

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

PRINTED: 11/15/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/01/2013
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NAME OF PROVIDER OR SUPPLIER ROCKWOOD SOUTH HILL	STREET ADDRESS, CITY, STATE, ZIP CODE EAST 2903 25TH AVENUE SPOKANE, WA 99223
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Rockwood South Hill-Spokane on 10/28/2013, 10/29/2013, 10/30/2013, 10/31/2013, and 11/1/2013. A sample of 22 residents was selected from a census of 68. The sample included 19 current residents and the records of 3 former residents.</p> <p>The survey was conducted by:</p> <p>Jessica Wolfrum, R.N., B.S.N. Theresa Kochevar, R.N., M.S.N. Cindy CoVile, R.N., B.S.N.</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Long-Term Support Administration Division of Residential Care Services District 1, Unit B 316 West Boone Avenue, Suite 170 Spokane, Washington 99201-2351</p> <p>Telephone: (509) 323-7303 Fax: (509) 329-3993</p> <p><i>Loew Heiner</i> 11/15/13 Residential Care Services Date</p>	F 000	<p>The numbered responses below correspond to the required elements of a POC as follows:</p> <p>1: How the nursing home will correct the deficiency as it relates to the resident.</p> <p>2: How the nursing home will act to protect residents in similar situations.</p> <p>3: Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur.</p> <p>4: How the nursing home plans to monitor its performance to make sure that solutions are sustained</p> <p>5: Dates when corrective action will be completed (no more than 45 days from the last day of the Inspection)</p> <p>6: The title of the person responsible to ensure correction</p>	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT	F 225		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE CEO/Administrator	(X6) DATE 11/27/13
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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 225	<p>Continued From page 1 ALLEGATIONS/INDIVIDUALS</p> <p>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.</p> <p>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).</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>	F 225	<ol style="list-style-type: none"> 1. The Resident #49 was assessed at the time issue was noted during survey and the nickel size skin area to left inner thigh has resolved. A report was generated and an investigation was conducted which ruled out abuse and neglect. Based on the the nurses note written the day previous (9/5/13) in which she witnessed resident scratching area, an origin was identified. The Licensed Nurse was counseled to following regulatory requirements with established policy and procedure for completing reports on all injuries. 2. All Licensed nurses' were in-serviced on the importance of following the facility policy and procedure for completing the necessary assessments and reports for ruling out abuse/neglect. 3. All new LN will have 1:1 training on proper reporting and facility procedure. 4. Under the Revised Skin Care Protocol, the DNS and/or RCM will monitor the Treatment Administrator Record on a weekly basis for potential abuse/neglect occurrences. 5. Corrective action will be completed by 12/15/13. 6. The DNS will ensure compliance

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F 225	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, it was determined the facility failed to investigate an injury of unknown source, in an area not generally vulnerable to trauma, for 1 of 22 sample residents (#49) to rule out abuse and/or neglect. In addition, the facility did not report the injury (considered substantial according to the reporting guidelines because of its location) to the State Survey and Certification agency as required.</p> <p>Findings include:</p> <p>Resident #49 had diagnoses of dementia, arthritis, and chronic pain. The resident's record indicated she required extensive assistance with most activities of daily living (including bed mobility, transfers, personal hygiene and toileting).</p> <p>An Interdisciplinary Progress Note on 9/6/13 documented the resident had a red, nickel-sized area on her left inner thigh. Treatment orders were obtained on 9/10 for the "open area on upper thigh."</p> <p>There was no investigation to determine a cause, or to rule out abuse and/or neglect. The resident was not asked about the injury, and there were no interviews from direct-care staff. The injury was not included in the reporting log (a document mandated by law), and it was not called in to the State Survey and Certification agency as required.</p> <p>Staff #D was interviewed on 11/1/13 at 11:50 a.m. She was not aware resident #49 had an injury to her inner thigh. She acknowledged the proper steps were not taken to rule out abuse and/or neglect (i.e. an investigation). When the surveyor showed Staff #D the documentation of the initial discovery of the injury, she indicated the</p>	F 225		
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F 225 F 272 SS=D	Continued From page 3 licensed nurse was fairly new and may need additional training. 483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; 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.	F 225 F 272	1. Resident #44 had a head to toe assessment on 11/4/13 and found the noted skin lesion to be resolved. A progress note was written, and the care plan was modified to reflect the current resident status. The individual licensed nurse was counseled regarding the need to ensure accurate assessments and that the care planning process is adequately completed. 2. All Licensed nurses and the MDS team were educated on the scope and importance of accurate assessment and the care planning process. 3. The MDS team was re in-serviced on the importance of accurate assessment and care planning process. 4. Monthly review by the DNS, RCM and MDS coordinator of the QI/QM indicators, to ensure all pieces of the RAI process are followed. 5. Corrective action will be completed by 12/15/13 6. The DNS will ensure compliance	

