

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

PRINTED: 04/12/2013
FORM APPROVED
OMB NO. 0938-0391

241

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505466	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/04/2013
NAME OF PROVIDER OR SUPPLIER . KENNEY, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 7125 FAUNTLEROY WAY SOUTHWEST SEATTLE, WA 98136	
(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 conducted at The Kenney SNF on 3/27/13, 3/28/13, 3/29/13, 4/1/13, 4/2/13, 4/3/13 and 4/4/13. A sample of 16 residents was selected from a census of 19. The sample also included the records of 5 former/discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████ MSW ██████████, RN, MN ██████████, RN, BSN</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Long Term Support Services Administration Residential Care Services, Region 2, Unit E 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388 Telephone: (253) 234-6000 Fax: (253) 395-5070</p> <p><i>Bonnie Joy</i> 4/12/2013 Residential Care Services Date</p>	F 000	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein.</p> <p>To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction.</p> <p>The following constitutes the facility's plan of correction such that all alleged deficiencies have been or will be corrected by the date or dates indicated.</p>	

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

TITLE

(X6) DATE

C. Mawe NHA

CEO / ADMINISTRATOR 4/24/13

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 156 SS=B	<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> <p>The facility must furnish a written description of legal rights which includes:</p>	F 156	<p>F 156 – A procedure will be developed to follow the instructions of the CMS NOMIC form 10123, dated 12/31/11 that is straight from the CMS web site. In-services will be completed by May 19, 2013 and will be ongoing. The Social Services Director will review annually for any updates to form 10123. Ongoing compliance will be assured by the Director of Health Services and the Social Services Director.</p> <p style="text-align: center;">RECEIVED MAY 16 2013 DSHS/ADSA/RCS</p> <p style="text-align: center;">RECEIVED APR 25 2013 DSHS/ADSA/RCS</p>		

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F 156	<p>Continued From page 2</p> <p>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 Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by</p>	F 156	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">MAY 16 2013</p> <p style="text-align: center;">DSHS/ADS/ARCS</p>	

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F 156	<p>Continued From page 3 such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure Residents #22, 33 and 46, three of three sample residents, received the proper notice of their right to appeal a decision to discontinue skilled nursing or therapy services covered by Medicare, Part A. Failure by facility staff to obtain and use the most current forms created by the federal Center for Medicare/ Medicaid Services (CMS), in accordance with revised policies, did not uphold the right of these residents to be accurately informed of their right to appeal and options for receiving continued services.</p> <p>Findings include:</p> <p>On 4/1/13, a sample of records was reviewed for residents who had been discharged (decertified) after receiving skilled nursing, physical therapy, occupational therapy and/or speech therapy services while in the skilled nursing section of the facility. Review of the documents provided for Residents #22, 33 and 46 revealed the form used to notify them was outdated. CMS had implemented a new form in May 2012.</p> <p>On 4/01/13 at 11:15 am, during an interview with a facility social worker, Staff E was asked about the facility's process of notifying residents when their skilled treatment would end and if there was a written policy for this process. Staff E stated he was not sure, but he would ask the Director of</p>	F 156			

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F 156	Continued From page 4 Nursing (DNS). He also provided a copy of the outdated form (CMS #10095 -NOMNC). He said he had inherited the form over a year ago from the previous social worker. On 4/1/13 at 1:45 pm, during an interview with Staff B, she was asked about the process of Medicare notices and appeal rights. She said residents were given a letter from CMS to inform them when Medicare coverage would end. On 4/2/13, she said there was no written policy for staff to follow; the facility used information from the CMS website.	F 156		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225	F225- The facility policies and procedures will be updated for the facility reporting requirements as reflected in chapter 1 of the purple book, which was effective March 23 rd 2011. Resident #15 and resident #35 have since discharged. In the future any reported allegation of abuse or neglect, even if unsubstantiated by facility investigation, will be reported as per departmental guidelines. All staff will be re-inserviced on facility reporting requirements and mandatory reporting requirements. This requirement is effective immediately, and ongoing compliance will be assured by the Director of Health Services. In the	

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F 225	<p>Continued From page 5</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to immediately report and thoroughly investigate an allegation of abuse by Resident #15, one of five sample residents for whom incident investigations were reviewed. The facility failed to notify the State Agency of an incident reported by this resident which included allegations of both physical and emotional abuse, which placed this resident, and potentially, other residents at risk for harm.</p> <p>Additionally, for a second resident (Resident #35), the facility failed to report or investigate an [REDACTED]</p> <p>Findings include:</p> <p>Resident #15 was admitted on [REDACTED]/12 with care needs related to a recent [REDACTED] and [REDACTED]. According to her Minimum Data Set Assessment dated 12/15/12, her</p>	F 225	<p>absence of the Director, the MDS/Unit Supervisor will be the designated reporter. All policy revisions/updates will be complete and inserviced on or before May 19, 2013.</p>	

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F 225	<p>Continued From page 6</p> <p>memory was intact. She required assistance from 2 staff with transfers and toileting.</p> <p>Review of the resident's closed record and facility's Incident log revealed an incident on 12/24/12, when the resident reported an allegation of rough treatment/ physical abuse as well as psychological abuse involving two nursing assistants who provided care for Resident #15.</p> <p>Review of an investigation completed by Staff V included a detailed statement by a member of the activity staff (Staff P) about the resident's report to her that two staff had been rough when assisting her to the commode earlier in the day on 12/24/12. The resident identified the two aides, and described being "practically dragged on the floor" when they helped her to a commode. She said they hurt her when providing pericare. She also described wishing she would die that night so she wouldn't need to have further care from them. Staff P documented she notified the charge nurse on duty on 12/24/12 (Staff V) and the facility's Director of Nursing (Staff B).</p> <p>According to the facility's Incident Log, the facility did not notify the State Hotline of the resident's allegation.</p> <p>LACK OF REPORTING/ THOROUGH INVESTIGATION: The facility's investigation of this incident was reviewed. The nurse on duty (Staff V) contacted one of the two NAC's by phone and wrote a brief statement in which he described providing care for Resident #15 while the activity staff member was present in the room. The events he described occurred after the incident reported by</p>	F 225			

