

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505409</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/25/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SUMMITVIEW HEALTHCARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3801 SUMMITVIEW AVENUE YAKIMA, WA 98902</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Summitview Healthcare Center on 6/18/14, 6/19/14, 6/20/14, 6/23/14, 6/24/14 and 6/25/14. A sample of 31 residents was selected from a census of 70. The sample included 28 current residents and the records of 3 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>Liisa Johnson, RN Lucy Fromherz, RN Pam Holt, RN Lisa Herke, RD Patti Rose, RN</p> <p>The survey team is from:</p> <p>Department of Social &amp; Health Services Aging and Long-Term Support Administration Residential Care Services, District 1, Unit D 3611 River Road, Suite 200 Yakima, WA 98902</p> <p>Telephone: (509) 225-2800 Fax: (509) 574-5597</p> <p><i>L. Cramer for District 1 D</i> Residential Care Services Date 9/24/14</p>	F 000	<p>Received Yakima RGS <b>OCT -1 2014</b></p> <p>IDR AMENDED by Lisa Cramer</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X D. Walgesie</i>	TITLE Administrator	(X6) DATE 09/30/2014
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157 SS=D	<p><b>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</b></p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that the physician was consulted for changes in pulse and blood pressures for 1 of</p>	F 157	<p><b>F-157 FACILITY RESPONSE</b></p> <p>On Resident #68 the physician completed a physical assessment and review of medications on 6/11/14 within the facility and noted patient to be stable with current treatment and care, and no changes were indicated. The physician's order did not say to <u>notify the physician</u> when the vital sign was out of parameter; it was to <u>hold the medication</u> for vital signs that were outside of specific parameters. The physician was in the facility again on 6/24/14 again reviewing medication regime and vital signs.</p> <p><b><u>PLAN OF CORRECTION</u></b></p> <p>Physician reviewed resident's medication regime and vital signs on 6/24/14.</p> <p>All residents were reviewed to ensure appropriate notifications were made. Nursing staff will continue to follow Standards of Practice and Physicians Orders.</p> <p>Nursing staff have been re-inserviced on following nursing standards of practice and physician notification. Director of Nursing is responsible for ensuring compliance.</p>	8/05/14
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F 157	<p>Continued From page 2</p> <p>6 residents (#68) reviewed for unnecessary medications. This failure placed the resident at risk for low blood pressure complications. Findings include:</p> <p>Resident #68. The resident was admitted to the facility [REDACTED] 11 with complicated medical diagnoses including hypertension (high blood pressure).</p> <p>The resident received several daily anti-hypertensive medications including Lisinopril, Atenolol, Norvasc, Hydralazine and a weekly Clonidine patch. The physician ordered blood pressures to be obtained before giving these medications to the resident. If the systolic blood pressure reading (the top number) was below 100, the licensed nurse was to hold the anti-hypertensive medication. If the pulse reading was below 50 bpm (beats per minute), the anti-hypertensive medication Atenolol was to be held and not given to the resident. The physician was to be notified if the readings were outside these parameters of the blood pressure and pulse for those identified anti-hypertensive medications.</p> <p>According to the June 2014 Medication Administration Record and the nurses progress notes, the resident's anti-hypertensive medication Hydralazine was held on 06/07/14, 06/08/14, 06/12/14, 06/15/14 and 06/23/14 for the scheduled noon doses and 06/14/14 and 06/19/2014 for the scheduled afternoon doses. The resident's anti-hypertensive medication(s) Lisinopril and Atenolol were held the evening of 06/14/2014 and 06/19/2014 related to low blood pressure and pulse parameters.</p>	F 157		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 157	<p>Continued From page 3</p> <p>On 06/23/14 at approximately 3:30 p.m., Staff Member C, a Licensed Nurse (LN), stated that they would call the physician if the resident's blood pressures and pulses continued to be low but they mainly looked if the resident was responsive and may not notify the physician. There were no notes that the physician was notified by either phone or fax.</p> <p>On 06/24/14 at approximately 10:00 a.m., Staff Member H, the Director of Nursing, stated that if a residents' blood pressure and pulses were outside the recommended parameters, the nurse would assess the resident and notify the physician.</p> <p>During an interview on 06/24/14 at approximately 11:50 a.m., Staff Member G, a LN, stated she went through the resident's blood pressures and noted that they were below the parameters. She faxed and called the physician after the concern was brought to the attention of the nursing staff by the surveyor.</p> <p>The facility failed to notify the physician in a timely manner concerning changes outside the parameters of resident's blood pressures and pulses.</p>	F 157		
F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 241	See response on page 5	