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F 272	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to accurately assess a non-healing skin lesion for 1 of 4 residents (#44), in a sample of 22, with a skin condition. Findings include:</p> <p>Resident #44 had diabetes, high blood pressure, and memory impairment. He was admitted to the facility in [REDACTED]. The Admission Nursing Assessment dated [REDACTED] documented the resident had a scab on his right forearm.</p> <p>A physician progress note on 9/9/13 documented the resident has had a non-healing skin lesion on the right arm for about a year. He ordered a dermatologist (doctor specializing in disorders of the skin) consult, and on 9/30/13 the resident had a procedure requiring a treatment and application of a dressing.</p> <p>In reviewing the State mandated assessments done every 3 months by the facility (a total of 7 since admission), there was identification of an open lesion (possibly identifying the non-healing skin lesion) on only 1 of them - dated 6/18/13. In addition, the resident had a more thorough comprehensive assessment (a standardized tool required annually) on 9/16/13. There was no identification of the skin lesion. The care plan of October 2013 was reviewed - there was nothing with regard to the non-healing skin lesion, the dermatology procedure, or the need for further treatment and dressing changes.</p> <p>The resident was observed and interviewed on</p>	F 272		

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F 272	Continued From page 5 10/29/13 at 12:50 p.m. He had a dressing on his right forearm. Upon questioning, the resident stated he thought the area got "burned", but did not remember how or when. Staff #D was interviewed on 11/1/13 at 9:10 a.m. She was aware that the resident had a lesion on his forearm, and that he recently had a procedure. She indicated that any long-standing skin issue should have been thoroughly assessed and care planned upon admission, and at the time of the subsequent comprehensive assessment completed September 2013.	F 272			
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 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. This REQUIREMENT is not met as evidenced	F 280	1. Resident #39 and #1 were assessed and care planning was modified to reflect the current status of each individual. 2. All licensed nurses and the MDS team were in-serviced on the requirements and importance of the RAI process, with emphasis on accurately performing assessments and care planning updates. 3. The individual licensed nurse was counseled on the importance of accurate assessment and care planning process. 4. A copy of the updated care plan problem and the Care Tracker Individual Plan report will be stapled to all fall incident reports. 5. corrective action will be completed by 12/15/13 6. The DNS will ensure compliance.		

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F 280	<p>Continued From page 6</p> <p>by: Based on observation, interview, and record review, it was determined the facility failed to review and revise care plans after continued falls and impulsive behaviors for 2 of 4 residents (#39,1), reviewed for falls, in a sample of 22. Findings include:</p> <p>1. Resident #39 had diagnoses of hip fracture and dementia. The resident had been re-admitted to the facility in [REDACTED] after a fall with a hip fracture. A review of the resident's falls after her re-admission was done at the time of the survey. The resident had additional falls on 8/24/13, 8/30/13 and 10/19/13. The resident continued to have restlessness and impulsive behavior, resulting in multiple attempts to self-transfer. The facility did not consistently analyze the reason for the behaviors, or consistently modify the care plan after the falls. After the fall on 8/30/13, the Post Fall Assessment documented the corrective action was for staff to toilet the resident more frequently at night, and ensure her call light was clipped to her gown - this information was not added to the care plan. Failure to modify the care plan after repeated incidents placed the resident at risk for additional falls and possible unresolved needs related to the restless and impulsive behavior.</p> <p>2. Resident #1 had dementia, osteoporosis, and a history of a leg fracture. The resident had a history of falls when admitted. A review of the resident's falls in the past 6 months was done at the time of the survey. The resident fell on 4/28/13, 5/13/13, 6/29/13 and 8/25/13. In reviewing both the investigations of the falls and the Interdisciplinary Progress Notes,</p>	F 280			