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F 225	<p>Continued From page 7</p> <p>Resident#15. Staff V apparently did not recognize this and accepted the NAC's description that there were no problems, without asking about the care the resident said she experienced.</p> <p>A similar statement was written by the second NAC, and again did not address the earlier episode of toileting which the resident reported being treated roughly by staff. Review of an "Incident Completion Checklist" filled out on 12/24/12 by Staff V, noted the State Hotline was not called. In response to two questions, "Has abuse been substantiated?" and "If abuse was suspected, was the State Hotline called?", Staff V wrote "N/A" (not applicable).</p> <p>Information from additional interviews with the staff members identified by Resident #15, to rule out potential abuse was not included in the investigation. The facility also failed to document interviews with other residents who were provided care by the named CNA's as part of this investigation, to rule out potential abuse.</p> <p>On 4/2/13 at 3:55 pm, the Director of Nursing (Staff B) was interviewed about this incident and investigation. She was asked when staff were required to notify the State Hotline of abuse, according to the facility's policy. She stated staff needed to have "reasonable suspicion of abuse" and "reasonable cause to believe abuse had occurred" before they reported it. She later said the report needed to be "substantiated" before it was called in to the State Abuse Hotline. She did not identify the need to immediately report an allegation of abuse as is required by both Federal and State regulations for skilled nursing facilities.</p>	F 225			

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F 225	<p>Continued From page 8</p> <p>Staff B read her statement from conclusion of investigation aloud. When asked if there was anything in the staff member's statement that she would consider abuse, she replied, "when she talked about being dragged to the commode" and "when she was fearful (of staff)..."</p> <p>Staff B was asked when the facility was required to call the State hotline. She replied, "When there is an allegation that I think is abuse or neglect, then I would call it in. My understanding is if I have no abuse or neglect, then I don't have to call it in, but if I substantiate there is no abuse or neglect, then I just log it." Review of the facility's current policy revealed it focused on State requirements for Mandatory reporters. It did not address the State and Federal requirements for a facility to report allegations of abuse, neglect or misappropriation immediately to the State.</p> <p>After reviewing the omission of this critical information in the policy, Staff P's statement and the content which would constitute allegations of physical/ emotional abuse was reviewed again, and the need to report this incident, and thoroughly investigate it addressed. After further discussion of the differences between Federal reporting requirements for Licensed facilities and State requirements for Mandatory reporters, Staff B acknowledged the policy needed to be revised.</p> <p>RESIDENT #35: This resident was admitted to the facility [REDACTED] 12 with care needs related to [REDACTED] with an [REDACTED]. The resident required extensive assistance for activities of daily living. The resident was participating in occupational</p>	F 225			

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F 225	<p>Continued From page 9 and physical therapy to regain strength. This resident died six days after admission to the facility.</p> <p>The admission assessment and nursing history noted cardio-respiratory and circulatory as, "normal". On 11/04/12 at 8:30 p.m, a nurse noted fine crackles in the resident's lungs and had the resident cough and deep breath which resulted in expulsion of a large amount of clear sputum. On 11/5/12, the physician assessed the resident and ordered lab work. The lab results dated 11/07/12 indicated signs of infection and a slight decrease in kidney function.</p> <p>On 11/7/12 at 1:00 p.m. the nursing progress notes said Resident #35's vital signs were stable and aspirin was held in preparation for the breathing tube placement scheduled for 11/8/12.</p> <p>On 11/07/12 at 6:00 p.m. the resident complained of shortness of breath and was placed on oxygen at 2 liters per minute, which resulted in oxygen saturation of 95%. No lung sound assessment was documented at this time.</p> <p>On 11/08/12 at 2:30 a.m., a late entry progress note revealed the resident had labored breathing at 10:45 p.m. (on 11/07/12) and oxygen saturation was abnormally low, at 65%. The oxygen treatment was initiated again and the saturation increased to 71%. The physician was notified and instructed staff to call 911. The resident was pronounced dead at the facility at 12:30 a.m. The medical examiner was notified by the nurse.</p> <p>The Reporting Guidelines for Nursing Homes (Appendices D and E) requires the unexpected</p>	F 225			

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F 225	Continued From page 10 death of a resident to be reported to the DSHS Hotline, record it in the facility's Incident log within 5 days, in addition to reporting it to the medical examiner. Review of the facility's Incident log revealed no investigation was completed regarding the [REDACTED] of Resident #35 on [REDACTED]/12. On 04/03/13 at 9:00 a.m. Staff B, DNS, confirmed an investigation regarding the care and circumstances prior to the resident's [REDACTED] was not done.	F 225			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to promote a dignified dining experience for Resident #5, one of one sample residents who was dependent on staff for assistance with dining. Facility staff mixed pureed food or incompatible fluids with her milk, instead of offering her food and fluids in their intended form. Failure to assist the resident with her meals as planned placed her at risk for decreased quality of life and decreased nutritional intake. Findings include: RESIDENT #5:	F 241	F241- All appropriate staff have been counseled regarding their breach in the standard of practice regarding food quality and its relationship to providing a dignified and enjoyable dining experience. No further inappropriate mixing of incompatible fluids will be allowed. Rather, food and fluids will be offered in their intended form and in compliance with each resident's individual dietary orders. Training on dietary practices and consistencies, and who is allowed to alter them will be done on or before May 19, 2013.		

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

PRINTED: 04/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505466	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/04/2013
NAME OF PROVIDER OR SUPPLIER KENNEY, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 7125 FAUNTLEROY WAY SOUTHWEST SEATTLE, WA 98136		
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F 241	<p>Continued From page 11</p> <p>This resident was a long-term resident of the facility with care needs related to [REDACTED], as well as [REDACTED], and [REDACTED]. According to her Minimum Data Set (MDS) assessment, dated 12/17/12, Resident #5 was totally dependent on staff for all aspects of her care. Her current care plan, dated 12/21/12, also documented she was "Totally dependent on staff for all intake" at meals. This care plan stated Resident #5 required a diet with thin (unthickened) liquids, with all foods to be of a pureed texture. Additional directives to staff in the care plan included: "Provide diet as ordered" and "allow ample time for swallowing/ eating".</p> <p>On 3/29/13 at 12:01 pm, during observation of Resident #5 being assisted with her lunch, a Nursing Assistant (Staff G) mixed pureed food from Resident #5's plate into her milk and offered sips of this to the resident. When Staff G was asked what Resident #5 ate for lunch, he stated "She ate pureed meat, yogurt and mixed fruit." Staff G acknowledged mixing these items from the resident's plate in her milk and giving this mixture to Resident #5. He was asked why he mixed the pureed food into the milk. He responded resident ate better that way. When asked if this Resident's care plan directed staff to mix food with fluids, he said he was not sure.</p> <p>During a second observation of staff assisting Resident #5 with lunch on 4/1/13 between 11:25 am and 12:15 pm, a similar observation of another Nursing Assistant (Staff H) mixing Resident #5's fluids together was made. At 11:46 am, Resident #5's tray of pureed food was served. She also had milk, a chocolate shake and orange juice served with the meal. She was</p>	F 241		