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F 241	<p>Continued From page 4</p> <p>by:</p> <p>Based on observation, interview and record review, the facility failed to provide care in a manner that promoted and enhanced resident dignity for 5 of 16 interviewed residents (#s 54, 92, 15, 81 and 63). Failure by staff to respond promptly to call lights placed the residents at risk for feelings of frustration and diminished self-worth as they waited for their needs to be addressed. Findings include:</p> <p>Resident #54. Per review of the care plan and progress notes, the resident was alert, oriented and able to make her needs known. She needed assistance with transfer to the bathroom. Assistance was needed due to a fall the resident sustained on 06/06/14. The resident was to have assistance during all transfers.</p> <p>On 06/18/2014 at approximately 4:00 p.m., the resident stated she had to "wait a half an hour or so... nearly every morning" to be assisted to the bathroom.</p> <p>On 06/19/14 at approximately 9:50 a.m. the resident's call light was illuminated above the door. The resident called out that she needed to go to the bathroom. Thirty minutes later, staff had not answered her light. The surveyor stepped into the hallway where staff saw the surveyor and answered the light. Staff Member M, a Nursing Assistant (NA), answered the light and assisted the resident to the bathroom. The resident stated that the NA would need to change her underwear due to the fact they were now soiled. Staff Member M stated she did not see the resident's call light and that she was unaware of the resident's need to go to the bathroom.</p>	F 241	<p><b>F-241 FACILITY RESPONSE</b></p> <p>During Survey, the answering of call lights was impeded and lengthened due to surveyors putting on the call lights of residents who were not present. This then created confusion and delayed timely answering of call lights of resident's who needed actual assistance.</p> <p><b><u>PLAN OF CORRECTION</u></b></p> <p>Identified residents were interviewed to ensure needs were met.</p> <p>All staff was re-inserviced on meeting resident needs in a timely manner.</p> <p>Residents will be asked periodically on satisfaction of call lights and response times.</p> <p>Director of Nursing is responsible for ensuring compliance</p>	08/05/14

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F 241	<p>Continued From page 5</p> <p>Resident #92. Per comprehensive assessment and the care plan, the resident was alert, oriented and able to make her needs known. She was ambulatory with a four wheeled walker.</p> <p>On 06/19/14 at approximately 2:00 p.m., stated she had talked to the nurse about not answering call lights timely and "it can be an hour..they don't answer them and my roommate (Resident #54) has had to wait a long time."</p> <p>Resident #15. The resident was alert and oriented and required assistance to transfer per her comprehensive assessment.</p> <p>On 06/19/14 at approximately 11:00 a.m., the resident stated that in the morning "it takes a half an hour until the call light is answered" for assistance to the bathroom.</p> <p>Resident #81. The resident was able to make needs known but required assistance with transfers to the bathroom per the current comprehensive assessment.</p> <p>On 06/19/14 at approximately 11:30 a.m., the resident stated that she had "to wait thirty minutes or more to get assistance after using the call light."</p> <p>Resident #63. The resident was able to make her needs known and needed assistance with transfers to the bathroom per the comprehensive assessment.</p> <p>On 06/19/14 at approximately 3:00 p.m., the resident stated she had to "wait thirty minutes for the NA's to answer the call light. In the past I have soiled myself waiting for assistance."</p>	F 241		

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F 252 SS=D	<p>483.15(h)(1) <b>SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</b></p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a homelike environment for the residents requiring meal assistance in the main dining room. This placed the residents at risk of a decreased quality of life due to the institutional character of the setting, thus lacking an environment as close to that of a private home as possible. Findings include:</p> <p>The dining room had a policy for ongoing twelve hour meal service from 7:00 a.m. to 7:00 p.m. Residents were able to enjoy the meal service at their leisure. Throughout the day, the number of residents eating in the dining room fluctuated, even at the tables where residents required assistance to eat.</p> <p>During the on-site survey, residents were observed in the dining room throughout the day. The main dining was a large rectangle shaped room. At one end, the main entry to the dining room opened off of a busy hallway.</p> <p>Directly inside of the main dining doorway, tables were positioned for the residents who required assistance to eat. Across from these tables, against the wall, were storage cupboards, a sink for hand washing, and an ice machine. When the</p>	F 252	<p><b>F-252 FACILITY RESPONSE</b></p> <p>There were 6 interviewable residents who are routinely sitting in that area of the dining room. Those residents were not interviewed at any time during survey. Residents are assessed for placement in the most appropriate eating environment utilizing the most appropriate utensils/serving dish upon admit, quarterly, and as needed by change of condition.</p> <p><b><u>PLAN OF CORRECTION</u></b></p> <p>All residents will be re-assessed for appropriate dining environment/utensils/serving dishes while respecting their personal choices.</p> <p>Resident council will be consulted on improving dining room environment. Dining room lead staff will audit noise level.</p> <p>Director of Nursing is responsible for ensuring compliance</p>	08/05/14