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F 280	Continued From page 7 the resident was identified as being confused, restless and impulsive. The facility did not consistently analyze the reason, or modify the care plan accordingly. A fall assessment (not dated) documented the resident should be placed in high traffic areas - this intervention was not on the current care plan. Staff #D was interviewed on 11/1/13 at 9:10 a.m. regarding residents #39 and #1. She agreed that care plans should be reviewed and revised after incidents in an effort to prevent their re-occurrence. Failure to modify the care plan after repeated incidents placed the resident at risk for additional falls and possible unresolved needs related to continued restlessness and impulsive behavior.	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide the necessary care and services for 2 of 4 residents (#44, 49), in a sample of 22, with alterations in skin integrity. Findings include: 1. Resident #44 had diabetes, high blood pressure, and memory impairment. He had been	F 309	1. Resident #44 and #49 had complete head to toe assessments and the areas reported during survey are completely resolved. 2A. All licensed nurses were in-serviced on changes to the Skin Care Protocol Policy and Procedure which includes weekly documentation in the nursing progress notes to coincide with the weekly skin checks. 2B. All licensed nurses were in-serviced on the timely processing of all medication orders. 3. Weekly documentation of current skin issues will be made in the nursing progress notes to coincide with the weekly skin check.		

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F 309

Continued From page 8
in the facility for a little over 1 year.
A physician's progress note on 9/9/13 documented the resident had a non-healing skin lesion on the right arm for about a year. The physician ordered follow-up by a dermatologist (a doctor specializing in skin disorders), and on [REDACTED] the resident had a procedure which required additional treatment and dressing changes when he returned to the facility.
In reviewing the resident's record, facility staff identified a "scab" on his right forearm on the Admission Nursing Assessment (dated [REDACTED]). In addition, the facility is required to complete (and submit to the state) a resident assessment every 3 months. The only identification of an open lesion on that assessment was on 6/18/13 - 6 other assessments were done before/after with no documentation of any skin problems.
A review of the facility treatment records revealed that the staff were documenting whether or not the lesion was healing - a + meant healing, a - not healing. All documentation was a +, despite the fact the lesion remained for over a year. There was no description of the wound. The lesion was not on the care plan.
After the resident returned from the dermatologist on 9/30/13, and was receiving wound care and dressing changes, there was no description of the wound - the record did not contain any information about what procedure had been done. An Interdisciplinary Progress note on that day documented the resident returned from the dermatologist with orders for additional care and treatment. There were no other entries related to the lesion/skin alteration. The resident was observed to have a dressing in place over the area on 10/29/13 at 12:50 p.m. He stated that he thought the area had been "burned" but wasn't sure. He was unable to state

F 309

4. Weekly audits of skin documentation will be completed by the DNS and RCM
5. Corrective action will be completed by 12/15/13
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F 309	<p>Continued From page 9</p> <p>how long the wound had been present, but he thought it was a long time.</p> <p>The facility failed to identify the lack of healing of the lesion, thoroughly assess the wound (both before and after treatment by a dermatologist), or include it in the care plan.</p> <p>In addition, resident #44 had a yeast rash to the groin, initially identified on 9/3/13. Most of the documentation was "red groin" with no actual description of the size and/or general appearance of the area. Several of the skin assessment notes said "no new skin issues." There was disparity in the facility +/- documentation as well. Some LN staff indicated the area was healing (by using a +) - some indicated it was not healing (by using a -). A fax to the physician on 10/10/13 documented the resident was having continued redness and irritation for 4 weeks and asked for an additional treatment. Despite the fact the area was not improving, there was not a thorough assessment/description of the area. The new treatment was done once daily from 10/16/13 through the end of October (the actual order was for the cream to be applied twice daily as needed to the "rash"). The last entry in the record was on 10/29/13, which indicated the cream was applied to the reddened groin.</p> <p>The facility failed to determine whether/not the rash was improving because they had not done a thorough assessment of the area (either before or after the additional treatment was added). This skin alteration was not part of the care plan.</p> <p>2. Resident #49 had dementia, arthritis, and chronic pain. She was receiving Hospice services for severe anemia. She required extensive assistance with most activities of daily living. An Interdisciplinary Progress Note on 9/6/13</p>	F 309		
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F 309	Continued From page 10 documented the resident was found to have a nickel sized red area on her inner thigh. No other assessment/description of the area was found. On 9/9/13, a Hospice social worker met with the resident. A staff person told her at that time about the red area on the inner thigh, as well as a possible yeast infection. She contacted the Hospice LN who initiated a treatment order for the open area on the thigh. Facility LN staff started the treatment on 9/11/13 - 5 days after the area was discovered. There was no additional description of the area on the thigh or any documentation related to a possible yeast infection. An Interdisciplinary Progress Note on 10/18/13 documented the Hospice nurse had been in to see the resident, and was going to order Nystatin (typically used for yeast infections/rashes). The facility nurse who wrote the note did not identify what the medication was to be used for, or describe the skin alteration which necessitated this treatment.	F 309			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure the residents environment was free from	F 323			