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F 241	<p>Continued From page 12</p> <p>observed to accept bites of food and sips of milk when offered. At 11:54 am, Staff H mixed the resident's milk and chocolate shake together, and offered sips of this mixture to the resident.</p> <p>By 11:58 am, the glass which held milk was empty and the level of fluid in the glass containing the mixture was down to the last 2-3 ounces. When observed again at noon, the level of fluid in Resident #5's glass had increased. Staff H was asked if he had added another health shake for the resident. He said "No", that he added more milk. It was pointed out the glass of milk had been empty when observed a few minutes earlier. He was asked if he had added any food to the fluid, he said "No". He then said he mixed her orange juice in with the milk and chocolate shake. When asked to consider how milk and chocolate mixed with orange juice would taste, and if this was something he would drink, he replied "No".</p> <p>On 4/2/13 at 3:45 pm, during an interview with the Director of Nursing (Staff B), the above observations were discussed. She was asked if there were any current residents for whom staff could mix food and fluids together during meals. She stated this was "not a normal practice". When asked if this practice was approved for use by Resident #5's care plan, she stated she didn't think it was, then commented this practice was "not acceptable".</p> <p>During an interview with the Dietary Manager on 4/3/13 at 8:10 am, she was asked if her department trained staff to mix pureed food and fluids together when feeding dependent residents. When the above observations were described to her, she stated if a resident needed</p>	F 241		

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F 241	Continued From page 13 more fluids added, this would need to be arranged by the dietitian and/or speech therapist, but should not be done by nursing assistants.	F 241			
F 247 SS=B	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 provide Resident #4, one of two residents reviewed for resident rights, and other residents with notice before they received a new roommate. This failure did not uphold the right of residents or family members to be notified prior to the arrival of a new roommate. Findings include: On 3/28/13, during an interview with the legal representative of a resident who was cognitively impaired, she was asked if staff notified her prior to a change of roommates. She stated she was not notified in advance, but when she came to visit one day, a new roommate had been moved in. On 4/2/13 at 1:15 pm, during an interview with Staff E, a social worker, he was asked if the facility had a written policy about resident room changes in the Skilled Nursing Facility. He said he wasn't sure, but the DNS (Staff B) might know. When asked which staff member was responsible	F 247	F247- The policy for admissions and discharges will be updated to include mandatory notification of any resident, already residing in a room, of any roommate changes. In addition, the policy will provide for the determination and consideration of each resident's individual preferences and taking them into account for potential roommates. Policy revisions will be completed on or before May 19, 2013. Continued compliance to be assured by the Director of Social Services and the Director of Health Services.		

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F 247	Continued From page 14 for notifying residents about a room change or a new roommate in the SNF, he replied "I believe it's either nursing or might be me... It's kind of interdisciplinary..." He then said the notice given was usually verbal. When asked how residents were notified, he said, "I believe they are given oral notice... If they're getting a new roommate, I'll give the roommate a verbal heads up, but they aren't given specific notice. It just sort of depends." When asked about residents with cognitive impairment, if the legal representative was notified, he said he wasn't sure if there was a formal procedure for that. During later conversations with the DNS and Administrator on 4/4/13, the lack of a written policy for this process was acknowledged.	F 247			
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being;	F 272	F272- Nursing staff, upon admission to the facility, will conduct an initial physical assessment, including dental status, and thereafter with the MDS update. This assessment will include each resident's functional capacity which includes but is not limited to an oral examination. The oral examination will include the condition of the teeth and the condition and fit of any dentures. Resident # 14 has been schedule to be seen on the next dentist visit. The visit will occur prior to May 19, 2013. Continued compliance will be assured by the MDS/Unit Supervisor and the Director of Health of Services.		

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F 272	<p>Continued From page 15</p> <p>Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined the facility failed to accurately assess Resident #14, one of one residents reviewed for dental services of a sample of 16 residents. The facility failed to accurately conduct an initial comprehensive assessment (MDS) of the resident's dental status which placed this resident at risk for unidentified and/or unmet needs.</p> <p>Findings Include:</p> <p>RESIDENT #14: This resident was admitted to the facility with diagnoses of [REDACTED], [REDACTED],</p>	F 272		

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F 272	<p>Continued From page 16</p> <p>_____ and _____ In an interview on 03/27/13 at 1:37 p.m. the resident stated her dentures were loose and easily moved by her tongue. This resulted in difficulty eating and occasionally, she bit her lip with her dentures, which was painful. To the best of her knowledge, she had not seen a dentist in approximately three years.</p> <p>During the interview, it was noted the dentures moved while the resident talked. In a second observation on 04/03/13 at 2:10 p.m., the resident's dentures moved when she talked, which appeared to slightly impede her speech clarity.</p> <p>Review of the admission MDS dated 01/07/13, indicated there were no dental problems present. Subsequent MDS assessments dated 01/24/13, 03/03/13 and 03/23/13 also noted no dental problems present.</p> <p>An interview with Staff C, the MDS nurse, on 04/01/13 at 5:30 p.m., revealed the MDS documentation of the oral assessment was determined from an interview with the resident where Staff C asked if any teeth were broken or there were problems with the resident's dentures. The MDS nurse also talked with the nurses' aides because they helped the resident clean her teeth. She stated Resident #14 had the nurses' aide clean her dentures.</p> <p>The MDS nurse stated she was not aware of the video training distributed by the Center for Medicare/ Medicaid Services (CMS) which demonstrated the extensive oral assessment needed to complete MDS documentation.</p>	F 272			