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F 252	<p>Continued From page 7</p> <p>ice machine was used, the motor running was loud and the ice fell with clunking sounds which could be heard throughout the assisted dining area.</p> <p>Past the tables for the assisted residents were multiple tables for residents capable of independently eating their meal, which comprised the larger part of the dining room. These tables were covered with table cloths and the area was quiet except for quiet resident and/or staff interactions.</p> <p>On 06/18/14 the noon meal was observed in the designated area for assisted dining. There were two 'U' shaped, gray colored tables pushed almost together to resemble a circle. Two nursing assistants sat in the middle on a rolling stools to assist residents with their meals. One resident sat between the gap where the tables came together. She used an small, dark colored table for her meal.</p> <p>Multiple individuals went past these tables to gain access to the dining room beyond. Thus, these residents being fed were visible to visitors, residents and/or staff not involved with them. Further, the noise level increased in this area as people talked, used the ice machine, and washed hands nearby.</p> <p>Lunch was served to nine residents on the tables without placemats. Three residents had brightly colored dishes and soup bowls. The other five residents ate only from dark colored mugs, clear glasses, and small clear bowls.</p> <p>On 06/18/14 at approximately 1:00 p.m., Staff Member Q, a Nursing Assistant (NA), stated she</p>	F 252		
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F 252	<p>Continued From page 8</p> <p>was not aware of the noise level as she was concentrating on assisting the residents.</p> <p>On 06/19/14 at 9:30 a.m., a country music channel was on the radio near the residents' assisted tables. During the next half hour, the following interruptions or disruptions for five residents with mental and/or physical impairments were noted: 1) staff used the sink for hand washing - running water and the banging of the trash lid were heard clearly; 2) multiple staff and residents either past the tables walking or in wheelchairs; 3) at 9:36 a.m, an empty, rattling wheelchair was pushed past; 4) the ice machine was utilized to fill three ice pitchers; 5) a janitor swept the floor surrounding the assisted table at 9:40 a.m.; 6) a licensed nurse dumped a plastic tub of ice in the nearby sink and filled it again from the ice machine; 7) conversation between a staff member and an independent resident was held next to the assisted tables; and 8) at 9:50 a.m., four residents continued to eat while the ice machine was used and multiple staff and residents continued to pass by the tables.</p> <p>On 06/25/14 at approximately 9:45 a.m., three residents were seated at the assisted dining table. Staff Member M, a NA, was at the ice machine filling 40 mugs with ice and then water. She stated she had used the ice machine for each of the mugs and agreed it was a noisy process. She then left the task and went to the nearby tables to assist the residents. The talking and music on the radio could easily be heard by the nearby assisted tables. Residents and staff were either passing by or stopping at the sink and ice machine continually. The noise level was elevated. When Staff Member M was asked about the noise level from the traffic past the</p>	F 252		

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F 252	Continued From page 9 table, the radio, and the nearby sink and ice machine, she stated that she did not notice it.  The residents, due to their mental status, were not able to be interviewed regarding their environment.  On 06/25/14 at approximately 10:15 a.m., Staff Member P, the Restorative Nursing Director, stated she was in charge of over-seeing the dining room. While reviewing the setting with the surveyor, there were still three residents continuing to eat breakfast. The above described noisy environment continued. She stated it was not an environment that was conducive for residents who required focus on eating either due to their physical and/or mental problems.	F 252			
F 256 SS=D	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS  The facility must provide adequate and comfortable lighting levels in all areas.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adequate lighting for activities of choice for 2 of 3 residents (#s 54,81) sampled for in-room lighting issues. Failure to provide adequate lighting for resident activities potentially decreased the resident's quality of life. Findings include:  Resident #54. Admitted to the facility on [REDACTED] 13. Per her latest comprehensive assessment dated 03/23/14, she was cognitively alert and had adequate vision with corrective	F 256	see response on page 11		

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F 256	<p>Continued From page 10</p> <p>lenses. She was independent with transfers and locomotion around the unit. The assessment also noted it was "very important" to the resident to have books and other reading material available.</p> <p>Review of the care plan revealed she enjoyed using her laptop computer to make cards, Facebook, email and play games. She also enjoyed reading and working word puzzles. The care plan also directed staff to provide written material for medical care education, including for new diagnoses, medications and treatments, as "she is a visual learner."</p> <p>On 06/24/14 at approximately 12:30 p.m., Resident #54 stated her daughter had to buy her a clip-on type lamp for lighting in her room because her room was dark. She stated even if curtains were opened the room was dark because trees shaded her window. She explained she liked to use her computer and read the newspaper and had complained to the facility staff about the poor lighting. However, the facility had not taken action and her daughter purchased the lamp.</p> <p>Resident #81. Admitted to the facility on [REDACTED] 13. Per her latest comprehensive assessment dated 04/17/14, she had adequate vision with corrective lenses; she was cognitively alert and was independent with walking about her room. The assessment also revealed she thought it was "very important" to have reading materials available.</p> <p>Review of the care plan revealed she loved reading newspapers, books and magazines, and that large print was easier for her to read.</p>	F 256	<p><b>F-256 FACILITY RESPONSE</b></p> <p>Resident #81's bulbs in her bedside lighting and over the sink lighting were changed to brighter bulbs on 6/24/14. QIO Resident Interview and Observation questionnaire was completed with resident on 6/13/14 and again on 7/15/14 with no lighting concerns communicated. QIO Resident Interview and Observation questionnaire was completed with resident #54 on 6/16/14 and again on 7/15/14 with no concerns expressed or identified in regards to lighting.</p> <p><b>PLAN OF CORRECTION</b></p> <p>Resident 81's light bulbs were replaced with brighter bulbs. Resident 54 was interviewed and was satisfied with the lighting levels.</p> <p>All residents were assessed for adequate lighting needs. QIO Resident Interview and Observation questionnaire will be completed within 20 days of admit and quarterly thereafter on all residents.</p> <p>Social Service Director is responsible for ensuring compliance</p>	08/05/14

