tell her they couldn't help her and then it would take up to 45 minutes for them to come back. Resident 56 agreed with her family member's comment and added that this happened all the time.</p> <p>At 2:54 PM, Resident 249's family member stated staffing at night was lacking and they had to wait a long time for assistance.</p> <p>At 3:28 PM, Resident 213 stated it usually took greater than ½ hour to have her call light answered. Resident 213 stated when this happened she "wet" herself.</p> <p>In an interview on 08/10/16 at 9:10 AM, Resident 93 stated she had to wait up to 50 minutes for pain medication and repositioning. Resident 93 stated this happened mostly on the night shift.</p>	F 353			

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F 353	Continued From page 54 At 9:57 AM, Resident 244 stated there should be more staff available to meet her need. Resident 244 stated she had to wait 30 minutes to 1 hour frequently. Resident 244 stated the facility staff was so busy at times that her husband had to take care of her at times. At 11:25 AM, Resident 102 stated there was not enough staff available to meet her needs without having to wait a long time. Resident 102 stated she would have her call light on for a long time and has had incontinent accidents due to not being able to get help. The resident stated "like this morning, had my call light on, no one came and I peed my pants, this makes me feel angry, helpless and embarrassed." At 1:14 PM, Resident 250 stated it took a long time to get his medication and to receive the necessary help to go to bed at night. At 2:46 PM, Resident 174 stated the facility was understaffed. Resident 174 stated there were times when you had to wait a "long time" to have her call light answered. Resident 174 felt there was a new staff member every day. In an interview on 08/16/16 at 6:30 AM, Anonymous Staff A stated on the night shift they needed assistance with call lights. Anonymous Staff A stated there were three Nursing Assistants at night. Anonymous Staff A stated the facility had recently added back an additional NA at nights to assist with call lights. At 1:24 PM, the facility Administrator and Director of Nursing Services (DNS) were made aware of the resident's concerns/comments. The DNS	F 353			

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F 353	<p>Continued From page 55</p> <p>stated she had recently added the NA on the night shift because the resident's acuity had changed. The DNS stated the facility had recently hired 11 new NA's and 5 new LN's which could contribute to the resident's feelings of staffing changes.</p> <p>RESIDENT 102 Resident 102 was admitted to the facility in [REDACTED] 2016 with diagnoses to include a [REDACTED]</p> <p>[REDACTED]</p> <p>In an interview on 08/10/16 at 8:59 AM, Resident 102 was asked if she was able to choose when to get up in the morning. The resident stated she does not get up in the morning when she requests, sometimes she would have to wait over an hour after calling on the call light. Resident 102 stated sometimes she had to go to the bathroom and ends up having an accident, "it makes me feel terrible". Resident 102 was asked if she chooses when to go to bed, the resident stated "not always". The resident stated the "staff state they cannot help me to bed now because they are too busy". The resident stated this made her "angry". The resident stated "had to wait for the nurse to give me my medicine, it takes over an hour and one time the nurse gave me my medicine while I was on the toilet, I thought that was really weird".</p> <p>In an interview on 08/10/16 at 11:20 AM, the resident stated "the call light is sometimes not in reach or the staff do not answer the call light for an extended amount of time". The resident stated "one time I was in the dining room and ask</p>	F 353			

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F 353	<p>Continued From page 56</p> <p>for help to go back to my room. I had to wait and ended up pooping on myself, I told the staff to take me back to my room now, and I ruined my pants". The resident stated other times after eating in the dining room you have to wait a half hour to get help to go back to your room. The resident stated this made her angry and made her feel helpless. The resident stated, "I do not get to brush my teeth, as often as would like, and the staff tell me that I should have asked for items sooner".</p> <p>In an interview on 08/15/16 at 1:29 PM, Resident 102 was asked how her weekend was, the resident stated "you know, it just seems that there is not that many people that work here on the weekends". The resident stated when using the call light over the weekend "had to wait an hour, there is just no one around, it is worse on the weekends". Resident 102 was asked if this affected the resident's care, the resident stated, "Yeah, I don't like soiling myself".</p> <p>RESIDENT 248 Resident 248 was admitted to the facility in [REDACTED] 2016 with diagnoses to include [REDACTED]</p> <p>In an interview on 08/09/16 at 11:26 AM, Resident 248 stated when the staff bring in my meal sometimes I have a question. They bring in my meal but abruptly leave the room, rushing out of my room; they do not even give me a chance to ask a question. The resident pointed to a sign hanging across the room reading "Stop, press your call button wait for assistance!" The resident stated "had an accident while having to wait for help to go to the bathroom". The resident stated</p>	F 353			