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F 323	<p>Continued From page 11</p> <p>potential accident hazards related to unsecure decor on resident room walls. Further, the facility failed to consistently implement planned interventions for 2 of 4 sample residents (#1,39) in accordance with the residents comprehensive care plan related to falls. Findings include:</p> <p>Environment</p> <p>1. During rounds throughout all days of survey 10/28 - 11/1/13, all resident rooms were observed with a 2-3" wide shelf attached to the wall, (shelves ranged in length from approximately 5-15' long). Items placed on the shelves included, but not limited to, large and small framed pictures, knick knacks, vases, clocks, plaques etc. The smaller pictures fit snugly in a pre-manufactured groove on the shelves, however the larger pictures/items were unsecure with the potential of falling off the shelves in the event of a natural disaster.</p> <p>During an interview 11/1/13 at 7:30 a.m., Staff #B verified the residents have some large framed pictures and other items on the shelves that are not secure and because the smaller framed pictures fit in the grooves, they are more secure. He further commented that the families like to bring in pictures, especially on the weekends and they place them on the shelves. "Honestly, they are not secure and probably would not be safe in the event of an earthquake."</p> <p>The facility failed to ensure that the residents environment was free of potential accident hazards.</p> <p>Falls</p>	F 323	<p>1A. The shelves which are a part of the original building plans from 2000 were inspected. All heavy items on shelves were removed and/or secured.</p> <p>1B. Resident #39 and #1 were assessed and care planning was modified to reflect the current status of each individual.</p> <p>2A. Signs were placed under each shelf to alert families and residents not to place items on the shelves without first consulting a nurse. A letter was sent from the CEO/Administrator to all families informing them of safety changes.</p> <p>2B. All licensed nurses and the MDS team were in-serviced on the importance of the RAI process, with emphasis on accurately performing assessments and care planning updates.</p> <p>3A. Daily room rounds will be completed by DNS, RCM, and Nursing staff members to include observations related to inappropriate items on the shelves.</p> <p>3B. The individual licensed nurse was counseled on the importance of accurate assessment and care planning process.</p> <p>4A. Periodic monthly audits of all room shelves, will be reported to the QA committee to ensure compliance.</p> <p>4B. A copy of the updated care plan problem and the Care tracker individual plan report print out will be stapled to fall reports and compared for accuracy.</p>		