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F 256	<p>Continued From page 11</p> <p>On 06/24/14 at approximately 11:40 a.m., Staff Member B, the Activities Director, stated Resident #81 enjoyed reading and utilized the book mobile to obtain reading material.</p> <p>On 06/24/14 at approximately 11:45 a.m., Staff Member A, an activities staff person, stated she assisted Resident #81 with obtaining books. She stated the large print was best for the resident. She explained the lighting wasn't "that great" in the resident's room, especially when the resident used the recliner chair for reading. She stated the resident had complained about the poor lighting about 2 months ago.</p> <p>On 06/24/14 at approximately 11:50 a.m., Resident #81 stated she enjoyed reading and pointed to a stack of books. She stated she liked to sit in her recliner and read, but the lighting was not quite good enough. She stated she had talked to the "people who bring me my books" about the poor lighting around a month ago.</p> <p>On 06/24/14 at approximately 12:30 p.m., Resident #81's room was observed with the resident's bed against the wall and located near the door, not near the window. Above the bed was a 3 to 4 foot horizontal light that directed light up and down the wall. On the opposite side of the room from the bed, a sconce type light illuminated the wall and an approximately 18 inch light was located above the mirror and over the sink. None of the light sources directed light near the recliner and no overhead light was installed.</p> <p>Failure by the facility to address lighting issues for residents requiring better light for their leisure and learning activities placed these residents at risk of</p>	F 256		

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F 256  F 279 SS=D	<p>Continued From page 12</p> <p>decreased participation in activities and care planning, potentially reducing their quality of life.</p> <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 observation, interview and record review the facility failed to develop a comprehensive care plan for 1 of 6 residents (#4) reviewed for unnecessary medications related to antipsychotic medication. Failure to develop a care plan with measurable goals and objectives placed the resident at risk for unmet needs. Findings include:</p>	F 256  F 279	<p><b>F-279</b></p> <p><b><u>PLAN OF CORRECTION</u></b></p> <p>The resident's next quarterly review and careplan update was completed early (6/25/14) to include careplanning of medication.</p> <p>All residents were re-assessed to ensure careplanning complete.</p> <p>Medical records will complete intermittent auditing</p> <p>Director of Nursing is responsible for ensuring compliance</p>	08/05/14

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 279	Continued From page 13 Resident #4. The resident was admitted to the facility on [REDACTED] 10 with diagnoses including depression, anxiety and dementia with behavioral disturbances.  According to the physician's orders on 05/14/14, Zyprexa, (an antipsychotic medication), was started for an increase in the resident's behaviors. The plan of care did not reflect this medication change including adverse side effects and target behaviors for this new class of medication.  On 06/25/14 at approximately 8:15 a.m., Staff Member F, a Licensed Nurse (LN) manager, stated that social services should update the care plan for the new medication Zyprexa. She stated that social services was also responsible to identify and input side effects of the medication and target behaviors on care plan.  During the interview on 06/25/14 at approximately 10:00 a.m., Staff Member D, the Social Services Director, stated that the nurses put the possible adverse side effects in the Care Plan and that Social Services should have input the targeted behaviors in the resident's care plan.	F 279			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  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.  A comprehensive care plan must be developed within 7 days after the completion of the	F 280	see response on page 15		

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F 280	<p>Continued From page 14</p> <p>comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to revise the care plans for 1) One of three residents (#4) related to pain management; and 2) Two of six residents (#s 25, 69) related to specific target behavior monitoring for psychoactive medication use. Failure to revise and update care plans placed residents at potential risk for unmet needs. Findings include:</p> <p>Resident #4. The resident was admitted to the facility on [REDACTED] 10 with diagnoses which include osteoporosis (a disease where bones become fragile and more likely to fracture) and a chronic fracture of the upper leg.</p> <p>On 06/19/14 at approximately 10:45 a.m., the resident was in the hallway yelling, "it hurts, it hurts..take this brace off." The resident was leaning on the left side of the wheel chair with the upper body over the left arm rest and her left elbow pressing on the left wheel chair arm to relieve pressure from the right side of her body.</p>	F 280	<p><b>F-280</b> <b>PLAN OF CORRECTION</b></p> <p>Identified resident's careplans and assessments were reviewed and updated as needed.</p> <p>All resident careplans have been reviewed and updated by the multidisciplinary team.</p> <p>The multidisciplinary team was re-inserviced on careplanning.</p> <p>Director of Nursing is responsible for ensuring compliance</p>	08/05/14