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F 272	Continued From page 17	F 272			
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop a comprehensive care plan to accurately describe care and services to be provided for Residents #1 and 33, two of twenty-one sample residents. Failure to identify the presence of ██████████ for Residents #1 and 33, as well as relevant interventions to promote healing, did not ensure their highest practicable level of physical well-being was</p>	F 279	<p>F279- Resident #1 has been discharged. Resident #33 has had his assessment updated to include that the observation areas are blanchable and therefore not stageable. The skin assessments have already been reviewed for all current residents to assure that all skin issues are properly monitored and are accurately reflected on the MDS. The existing "admit protocol" for new admissions, which includes skin checks, has been added to the initial chart audit. A new semi-alert charting system is being introduced to include charting on ongoing skin concerns. The NAC bath form is being updated to include the charge nurse's signature, verifying a skin assessment. The charge nurses will continue the weekly skin checks, in the electronic MAR, which reflects a head-to-toe assessment which is charted in the medical record by exception. The introduction of the semi-alert charting system will be completed on or before May 19, 2013. Continued compliance to be assured by the Director of Health Services and the MDS/Unit Supervisor.</p>		

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F 279	<p>Continued From page 18 addressed.</p> <p>Findings include:</p> <p>RESIDENT #1: Resident #1 was admitted [REDACTED]/13 with care needs related to [REDACTED]. An initial nursing assessment dated 2/28/13, documented the presence of this [REDACTED] on his [REDACTED]. His initial Minimum Data Set (MDS) assessments, dated 3/7/13 and 3/14/13, both identified Resident #1 had a Stage 1 pressure ulcer.</p> <p>Review of Resident #1's care plan, dated 3/7/13, identified only a potential skin problem, but did not identify the presence of an actual [REDACTED]. Review of this resident's record found no documentation by staff regarding the monitoring of the condition of his skin.</p> <p>On 4/3/13 at 10:40 am, the lack of accurate care planning for Resident #1 was reviewed with Staff C, the facility's MDS coordinator, as well as the failure by staff to utilize information from the MDS and CAAs and incorporate this into the resident's care plan.</p> <p>RESIDENT #33: Similar findings were made for this resident, who was admitted with a [REDACTED] on [REDACTED]/13, according to his initial MDS assessment dated 03/06/2013. The CAA's, dated 3/8/13, also noted the presence of a [REDACTED]. When observed on 4/1/13 and 4/2/13, Resident #33 was up for meals and for therapy, but rested in bed between meals.</p>	F 279		

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F 279	Continued From page 19 Review of this resident's current care plan, dated 3/7/13, revealed staff had identified a "potential" problem for his skin, but had not addressed the presence of an actual [REDACTED] when he was admitted. On 4/3/13 at 10:40 am, during an interview with Staff C, the facility's MDS coordinator, the lack of accurate care planning for Resident #33 was reviewed, as well as the failure by staff to utilize information from the MDS and CAAs, and incorporate this into the resident's care plan.	F 279			
F 282 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure weekly skin checks were completed for Residents #1, 33, 9 and 14, four of four sample residents reviewed for pressure ulcers or other skin conditions, out of a sample of 21 residents. Failure by nursing staff to complete assessments of resident skin in accordance with the care plan and physician orders did not ensure interventions were effective in promoting healing and/or prevention of new pressures sores. Findings include: RESIDENT #1:	F 282	F282-As stated in F279 above, all residents have been reviewed and assessed for appropriate skin monitoring and for the corresponding accurate reflection of such on the MDS. The "Admit Protocol" has been added to the audit for all new admissions which is the system for placing the weekly skin checks into the electronic MAR. In addition, the weekly bath sheets are to be signed by the nurse to assure the head to toe weekly assessment. Semi-alert charting has been added to account for conditions that continue past the 72 hour alert parameters. The skin assessment policy and procedures will be updated to reflect the changes. Policies and charting procedures will be updated, inserviced, and in place on or before May 19, 2013. Continued compliance will be		

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F 282	<p>Continued From page 20</p> <p>Resident #1 was admitted [REDACTED]/13 with care needs related to several [REDACTED]. Review of an initial nursing assessment, dated 2/28/13, documented he had a [REDACTED] on his [REDACTED], but no measurement or other description.</p> <p>According to Minimum Data Set (MDS) assessments dated 3/7/13 and 3/14/13, Resident #1 had a [REDACTED] Care Area Assessments (CAAs) dated 3/12/13, also documented the [REDACTED] was on his [REDACTED] and identified a number of risk factors for pressure ulcers, including fragile skin, dependence on a wheelchair for mobility, urinary incontinence and use of blood thinning medication.</p> <p>A physician's order, dated 2/28/13, stated "head to toe skin assessment on day of admit and weekly" was in the Medication Administration Record (MAR) for the month of March 2013. The care plan, dated 3/7/13, also stated staff would complete a weekly skin check. Review of nursing progress notes and computerized records (MAR) for March 2013, found no documentation by staff regarding the condition of Resident #1's skin, including the [REDACTED].</p> <p>On 4/3/13 at 9:55 am, during an interview with the DNS (Staff B), evidence staff were monitoring this resident's pressure ulcer was requested. Staff B stated it should be recorded in the MAR, but after reviewing the March MAR, she acknowledged there was no documentation by staff of weekly assessment/ monitoring of the resident's skin, including the pressure sore. She also reviewed a separate binder in which she said she recorded</p>	F 282	assured by the Director of Health Services and the MDS/Unit Supervisor.	