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F 323	<p>Continued From page 12</p> <p>1. Resident #39 had diagnoses of dementia and osteoporosis. Per the record, she was re-admitted in [REDACTED] after having a fall at the facility and fracturing her hip. The record documented the resident was confused at times, restless, and impulsive.</p> <p>Investigations of falls after readmission to the facility were reviewed. On 8/24/13, the resident was found by family on the floor in her room. The resident was trying to self-transfer. The staff did not follow the care plan intervention to leave the resident's door open so she could be watched. The reason why the resident tried to self-transfer was not explored.</p> <p>The resident fell again on 8/30/13 attempting to take herself to the bathroom. The corrective measures of increasing the frequency of her toileting schedule and ensuring her call light was clipped to her gown were never added to the plan of care.</p> <p>She fell on 10/19/13 - the resident stated she was trying to answer the phone (which was within reach). The care plan was not modified in any way after the incident.</p> <p>Licensed nurses had been tracking the number of times the resident triggered her fall alarm - which would sound when she tried to self-transfer or stand. In reviewing both those records and the Interdisciplinary Progress Notes, the resident continued to exhibit restlessness, confusion and impulsivity. An assessment of possible causal factors for these behaviors was not present in the record.</p> <p>The resident was observed periodically throughout the survey. The door to her room was shut (with the resident inside) on several occasions including the morning of 10/29/13, 12:10 p.m. on 10/31/13, and the morning of 11/1/13.</p>	F 323	<p>5A. Corrective action will be completed by 11/22/13</p> <p>5B. Corrective action will be completed by 12/15/13</p> <p>6. The DNS will ensure compliance</p>	
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F 323	<p>Continued From page 13</p> <p>The facility failed to consistently follow care plan interventions for injury prevention, and assess possible causal factors for continued confusion, restlessness and impulsiveness. This placed the resident at risk for additional falls and possible unmet needs.</p> <p>2. Resident #1 had dementia, osteoporosis, and a history of a leg fracture. She was identified as a high fall risk.</p> <p>A review of the resident's falls was done at the time of the survey. The resident fell on 4/28/13. Staff had failed to follow the care plan interventions of ensuring she had a fall alarm in place, not leaving her wheelchair next to the bed, and placing a fall mat by the bed. In addition, the investigation of the incident indicated the resident had been restless, but did not determine why.</p> <p>The resident fell again on 5/13/13. Staff had failed to place the fall alarm, and the wheelchair was determined to be too close to the resident (causing her to try and reach it). The resident was again identified as restless and impulsive. No analysis of the cause for these behaviors was in the record (i.e., pain, hunger/thirst, need to toilet, etc.). The care plan was not modified after this incident.</p> <p>A fall assessment (undated) documented the resident should be left in high traffic areas as she would allow - this intervention was not present on the care plan. The resident was observed several times during survey in her wheelchair in her room.</p> <p>The resident fell on 6/29/13. The bed was found to not be in the locked position, and the resident was found between the bed and the wall. The primary cause of the fall was determined to be restlessness, but there was no analysis of why she was restless.</p>	F 323		
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F 323	Continued From page 14 The facility failed to consistently follow care plan interventions for injury prevention, and to assess possible causal factors for continued restless. This placed the resident at risk for additional falls and possible unmet needs.	F 323	1. Resident #36 was assessed by the nutrition committee and appropriate interventions were identified and implemented. The policy for Weekly Weight Committee was revised and implemented.		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to assess, monitor, implement planned interventions and re-evaluate continued weight loss for 1 of 7 residents (#36) reviewed for nutrition in a sample of 22. Findings include: Resident #36 had diagnoses including dementia and depression. Per record review, on [REDACTED] the resident was admitted to the facility with a baseline weight of 130.5 pounds. The resident required assistance with eating and was at risk for weight loss. Per facility policy, the resident was to be weighed weekly and monitored for weight changes.	F 325	2. The Policy and Procedure for obtaining weights was revised. A Policy and Procedure for the Weight Review committee was written which delineates the parameters for weight evaluations. The Policy and Procedure for Every Bite Counts program was revised. The weekly weight review will be the determining factor for intervention effectiveness. 3. The Policy and Procedure for obtaining weights was revised. A Policy and Procedure for the Weight Review Committee was written which delineates the parameters for weight evaluations. The Policy and Procedure for Every Bite Counts program was revised. The weekly weight review will be the determining factor for intervention effectiveness. 4. A weekly weight assessment through the committee will be monitored by the DNS and/or RCM and reported periodically to the Quality Assurance Committee. 5. Corrective action will be completed by 12/15/13 6. The DNS will ensure compliance.		