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F 280	<p>Continued From page 15</p> <p>Due to her yelling, staff transferred the resident to her bed. The resident had an aluminum/metal orthotic brace that covered the right side of the waist line and extended from the hip downward to the right thigh, knee, ankle and foot. There were velcro ties that held the lower brace areas together which the resident was observed adjusting herself.</p> <p>The resident's right hip/leg brace was removed by nursing staff and the resident was calm and was able to participate with her care.</p> <p>A review of the resident's plan of care revealed that there was no monitoring of the resident's pain with exception of the nursing assistant staff notifying the licensed nurse if there was pain expressed by the resident.</p> <p>The last pain assessment was dated 03/20/14 and documented that the resident "sometimes" experienced pain. The routine Tylenol was effective with a narcotic medication as needed for breakthrough pain.</p> <p>A physician's visit on 05/07/14 documented a change in the narcotic medication from a 'as needed' to a routine dose for an increase in the resident's behaviors. These behaviors were related to an increase in pain according to the physician.</p> <p>The care plan was not revised to reflect the changes in the resident's pain to include the right hip/leg brace discomfort and changes in the resident pain medication.</p> <p>Resident #25. Admitted to the facility on [REDACTED] 14 with diagnoses including insomnia, memory loss</p>	F 280		

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F 280	<p>Continued From page 16 and depression. Per review of physician's orders the resident had received Trazodone every evening for the diagnosis of insomnia.</p> <p>Review of the resident's care plan dated 04/30/14 for Psychotropic medication use (trazodone) revealed the resident's target behavior (indication for its use) was "trouble sleeping." The care plan did not include interventions on how to monitor the effectiveness of the insomnia medication through documenting how many hours the resident slept each shift.</p> <p>On 06/23/14 at 1:55 p.m. Staff Member K, Social Services, stated there were no hours of sleep monitoring done for Resident #25 nor was it on her care plan to do so.</p> <p>Resident #69. The resident was admitted to the facility on [REDACTED] 14 with diagnoses which include anxiety and a cognitive communication deficit.</p> <p>The resident experienced insomnia (sleeplessness) and trazodone was added at bedtime to help the resident sleep.</p> <p>The care plan failed to identify the monitoring for the trazodone side effects and did not include the monitoring if the medication was effective or not in helping the resident sleep.</p> <p>On 6/20/14 at approximately 3:30 p.m., Staff Member D, the Social Services Director, stated that there were no directives for monitoring target behaviors. The nursing staff were to monitor for side effects of medications but were not doing so.</p>	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309	see response on page 18		

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F 309	<p>Continued From page 17</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide the necessary and timely assessment of 1 of 3 resident's (Resident #4) agitation related to pain when reviewed for positioning. In addition, the facility failed to monitor how Resident #4's pain affected her behaviors. These failures resulted in the resident being administered an unnecessary medication.</p> <p>Resident #4. Diagnosed with chronic fractured right hip/femur with pain, anxiety and depression.</p> <p>On 06/19/14 at approximately 10:45 a.m., the resident was in the hallway yelling, "it hurts, it hurts..take this brace off." The resident was leaning on the left side of the wheel chair with the upper body over the left arm rest of the wheel chair and left elbow pressing on the left wheel chair arm to relieve pressure from the right side of the resident's body.</p> <p>Nursing staff transferred the resident from the wheel chair to the bed and removed her brace. The resident had a right side aluminum/metal orthotic brace that covered from the waist line and extended to the hip and downward to the</p>	F 309	<p><b>F-309 FACILITY RESPONSE</b></p> <p>Resident #4 The resident was monitored for pain by the direct caregivers every day and any indication of pain was reported to the nurse and pain was treated. The physician who is in the building 2-3 days per week completed a thorough assessment on 6/11/14. The assessment indicates advanced dementia with aggressive behaviors and that the resident was stable with marked improvement after initiation of Zyprexa. The resident's son and medical decision maker notified staff upon admit that the Orthopedic Surgeon indicated the brace was necessary to prevent any trauma to the leg which would result in amputation. This information was verified with the physician. The use of the brace was reviewed at every quarterly care conference.</p> <p><b><u>PLAN OF CORRECTION</u></b></p> <p>Resident #4 has been re-assessed and careplan has been reviewed and updated by the multidisciplinary team to ensure resident attains or maintains the highest practicable physical, mental, and psychosocial well-being. All residents have been re-assessed and careplans have been reviewed</p> <p style="text-align: right;"><i>Continued on next page</i></p>		