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F 282	<p>Continued From page 21</p> <p>resident skin assessments, but did not find any information there. She acknowledged this resident's ██████████ had not been monitored, in accordance with his care plan and MD orders during his four week stay.</p> <p>RESIDENT #33: Resident #33 was admitted on ████████/13 with care needs related to ████████ and ████████. His initial MDS assessment dated 3/6/13, noted he had a Stage 1 ██████████ present when he was admitted. The CAA's, dated 3/8/13, stated Resident #33 had a Stage 1 ██████████ on his ██████████.</p> <p>Review of physician treatment orders for March 2013 included "head-to-toe weekly skin check" as well as an order to apply an ointment to his left ████████ every morning and evening, during the month of March. His care plan, dated 3/11/13, also directed Licensed Nursing staff to "Perform head to toe weekly skin assessment".</p> <p>When observed on 4/1/13 and 4/2/13, Resident #33 was up at meal times and for therapy, but rested in bed between meals.</p> <p>On 4/2/13 at 3:20 pm, Staff B was interviewed regarding monitoring of the resident's ██████████. She stated she kept her own monitoring system for any pressure ulcers or skin issues. Review of her log revealed 3 entries for Resident #33. On 3/4/13 the Stage 1 on his ██████████ measured 1.5 centimeters(cm) by 1.7 cm, and was described as "reddened, not open".</p> <p>On 3/14/13, the area was 1.5 cm by 1.4 cm and was "red, with blanchable surrounding tissue" On</p>	F 282		

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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: 505466	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/04/2013
NAME OF PROVIDER OR SUPPLIER KENNEY, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 7125 FAUNTLEROY WAY SOUTHWEST SEATTLE, WA 98136		
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F 282	<p>Continued From page 22</p> <p>3/25/13, the pressure sore was 1.3 cm by 1.5 cm.</p> <p>This information was kept in the DNS's office, so was not available in the medical record for staff to review.</p> <p>Staff B was asked about how nursing staff monitored the resident's pressure ulcer. She said nurses were to create a weekly skin assessment form and record these measurements in the computerized MAR each week. When asked to provide these assessments, she looked through Resident #33's online records, but after searching, acknowledged the weekly assessments were not documented there. Without regular monitoring of the resident's skin condition, staff could not establish if current interventions were effective or needed to be revised.</p> <p>RESIDENT #9: This resident was admitted with care needs related to recovery from _____, _____, _____ and _____.</p> <p>Record review of the "Admission Nursing History and Assessment" dated _____/13, revealed the resident had 2 bruises on her inner arm and one on the top of each hand related to intravenous fluid administration while hospitalized. She also had a blanchable reddened area on the _____, an _____ site on her _____ and a discolored brownish area on the left lower extremity.</p> <p>Review of physician orders dated 03/04/13, revealed an order for "head-to-toe skin check upon admission and weekly on day shift of bath".</p>	F 282		

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F 282	<p>Continued From page 23</p> <p>An interview with Staff F, a licensed nurse, on 04/02/13 at 9:00 a.m. revealed the nursing assistant alerted the licensed nurse to bath time for skin assessments. Then the licensed nurse noted the skin assessments on the computerized document known as the nursing reporting notes which are emailed between nursing staff. Staff F could not find an example of a head-to-toe skin assessment on this document.</p> <p>An interview with Staff I, a nursing assistant, on 04/02/13 at 2:30 p.m. revealed nursing assistants were directed to document skin issues on the bath monitoring forms. Review of Resident #9's bath monitoring form revealed the skin assessment portion was left blank.</p> <p>An interview with the Staff B, on 04/02/13 at 3:30 pm, revealed the skin assessments were documented in the progress notes by exception only. Staff B explained the documentation on the computerized Medication Administration Record (MAR) only indicated the LN who did the assessment. The DNS stated she did not have documentation of the actual assessment.</p> <p>The documentation found in the nursing progress notes referred only to the healing progress of the [REDACTED] site. The nursing notes had not addressed the other skin issues found on admission.</p> <p>RESIDENT #14: This resident was admitted with care needs related to an [REDACTED], [REDACTED], and [REDACTED].</p>	F 282		

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F 282	<p>Continued From page 24</p> <p>Review of the "Admission Nursing History and Assessment" form noted this resident had multiple scabs bilaterally on her upper extremities and lower left extremity, as well as an unstageable [REDACTED] on the heel of her [REDACTED] and "callus necrotic tissue" on her [REDACTED]</p> <p>Observations on 3/27/13 and on 04/03/13 revealed a skin tear between the thumb and forefinger of the right hand and a skin tear on the tip of the nose.</p> <p>Observation on 04/01/13 at 9:40 a.m. revealed the skin on the [REDACTED] peeled off and a scabbed area on the [REDACTED] lower [REDACTED]</p> <p>Record review of the nursing progress notes revealed the skin assessment of the left shin and heel were noted for the first two weeks, then no notation during the next three weeks. On 03/25/13, a notation regarding another bruise on the left shin had decreased in swelling and was not causing pain. There was no documentation of when it first appeared.</p> <p>An interview with Staff B, on 04/02/13 at 9:30 a.m., revealed skin issues were reported to the DNS by the licensed nurses twice a week. The documentation of all skin issues were kept in the office of the DNS. Staff B stated she "tracks skin issues for all residents on one form, then I flip through the pages... If it looks like the wounds are not healing I check it myself". She explained skin assessments were charted in the nursing progress notes by exception. When asked for the documentation of the three skin issues observed (see above) on Resident #14, no documentation</p>	F 282		

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F 282	Continued From page 25 could be found. Review of the bath monitoring forms for Resident #14 initialed by nurses' aides revealed no documentation regarding skin issues over the last 3 weeks. Review of the Skin at Risk protocol dated, 8/2011, revealed "Any areas of redness, bruising and skin breaks are reported immediately to the nurse and documented on the Skin Check form". This procedure was not described by either the Licensed Nurse or nursing assistants during interviews.	F 282			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to provide appropriate treatment and services for Resident #14, one of three residents evaluated for urinary continence of the 21 sample residents. Failure to provide assistance as detailed in the individualized toileting program placed the	F 315	F315—Staff, including therapy staff, will be inserviced on the individual toileting program for resident #14. The identification of the types of incontinence and the appropriate response to toileting has been done on all current residents. Identification of the specific type of incontinence has been added to the admit check list to assure that an individualized program is developed for each resident. In-servicing and implementation to be completed on or before May 19, 2013. Ongoing compliance will be assured by the Director of Health Services.		