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F 353	Continued From page 57 it "made me feel uncomfortable to have an accident". In an interview on 08/16/16 at 2:34 PM, the resident was asked to elaborate on a time when the staff rushed out of the room when the resident had a question. The resident stated "almost every morning when the breakfast tray is delivered". The resident stated "needs additional items like butter". The resident stated "the staff leave and I have to call on the call light for the staff to come back then by the time, they come back and I receive butter, my breakfast is cold". The resident stated that other times "will ask for something and they never come back with the item". The resident was asked how this made her feel, the resident stated "it makes me mad, mad, mad". In an interview on 08/16/16 at 2:48 PM Staff O Nurse Aide Certified (NAC) was asked if you feel rushed in anyway during your shift. Staff O stated "yes, always, we are providing care for human beings". Staff O was asked do you feel you have time to ask the resident if there are other care needs prior to leaving a resident's room. Staff O stated "not realistically, we have to know how to manage our time, and we have to prioritize resident's needs for example we have to tend to a resident that needs to toilet over a resident that needs a drink".	F 353			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 425			

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NAME OF PROVIDER OR SUPPLIER MIRA VISTA CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 300 SOUTH 18TH STREET MOUNT VERNON, WA 98274
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F 425	<p>Continued From page 58</p> <p>them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure pharmaceutical services, which assured the accurate dispensing and administration of all drugs to meet the needs of each resident for 1 of 6 sample residents (27) reviewed for unnecessary drugs. Failure to administer medications as ordered placed Resident 27 at risk for medication-related complications.</p> <p>Findings include:</p> <p>Resident 27 was a long term care resident with diagnoses to include [REDACTED]</p> <p>Review of a physician order, dated 05/16/16,</p>	F 425		
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F 425	<p>Continued From page 59</p> <p>revealed the resident received [REDACTED] 40 milligrams every day. The physician directed the Licensed Nurse (LN) to weigh the resident daily and if the resident weighed above [REDACTED] pounds, the LN would administer the [REDACTED]</p> <p>Review of the Medication Administration Record (MAR) from May 18th to July 22nd revealed the resident was not weighed daily and the [REDACTED] was administered every day.</p> <p>Review of a physician order, dated 07/22/16, directed the LN to hold the [REDACTED] if the resident's weight was [REDACTED] pounds (lbs) or less.</p> <p>Review of the MAR from July 23rd to August 16th revealed, the resident received [REDACTED] on August 4th, 13th and 15th when the resident's weight was [REDACTED] lbs or less.</p> <p>In an interview on 08/17/16 at 11:16 AM, the Director of Nursing Services (DNS) agreed the resident should not have received the [REDACTED] when his weight was [REDACTED] pounds or below and the resident should have been weighed daily. The DNS was not able to provide any additional information.</p>	F 425	<p>F425</p> <p>Corrective action for residents found to be affected by this deficiency</p> <p>Resident #27 orders were revised to include supplemental documentation for weight.</p> <p>Corrective action for residents found to be affected by this deficiency</p> <p>Health Information & Pharmacy completed audit of all resident records with medications including parameters, and supplemental documentation is present.</p> <p>Measures that will be put in to place to ensure this deficiency does not recur</p> <p>Licensed staff will be educated on entering supplemental documentation for orders that require parameters.</p> <p>Measures that will be implemented to monitor the effectiveness of the corrective action taken to ensure this deficiency has been corrected and will not recur</p> <p>Audit to be completed for orders with parameters once a week for 4 weeks, and then once per month for 2 months. Audit results to be reported to the quality assurance committee.</p> <p>Director of Nursing to ensure compliance</p>	9/30/16
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Nursing Home Survey Report
STATE AND CORRESPONDING FEDERAL REQUIREMENTS

1. Page 1 of 2 Pages

2. DATES OF DATA COLLECTION
08/09/16, 08/10/16, 08/11/16,
08/15/16, 08/16/16, 08/17/16, 08/18/16

3. NAME OF FACILITY Mira Vista Care Center		4. TYPE OF SURVEY <input checked="" type="checkbox"/> Full <input type="checkbox"/> Post <input checked="" type="checkbox"/> Complaint <input type="checkbox"/> Other: specify _____		5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Holiday	
6. STREET ADDRESS 300 South 18 th Street		CITY Mount Vernon	STATE WA	ZIP CODE 98274	7. LICENSE NUMBER 957

NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.