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F 309	<p>Continued From page 18</p> <p>thigh, knee, ankle and foot. There were velcro ties that held the lower brace areas together. (Previously, the resident had been observed adjusting and pulling these ties to adjust the brace on her leg.)</p> <p>After the brace was removed, the resident was calm and able to participate with her care.</p> <p>A review of the resident plan of care revealed that there was no monitoring of the resident's pain with exception of the nursing assistant (NA) staff notifying the licensed nurse (LN) if there is pain expressed by the resident.</p> <p>The last pain assessment was 03/20/14 and documented that the resident "sometimes" experienced pain. The routine Tylenol was effective along with the oxycodone (a narcotic) used for breakthrough pain.</p> <p>The 03/24/14 quarterly review of psychotropic medications revealed the resident still wanted to go home and "gets wound up, yells; hates the brace on femur (thigh bone); plan: increase buspar to double the dose twice a day."</p> <p>A physician's visit note dated 05/07/14 revealed a changed order for routine oxycodone due to the "increase in resident's behaviors related to increased pain." Additionally, the resident was scooting self out of the wheel chair and refusing to have staff place the right leg orthotic brace.</p> <p>The physician's 05/14/14 documentation revealed the resident was placed on Zyprexa (antipsychotic medication) for yelling out at night and not taking medications. A diagnosis was added of advanced dementia with behavioral</p>	F 309	<p><i>Continued from previous page</i></p> <p>and updated by the multidisciplinary team to ensure residents attain or maintain the highest practicable physical, mental, and psychosocial well-being.</p> <p>The multidisciplinary team was re-inserviced on careplanning.</p> <p>Director of Nursing is responsible for ensuring compliance</p>	08/05/14

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F 309	<p>Continued From page 19</p> <p>disturbances and aggressive behaviors. The routine buspar (for anxiety and depression) was discontinued without any explanation except she was more agitated. The ativan (antianxiety medication) as needed for anxiety was continued.</p> <p>The April, May and June 2014 nurses progress notes documented that the resident had continued with the same behaviors that were present at admit. The medication administration record indicated that the resident does refuse her medications at times but was basically the same according to documented target behaviors for the ativan and the buspar. The targeted behaviors included wanting her cat and to see her parents and becoming tearful when she wanted to go home. (Although quantitatively documented, there was no assessment related to the meaning of the resident's expressions.)</p> <p>According to the progress notes the resident was able to be successfully redirected by the social services, the Chaplin and other staff. There were a few episodes when the antianxiety (Ativan) was given following her expressions of wanting the cat, parents and/or to go home with noted decrease in the expressions afterwards.</p> <p>On 06/19/2014 at approximately 11:15 a.m., Staff Member N, a LN, stated the resident had reoccurring venous ulcers on her right lower leg and great toe which did cause her pain. The LN also stated the orthopedic doctor said the right leg brace was to be on when the resident was out of bed. The resident "does not like the brace and does not like it to be put on her leg." (The resident had the brace placed five years ago with the last inquiry to the orthopedic physician regarding the placement of the brace in 2012.)</p>	F 309			

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F 309	Continued From page 20  During the 06/19/14 interview at approximately 11:15 a.m., Staff Member O, a LN, stated the resident did better with the pain medication, because of the pain the right leg brace caused the resident, rather than using the antianxiety medication. The NA's tell the nurses if the resident was having behaviors and/or pain so the pain medication could be given.  On 06/24/14 at approximately 8:45 a.m., the resident expressed that the right leg brace was a "bother and painful" at times to her lower back and right knee related to the positioning of her right leg. The resident demonstrated picking up the brace straps in the middle of her knee to readjust the positioning to help with the pain of the right knee and lower leg. She said she fell in her apartment 5 years ago and fractured her right upper leg that caused her to end up in the nursing home facility. She was not able to walk without assistance, needed help to have the brace placed, and transfer from wheel chair to bed. The resident was seated in her wheel chair leaning to her left side and rubbing her right upper leg during the interview. She stated she would like to have another assessment to modify the brace "or something else." According to the resident, she stated "it affects my mood, pain, nervousness and daily activities."  On 06/24/14 at approximately 10:50 a.m., Staff Member F, a nurse manager, stated we "are working with getting an appointment with the orthopedic surgeon" concerning the right leg brace. (This was done following the 06/19/14 interview with the surveyor.) "The last time we looked at getting something else done with the brace was in 2012; the surgeon wouldn't look at	F 309			