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F 315	<p>Continued From page 26</p> <p>resident at risk for deterioration of her bladder function.</p> <p>Findings include:</p> <p>RESIDENT #14: This resident was admitted to the facility with care needs related to [REDACTED], an [REDACTED] and [REDACTED].</p> <p>In an interview on 04/03/13 at 2:15 pm, the resident said she preferred to use the toilet for bowel and bladder needs. The resident explained she had used the toilet in the past and wanted to try again. However, she stated " I know it's easier for the aides to change my pants". The resident explained she used a grab bar in the bathroom and got on the toilet with the assistance of the aides.</p> <p>Record review of nursing care plan revealed a toileting program was currently in place.</p> <p>An interview with Staff C, the MDS nurse, on 04/03/13 at 2:20 pm, confirmed she had initiated a toileting program for the resident in the nursing care plan. Staff C also produced a detailed schedule the aides were to follow. The resident was to be taken to the toilet a minimum of five times each day and whenever the resident requested. Staff C confirmed this toileting program was to be followed regardless if the resident was incontinent when the aides provided assistance.</p> <p>An interview with the Staff I, a nursing assistant, on 04/03/13 at 2:25 p.m. revealed the resident was not taken to the toilet if the aides found her</p>	F 315			

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F 315	Continued From page 27 ██████████ at the time of assistance. Staff I explained the aides took the resident to the toilet when she asked, which most frequently happened when the resident needed to have a bowel movement. Staff I stated she documented how many times a resident went to the bathroom on the Input and Output (I & O) flow sheet. Record review of the most recent I & O flow sheet revealed the aides only documented episodes of incontinence and the resident had not been taken to the toilet at any time the past seven days. On 04/03/13 at 2:55 p.m. Staff F, who was responsible for supervision of the aides, stated she relied on review of I & O flow sheets completed by the aides to know the number of times a resident was taken to the bathroom.	F 315			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to maintain a medication error rate no greater than 5%. There were 3 medication errors observed during the administration of 26 medications, which affected 3 of 9 residents (Residents #12, 5 and 50). This resulted in a medication error rate of 11.5%. Failure to administer medications according to the physician's orders and/or the medication manufacturers' specifications had the	F 332	F332 - Nursing staff responsible for the administration of medications will be re-inserviced relative to the "5-rights" of medication administration. The individual medication errors for residents #12, #5, and #50 were reported to the medical director, who is also the primary care physician for these skilled nursing residents. It was determined that no medication order changes were indicated as a result. In addition to the inservicing, Staff F will be assigned to at least one med pass audit by the pharmacy on or before substantial compliance on May 19, 2013. Staff F has been required to		

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F 332	<p>Continued From page 28</p> <p>potential to impact the therapeutic effects of the medications.</p> <p>Findings include:</p> <p>RESIDENT #12: On 04/01/13 at 5:05 pm., Staff F, a Registered Nurse, administered [REDACTED] 3 mg instead of [REDACTED] 4 mg. This constituted to a medication error. Review of the physician's order dated 03/31/13, stated "Give [REDACTED] 4 mg on 03/31/13, 04/01/13..."</p> <p>On 04/01/2013 at 5:10 pm., Staff F was asked what [REDACTED] dosage she gave the resident. She stated she had given Resident #12 [REDACTED] 4 mg. After she checked the [REDACTED] dosage again, Staff F acknowledged she had given the resident a lower dose than was ordered by the physician. On 04/01/13 at 5:30 pm, the above error was discussed with the DNS, Staff B, who acknowledged this constituted a medication error.</p> <p>RESIDENT #5: On 04/01/13 at 08:10 am, during observation of morning medication pass, Staff F did not ensure Resident #5 received her full dose of [REDACTED] medication ([REDACTED], 17 grams). Staff F mixed a teaspoon full of [REDACTED] (PG) with water and administered it to Resident #5. Review of physician's order, dated 01/25/11, stated "[REDACTED], mix 17 gm in juice or water and drink daily as directed by doctor."</p> <p>On 04/01/2013 at 08:15 am, Staff F was asked how she ensured she was giving the correct</p>	F 332	<p>fill out her own medication error reports and is writing a plan of prevention to be approved by the Director of Health Services. All licensed nurses will be made aware of the errors and how to prevent future errors. Continued compliance to be assured by the Director of Health Services.</p>	

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F 332	Continued From page 29 dosage of PG, Staff F said 1 teaspoon full of the powder was equivalent to 17 grams. Staff F was asked to pour a teaspoon full of PG in a measuring cup. The amount given to this resident was 5 gm instead of 17 gm, as ordered by the physician. Staff F acknowledged the error. This constituted the second medication error. On 04/01/13 at 1:30 pm., the above error was discussed with Staff B, who acknowledged this constituted a medication error. RESIDENT #50: On 04/03/13 at 7:33 am, this resident received a crushed enteric coated [REDACTED] along with 4 other crushed medications mixed in applesauce. Staff F, a licensed nurse, stated she crushed the resident's medications because the resident had a history of refusing medications. Staff F stated she crushed the medications to increase compliance. At 7:37 am, Resident #50 commented about the bad taste when she consumed her medications. Then the resident made a burping sound and the nurse asked if the resident was okay. Review of the Medication Administration Record (MAR) found there were no orders by the physician to crush this resident's medications. The manufacturer's instructions not to crush the [REDACTED] were printed on the label of the bottle. The enteric coating was to decrease gastrointestinal upset. This constituted a medication error. Staff B also acknowledged this incident was a medication error because the manufacturer instructions were not followed.	F 332			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333	F333- The resident did receive the proper medication dosage in a		

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F 333	<p>Continued From page 30</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to ensure Resident #12, one of nine residents observed for medication administration, was free from a significant medication error. This resident was given less than the prescribed dose of an anticoagulant medication, placing her at greater risk for developing a blood clot, which is classified as a significant medication error. Failure to ensure medications were administered as ordered by the physician placed this resident at risk for not receiving the benefits of the medication and/ or worsening of her condition.</p> <p>Findings include:</p> <p>On 04/01/13 at 5:05 pm., Staff F (a Registered Nurse), administered [REDACTED] 3 mg instead of [REDACTED] 4 mg to Resident #12. This constituted a medication error. Review of the physician's order dated 03/31/13, stated "Give [REDACTED] 4 mg on 03/31/13, 04/01/13..."</p> <p>On 04/01/13 at 5:10 pm., Staff F was asked what [REDACTED] dosage she gave the resident. She stated she had given [REDACTED] 4 mg. After she checked the [REDACTED] dosage again, Staff F acknowledged she had given the resident a lower dose than was ordered by the physician.</p> <p>On 04/01/13 at 5:30 pm, the above error was</p>	F 333	<p>timely fashion, as the error was pointed out at the time of med pass. The staff that made the error (staff F) will complete an error report and a plan of correction to prevent future errors of this kind. Pharmacy will follow up with a med pass audit for this individual's compliance and review of the 5 rights of medication pass. Completion to be on or before May 19,2013. Continued compliance to be assured by the Director of Health Services.</p>	