8.	9. WASHINGTON ADMINISTRATIVE CODES 388-97	10. CODE OF FEDERAL REGULATION 42 CFR 483.	11. FEDERAL DATA TAG NUMBER	12. REPEAT DEFICIENCY FROM SURVEY DATED	13. NEW CITATION ON POST SURVEY	14. LICENSEE'S PLANNED DATE OF CORRECTION
<input checked="" type="checkbox"/> The requirements of the following WAC's and corresponding CFR's were not met. The text of the statements of deficiencies and the licensee's plan of correction may be read on CMS form 2567, dated: <u>08/18/16</u> **Licensee must complete column 14. <input type="checkbox"/> The following deficiencies were determined to be corrected.	-033(1)(a)	483.10(b)(8)	F 156		<input type="checkbox"/>	9/30/16
	-0640(2)(a)(b)	483.13(c)(3)	F 226		<input type="checkbox"/>	9/30/16
	-0900(3)	483.15(b)	F 242		<input type="checkbox"/>	9/30/16
	-580(1)(b)	483.15(e)(2)	F 247		<input type="checkbox"/>	9/30/16
	-0940(1)	483.15(f)(1)	F 248		<input type="checkbox"/>	9/30/16
	-0880(2)	483.15(h)(2)	F 253		<input type="checkbox"/>	9/30/16
	-1000(1)(c)(i)	483.20(a)	F 272		<input type="checkbox"/>	9/30/16
	-NA	483.20(i)	F 278		<input type="checkbox"/>	9/30/16
	1020(1),(2)(a)(b)	483.20(k)	F 279		<input type="checkbox"/>	9/30/16
	-1020(2)(f)	483.20(k)(2)	F 280		<input type="checkbox"/>	9/30/16
-1620	483.20(k)(3)(ii)	F 282		<input type="checkbox"/>	9/30/16	
-1060(1)	483.25	F 309		<input type="checkbox"/>	9/30/16	

15. Surveyor's Signature(s)

SIGNATURE <i>C. Southley MSN/Ed, RN</i>	DATE 8/30/16	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

16. Licensee or Agent

SIGNATURE OF LICENSEE (OR AGENT) <i>[Signature]</i>	TITLE Administrator	DATE 9/12/2016
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AGING AND LONG-TERM SUPPORT ADMINISTRATION
Nursing Home Survey Report
 STATE AND CORRESPONDING FEDERAL REQUIREMENTS

1. Page 2 of 2 Pages

2. DATES OF DATA COLLECTION
 08/09/16, 08/10/16, 08/11/16,
 08/15/16, 08/16/16, 08/17/16, 08/18/16

5. TIME OF SURVEY Day Night
 Weekend Holiday

7. LICENSE NUMBER
 957

3. NAME OF FACILITY
Mira Vista Care Center

4. TYPE OF SURVEY
 Full Post Complaint Other: specify _____

6. STREET ADDRESS
 300 South 18th Street

CITY
 Mount Vernon

STATE ZIP CODE
 WA 98274

NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.

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<input checked="" type="checkbox"/> The requirements of the following WAC's and corresponding CFR's were not met. The text of the statements of deficiencies and the licensee's plan of correction may be read on CMS form 2567, dated: <u>08/18/16</u> **Licensee must complete column 14.	-1060(3)(g)	483.25(h)(2)	F 323		<input type="checkbox"/>	9/30/16
	-1060(3)(k)(i)	483.25(l)(1)	F 329		<input type="checkbox"/>	9/30/16
	-1080(1), 1090(1)	483.30(a)(1)&(2)	F 353		<input type="checkbox"/>	9/30/16
	-1300(1)(b)(ii)	438.60(a)	F 425		<input type="checkbox"/>	9/30/16
<input type="checkbox"/> The following deficiencies were determined to be corrected.					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	

15. Surveyor's Signature(s)

SIGNATURE <i>C. Sirekody MSN/Ed, RN</i>	DATE 8/30/16	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

16. Licensee or Agent

SIGNATURE OF LICENSEE (OR AGENT) <i>[Signature]</i>	TITLE Administrator	DATE 9/12/2016
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