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F 309	<p>Continued From page 21</p> <p>the brace and just said [the resident] needed it." The buspar was increased in March, 2014, which made her more agitated. She stated she had noted the resident had decreased anxiety with zyprexa (antipsychotic). Staff Member F felt it was not a pain issue but an agitation issue due to her increased dementia. (However, there was no documentation of an assessment for and monitoring of the appropriate behaviors which would indicate the need for an antipsychotic medication. Further, without the pain monitoring, there was no information regarding how it affected the resident's behaviors. Additionally, there was no documentation regarding that the resident was experiencing worsening dementia other than the yelling.)</p> <p>During the 06/24/14 interview at approximately 11:15 a.m., the resident was yelling for help. Staff Member F, went to assist the resident who complained of pain with the leg brace hurting her back and right knee. The resident was able to describe and specifically locate the pain by pulling up the brace and pointing to her knee and back when Staff Member F asked what was wrong.</p> <p>On 06/24/14 at approximately 4:30 p.m., Staff Member F, a nurse manager, stated there were no prior pain monitors for the resident prior to the request for them by the surveyor. The pain monitors were then done for acute pain issues only from 06/19/14. (Without the pain monitoring, there was no ability to discern between pain and behaviors.)</p> <p>The facility failed to consider all factors that may influence the selection and dosing with the antipsychotic or the pain medication including the cause of the resident's pain.</p>	F 309			

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F 329 SS=D	<p><b>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to 1) consistently monitor the effectiveness of medication for 5 of 6 residents (#s 4,9,25,69 and 2) the indication for use for 1 of 6 residents (#4) reviewed for psychoactive medication. These failures placed residents at potential risk of receiving unnecessary medications and/or not receiving effective treatment. Findings include:</p>	F 329	<p><b>F-329 FACILITY RESPONSE</b></p> <p>Resident #69 was admitted to the facility on [REDACTED] 14. An intervention on the resident's careplan dated 4/16/14 states to give psychotropic medication as ordered by physician and to monitor and document for side effects and effectiveness. The resident is alert, oriented and interviewable, however it does not appear that she was interviewed by any survey staff. The resident was on Trazodone prior to her admit from an independent setting and planned to discharge back. She did not want any changes in her medications.</p> <p><b>PLAN OF CORRECTION</b></p> <p>All resident drug regimens, including the residents identified, have been reviewed to ensure they are free of unnecessary medications. The multidisciplinary team was re-inserviced on utilization of unnecessary medication. The Pittsburgh Sleep Index will be completed when resident indicates a disruption or impairment of their sleep. The multidisciplinary team will be responsible to ensure compliance</p>	08/05/14	

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F 329	<p>Continued From page 23</p> <p><b>MONITORING AND INDICATION FOR USE:</b></p> <p>Resident #4. The resident was admitted to the facility on [REDACTED] 10 with diagnoses to include depression, anxiety and dementia with behavioral disturbances.</p> <p>The medical record revealed that the resident was taking Buspar (an antidepressant/antianxiety medication) and Ativan (an antianxiety medication) as need for anxiety.</p> <p>On 03/24/14 the physician ordered an increase of the Buspar due to resident yelling and wanting to go home. The resident was also taking Ativan as needed.</p> <p>On 05/14/14 Zyprexa (an antipsychotic) was added for yelling out at night and an increase in resident's behaviors. The Buspar was discontinued due to increase agitation. (Per pharmacy reference: Zyprexa should be prescribed for schizophrenia and bipolar mania - mental illnesses. A 'black box' warning exists against Zyprexa use for dementia in the elderly related psychosis due to increase risk of death.)</p> <p>On 06/25/14 at approximately 8:15 a.m., Staff Member F, a nurse manager, stated that social services would update the care plan for the new medication Zyprexa and identify and input side effects of the medication and resident's target behaviors for monitoring. There was no AIMS (abnormal involuntary movement scale) assessment done for the resident, as recommended by the facility pharmacist, after beginning Zyprexa.</p>	F 329		

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F 329	<p>Continued From page 24</p> <p>During the interview on 06/25/14 at approximately 10:00 a.m., Staff Member D, the Social Services Director, stated that the nurses put the possible adverse side effects in the care plan and that social services should input the targeted behaviors in the resident's care plan.</p> <p>The facility failed to identify the resident indication for use of Zyprexa and it's effectiveness. The cause of the resident behavior was not established prior to or during it's use.</p> <p><b>MONITORING:</b></p> <p>Resident #9. Admitted to the facility on [REDACTED] 13 with diagnoses including anxiety and depression and [REDACTED] (anxiety in certain environments, mostly commonly public places). Her comprehensive assessment dated 06/11/14 revealed she also had short and long term memory problems, and required extensive assistance with most daily living activities.</p> <p>Review of the medical record revealed she was prescribed and received two antidepressant medications, Celexa and Remeron. For her mood disorder, she was also prescribed and received Depakote (an anticonvulsant medication sometimes used to treat mood disorders).</p> <p>Review of the care plan revealed the goal of the three medications was to reduce signs of depression and for mood stabilization. Direction to staff included monitoring, documenting and reporting to the physician any ongoing signs of depression or unstable mood, including refusal of care, agitation, crying, fear of being with others and other symptoms.</p>	F 329			