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F 333 F 371 SS=F	<p>Continued From page 31 discussed with Staff B, the DNS, who acknowledged staff were to administer medications as prescribed by the physician.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure staff stored, prepared and served food under sanitary conditions. Failure to identify and repair a damaged door, and to prevent water from dripping and re-freezing on cartons of food in a freezer did not ensure food was stored in a sanitary manner. Additionally, failure by staff to complete thorough hand washing, to properly wash and rinse vegetables and to check food temperatures prior to meal service, placed residents at risk for food-borne illness.</p> <p>Findings include:</p> <p>LACK OF SANITARY STORAGE: On 3/27/13 during initial observations of the facility's dietary department, between 8:55 and 9:25 am, in the main freezer, condensation which had dripped from a condenser was found to have</p>	F 333 F 371	<p>F371-Lack of Sanitary Storage: An outside service vendor has been contacted to repair the condensation dripping. Work to be completed by April 30, 2013. No food will be stored in the area of dripping until repairs can be made. Trays and plastic bins have been placed under the areas of condensation and all food has been removed from those areas. Continued compliance will be monitored and assured by the Director of Dining Services and the Director of Facilities.</p> <p>Wooden Screen Door: The screen door was repaired on the day of observation. The screen was replaced and a new metal threshold was installed to prevent entry by pests. Continued compliance will be assured by the Director of Dining Services and the Director of Facilities.</p> <p>Lack of Hand Washing: Each staff member identified in the survey has received an individualized in-service to assure proper hand-washing practices through return demonstration and observation. In</p>	

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F 371	<p>Continued From page 32</p> <p>refrozen on a carton of frozen pastry. This observation was discussed with the Dietary Manager (Staff D) at 9:25 am.</p> <p>During a return visit to the kitchen on 4/2/13 at 9:42 am, the carton of frozen pastry was again found on the shelf under the condenser, with frozen water present, as seen on 3/27/13. When Staff D was asked about the condensation, she said she had someone come in the night before, who reportedly said, "There was a small crack in the insulation, but the moisture should evaporate". The need to prevent moisture from dripping on cartons of food and potentially contaminating them was again discussed.</p> <p>At 9:15 am on 3/27/13, a wooden door from the outdoor delivery drive leading into the main kitchen was found open, with a gap along the bottom of the door which measured approximately 3 inches long by 1 to 1.5 inches high. This gap was large enough to allow insects or vermin to enter the kitchen. This observation was discussed with the Dietary Manager (Staff D) at 9:25 am.</p> <p>LACK OF HAND WASHING:</p> <p>1. On 3/27/13 at 9:20 am, a dishwasher, Staff K, was observed to load soiled dishes into racks and dispose of food refuse with his bare hands. At 9:22 am, Staff K went to a sink and was observed to rinse his hands for approximately 3 seconds. He did not use soap to wash his hands. He then began to handle clean pans and dishes with his bare hands. At 9:23 am, this observation was discussed with Staff D, who counseled Staff K to wash his hands longer.</p>	F 371	<p>addition, dining staff will be inserviced on proper glove changing techniques along with hand-washing. Dining staff will no longer use hand sanitizing agents between glove changes. Continued compliance will be assured by the Director of Dining Services and the Director of Health Services. All training and compliance to be in effect by April 25, 2013.</p> <p><u>Improper Washing of Vegetables:</u> All food handling and preparation staff will be trained on the proper use of vegetable wash. Vegetable wash will be rinsed off thoroughly under running water or in accordance with the manufacturer's recommendations. Continued compliance will be assured by the Director of Dining Services and completed by April 25, 2013.</p> <p><u>Failure to Check Initial Food Temperatures:</u> Step-by-step procedures for the proper taking of food temperatures will be reviewed with all cooks, including substitute cooks. This will be completed by April 25, 2013. All food temperatures are monitored and recorded on a daily flow-sheet.</p>		

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F 371	<p>Continued From page 33</p> <p>2. During a second kitchen observation on 4/2/13, at 9:28 am, Staff K was again observed to handle soiled dishes and pans without wearing gloves. After several minutes, he briefly rinsed his hands. Without thoroughly washing his hands, he again began to handle clean dishes. When Staff D was notified of this observation, Staff K claimed he had washed his hands and was again told he needed to wash them longer.</p> <p>3. During observations on 4/2/13 from 11:10 am until 11:55 am, Staff J, who served lunch to residents in the SNF dining room, was observed to exit the dining room to the kitchen and returned both times without washing his hands before he served food. At 11:20 am, Staff J left the dining room and returned with trays of clean bowls. He did not wash his hands after he returned, but put on a pair of gloves before serving soup. At 11:35 am, he again left the serving area to get a thermometer from the kitchen and did not wash his hands after he returned, which is required prior to handling/ serving food.</p> <p>4. Additionally, on 4/2/13 at 7:50 am, a Nursing Assistant, Staff G entered the dining room, and did not wash his hands. He was observed to wipe his mouth with his hand, then roll a stool to a table by Resident #25. After scratching his head, he served cups of coffee to Resident #50 and a second resident.</p> <p>After this observation, at 8:05 am, Staff D was asked about the facility's hand washing policy for staff serving meals. She replied staff were "to wash their hands when they enter the kitchen or the dining room, or if their hands become soiled". The observations of Staff G, J, and K, and the</p>	F 371		