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F 329	<p>Continued From page 25</p> <p>On 06/20/14 at approximately 2:20 p.m., Staff Member D, the Social Services Director, reviewed Resident #9's electronic chart. She stated the target behaviors would be monitored by the Nursing Assistants (NA) and documented in the flow sheets in the electronic record. She explained that Resident #9 was discharged to the hospital on [REDACTED] 14 and returned [REDACTED] 14. She stated when the resident returned from the hospital, the monitoring of the target behaviors was not assigned to the NA's, so it had not been done since [REDACTED] 14 (16 days). She stated the target behaviors should have been monitored.</p> <p>On 06/23/14 at approximately 2:20 p.m., Staff Member E, a NA, stated she cared for Resident #9 regularly, and the resident could make her needs known and she used her call light if she needed something. She stated the resident did not have any behaviors, and the NAs did not monitor the resident for any behaviors.</p> <p>On 06/23/14 at approximately 2:40 p.m., Staff Member F, a Nurse Manager, stated social services was responsible for developing the monitors for target behaviors. But this monitoring was not being done.</p> <p>Resident #25. Admitted to the facility on [REDACTED] 14 with diagnoses including insomnia, memory loss and depression. Per review of the June 2014 physician orders and Medication Administration Record (MAR), the resident had received Trazodone every evening for the diagnosis of insomnia and celexa every day for diagnosis of depressive disorder.</p> <p>The 04/14/14 resident's care plan for "Psychotropic medication use" identified the</p>	F 329		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	<p>Continued From page 26</p> <p>resident's target behaviors (indication for its use) were: "loss of interest and trouble sleeping." The goal was "to be on the lowest dose of psychotropics" to treat the target behaviors for "improved quality of life without adverse side effects." The interventions listed were to review the resident's psychotropic medications quarterly and as needed.</p> <p>On 06/23/14 at 11:30 a.m., Staff Member H, the Director of Nursing, stated that a resident's hours of sleep documentation would be found on the MAR as well as monitors for adverse side effects of psychoactive medications.</p> <p>Review of the June 2014 MAR revealed no hours of sleep documentation and verified by Staff Member J, a Licensed Nurse, on 06/23/14 at 1:43 p.m. She stated "hours of sleep were usually documented on the MAR every shift when a resident was taking a routine sleep aid," however, there was no sleep monitor or monitor for signs of depression.</p> <p>On 06/23/14 at 1:55 p.m. Staff Member K, Social Services, stated there were no hours of sleep monitoring done for Resident #25 because she was admitted on Trazodone and "her medications seemed to be working ok for her." This she stated was determined by the absence of negative reports from nurses in the progress notes.</p> <p>Resident #69. Admitted to the facility on [REDACTED] 14 with diagnoses that include anxiety and cognitive communication deficit.</p> <p>The resident was diagnosed with insomnia</p>	F 329			

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F 329	Continued From page 27 (sleeplessness) and was given Trazodone (for sleeplessness) at bedtime.  The care plan failed to identify the monitoring for the Trazodone side effects and did not include the monitoring if the medication was effective.  On 06/20/14 at approximately 3:30 p.m., Staff Member D, the Social Services Director, stated she was unaware that there were no directives to staff for monitoring the resident's target behaviors. The nursing staff were to monitor for side effects of Trazadone and the hours the resident slept, but it was not being done.	F 329			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the consulting pharmacist conducted a complete and accurate review to identify irregularities for 1 of 6 sampled residents (#4) reviewed for unnecessary medications. Findings include:	F 428	see response on page 29		

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F 428	<p>Continued From page 28</p> <p>Resident #4. The resident was admitted to the facility on [REDACTED] 10 with diagnoses that include anxiety, depression and dementia with behavioral disturbances.</p> <p>An order for Zyprexa (an antipsychotic) was started on 05/14/14.</p> <p>The facility pharmacy consultant review for June 12, 2014, failed to notify the facility that there was not an appropriate indication for use for the medication Zyprexa. The diagnosis used was dementia with behavioral disturbances. There was no monitoring of target behaviors or adverse side effects of the medication by the facility.</p> <p>Failure to properly identify indication for use of the medication and target behaviors placed the resident at risk for adverse effects and an unnecessary medication.</p>	F 428	<p><b>F-428</b></p> <p><u>PLAN OF CORRECTION</u></p> <p>Reviewed survey findings with licensed pharmacist. AIMS completed for resident #4 on 6/25/14.</p> <p>Licensed pharmacist completed review for all residents to ensure compliance.</p> <p>Licensed Pharmacist was re-inserviced on guidelines for completion of medication regimen review.</p> <p>Director of Nursing will be responsible to ensure compliance</p>	08/05/14	