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F 371	<p>Continued From page 34</p> <p>lack of hand washing described above were discussed at this time and the requirements for staff serving meals to complete hand washing when indicated was acknowledged.</p> <p>5. During observations of the breakfast service on 4/3/13 between 7:10 am and 8:15 am, a cook serving breakfast in the SNF dining room (Staff S) was observed to remove her gloves and use a hand sanitizer before regloving, rather than wash her hands on three different occasions (at 7:30 am, 7:35 am and 7:37 am) as she prepared eggs, toast and served plates of food for residents. Current food sanitation regulations prohibit use of hand sanitizers in place of hand washing in food service areas.</p> <p>At 8:05 am on 4/2/13, Staff D was interviewed about the facility's policy regarding use of chemical sanitizers and hand washing, When asked about use of chemical hand sanitizers by staff, she said, "If they are doing the same chore, they can use the hand sanitizer, if they don't leave the area". When information from the current regulations which state antimicrobial gels/ sanitizers were not to be used in place of proper hand washing techniques in a food service setting, she said she was not aware of this requirement.</p> <p>IMPROPER WASHING OF VEGETABLES: On 4/2/13 at 9:50 am, Staff M was observed washing several heads of lettuce at a sink, using a commercial vegetable wash. Once finished, she did not rinse the lettuce, but placed them in a plastic bowl and prepared to leave the area. Staff M was asked if the lettuce needed to be rinsed. A second staff (Staff O) asked her if she rinsed it off</p>	F 371		

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F 371	<p>Continued From page 35</p> <p>after washing it. Staff O acknowledged she hadn't rinsed the lettuce to remove the chemical. Instructions on the bottle's label stated after use of the vegetable wash, food was to be "rinsed with potable water".</p> <p>At 9:54 am on 4/2/13, a follow up discussion with the Dietary Manager (Staff D) and Staff O occurred regarding the lack of rinsing the vegetables. Staff O said when Staff M was asked why she didn't rinse lettuce after washing it, Staff M said it was "Because it was going to be a garnish". Discussed that garnishes may be eaten and garnishes are in contact with other food, so the lack of rinsing had the potential to contaminate food. Later review of information regarding the active ingredients of the vegetable wash revealed it contained hydrogen peroxide and acetic acid.</p> <p>FAILURE TO CHECK INITIAL FOOD TEMPERATURES: During observations of the noon meal on 4/2/13 from 11:10 am until 11:55 am, staff assigned to obtain initial food temperatures before serving the meal failed to take temperatures when required. Between 11:10 and 11:16 am, Staff J placed hot food on the steam table. From 11:16 am until 11:26 am, he began to serve soup to residents without checking initial food temperatures.</p> <p>At 11:26 am, Staff J was asked about checking initial food temperatures. He said the cook already took the temperatures. At 11:35 am, a cook (Staff L) came to the dining room to checked the food temperatures. Staff L said she had not checked the food temperatures because she was a substitute and forgot the routine.</p>	F 371			

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F 371	Continued From page 36	F 371			
F 441 SS=E	<p>Two items served from the tray line were found to be less than the required temperature of 135 degrees Fahrenheit (dF). A roast beef sandwich was 112 dF at 11:37 am and a mechanical soft roast beef sandwich was 100 dF. After taking these temperatures, Staff L did not comment or take any action to provide menu items that were at the proper temperature.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their</p>	F 441	F441- Staff T and Staff U have received counseling for failure to properly observe infection control practices. Staff will be in-serviced on the process of going from dirty to clean and how and when to change gloves and wash their hands. A newly updated hand washing policy and procedure is being developed and all staff will be in-serviced on this new policy. The policy and its observance will ensure proper adherence to accepted infection control practices. Policy and in-servicing to be completed on or by May 19, 2013. In-servicing and continued compliance to assured by the Director of Health Services.		

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F 441	<p>Continued From page 37</p> <p>hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policies, the facility failed to ensure staff washed hands when required. Failure to remove soiled gloves and wash hands when indicated, placed residents at risk for exposure to infectious organisms.</p> <p>Findings include:</p> <p>On 4/1/13 at from 3:50 pm until 3:58 pm, Staff T and U were observed as they provided [REDACTED] care to Resident #4. Staff T removed the [REDACTED], cleaned the resident's [REDACTED] with disposable wipes. After washing the resident, he did not remove his gloves or wash his hands. He began to dress the resident, touching the resident's leg and clean clothing while wearing the same gloves worn during pericare.</p> <p>When Staff T was asked if he had changed gloves or washed his hands, he said he had changed his gloves (although this wasn't observed). He then removed the gloves he was wearing and reached for a clean pair of gloves,</p>	F 441		

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F 441	Continued From page 38 but did not wash his hands. When Staff T was asked if staff were to wash hands before putting on clean gloves, a nurse (Staff F) who had entered the room and apparently overheard this question, responded with an emphatic "Yes!" before Staff T could reply. Additionally, as previously documented in F371, Food Sanitation, observations of staff failing to complete hand washing when indicated during meal service to residents were made on multiple days for other staff (Staff G, J, K and S). These observations were discussed with the dietary manager on 4/3/13 at 8:15 am and the need for consistent adherence to hand washing policies acknowledged. On 4/4/13, review of the facility's Infection Control Protocols, dated 1/21/08, revealed basic goals and expectations that "...infection control techniques will be followed by all staff, especially proper hand washing before and after performing services to residents". Additional guidelines for staff hand washing specified in the protocols included directives for staff to wash their hands after changing a resident's incontinence brief, before and after serving food, and between dirty and clean functions when washing dishes.	F 441			
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.	F 518	F518- All staff will be trained on the emergency procedures as part of the new hire orientation and annually thereafter. Training of current staff to be completed again on or before May 19, 2013. This training will include proper responses to earthquake as well as		

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F 518	<p>Continued From page 39</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of facility emergency policies, the facility failed to train 2 of 5 employees regarding emergency procedures to ensure they were knowledgeable. This placed residents at risk for an unsafe or ineffective response by staff in the event of an emergency.</p> <p>Findings include:</p> <p>On the morning of 04/03/13, a sample of five employees were interviewed about their training and knowledge of the facility's emergency procedures. Two of the five staff were unable to identify guidelines or procedures they should follow if an earthquake occurred.</p> <p>When asked what she would do in the event of an earthquake, Staff Q stated she didn't know, and had not been trained. When a second staff member, Staff R was asked what she would do if there was an earthquake, she also said she didn't know, and that she had not received training.</p> <p>On 4/03/13 at 11:55 am, the facility's Maintenance Director, Staff N, was interviewed about the frequency of staff training sessions about emergency preparedness in the facility. He said the training was held at an annual staff meeting, as well as at staff training twice a year. During review of training records and further discussion about staff training, he acknowledged it had been difficult to train all staff.</p>	F 518	<p>other facility emergencies. Continued compliance to be assured by the Director of Facilities.</p>		

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