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F 325	<p>Continued From page 15</p> <p>On 6/6/13 the resident's weight was documented at 132 pounds. The resident was not weighed again for two weeks (6/21/13), at which time her weight was 120 pounds for a total loss of 12 pounds (9% of her body weight), in 15 days. Although this represented a significant unplanned weight loss for the resident, the facility did not identify the loss, evaluate the potential causes, or put new interventions in place to prevent further weight loss until 7/9/13 (18 days later) when the Nutrition Committee recommended fortified, high calorie foods to the resident's diet.</p> <p>The resident's weight stabilized between 124 to 128 pounds during August and September 2013. On 9/26/13 the resident's weight was documented at 128 pounds. Per review of the weight record, no other weights were documented until 10/9/13. On 10/9/13 the resident's weight was 121 pounds demonstrating a loss of 7 pounds (5% of her body weight), in 13 days. Again, there was no documentation to indicate the facility identified, evaluated, or intervened to prevent further weight loss.</p> <p>On 10/15/13, the Nutrition Committee recommended the resident receive shakes with the dinner meal, at bedtime and to monitor the amount consumed. On 10/16/13, the resident's weight declined to 118.5 pounds, reflecting a total loss of 9.5 pounds (8% of her body weight). Per review of the medical record, there was no documentation to indicate the resident was receiving/accepting the shakes per the plan of care and/or monitoring of the resident's overall intake.</p> <p>During an interview on 11/1/13 with Staff #C (Registered Dietary Technician), she could not explain why the weight loss had not been evaluated, followed-up on, or referred to the Dietary Technician and/or Registered Dietician.</p>	F 325		

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F 325	Continued From page 16 "We dropped the ball on this one". Further, they were "offering" the shakes to the resident and because there was no specific physician order for the shakes, they were not tracking and/or documenting resident's intake, refusals etc. During an interview on 11/1/13 at 9:30 a.m., the resident could not recall if she was getting a shake or not. "I just eat what they give me." The failure of the facility to identify, evaluate, intervene timely with changes to the plan of care, and consistently implement planned interventions placed the resident at risk for a decline in her condition related to weight loss.	F 325			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	1A). The staff member who inadvertently did not push the medication drawer with enough force to ensure the auto-lock feature was engaged, was counseled on the importance of complete closure of the medication cart. 1B). The staff member was counseled on the importance of not leaving medications at the bedside, without proper assessment and care planning to ensure safety. 2A). A mandatory in-service was held to ensure all licensed nurses are aware of the importance of complete cart closure prior to leaving the area. 2B). A in-service was held to instruct staff on the the need for proper assessment and documentation for resident safety and the necessity of following the self-medication protocol according to resident needs. 3. The DNS and RCM will perform random walk through "rounds" to ensure medication drawers are fully secured and no medications are being left at the bedside. 4. Monitoring will continue with audits to observed medication pass, performed by pharmacy service, DNS and RCM. 5. Corrective Action will be completed by 12/31/13		

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F 431	<p>Continued From page 17</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that medications were locked, supervised, and inaccessible to residents on 1 of 2 medication carts. Findings include:</p> <p>1. On 10/30/13 at 10:55 a.m., the South medication cart was unlocked and unsupervised. The cart was located by a common area where residents watch TV, read etc. There was no facility staff in the immediate area. A confused resident, sitting in a wheel chair next to the medication cart, opened two drawers on the cart thus allowing her access to the medications. The resident proceeded to go through items located on the side of the medication cart, obtaining a stethoscope and blood pressure cuff and then wheeled down the hall with the items.</p> <p>Facility staff working in the dining room adjacent to the cart were notified by surveyor of the unlocked cart. A staff person stood by the cart until Staff #A came down the hall, realized the cart was unlocked and open and she immediately locked the cart. The licensed nurse verified the medication cart was to be locked at all</p>	F 431	6. The DNS will ensure compliance	

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F 431	<p>Continued From page 18 times.</p> <p>2. On 10/30/13 at 8:00 a.m., Resident #57 was up eating breakfast and watching TV. A souffle cup containing approximately 5-6 pills and another cup containing 1 pill were sitting on the bedside table where the resident was eating. The resident commented, "the nurse left those for me to take, sometimes they stay and watch, other times leave them for me to take. Inconsistent." The resident resided in a semi-private room, sharing the room with another resident. During an interview with Staff #A, she commented, "I don't always leave them, he can be slow so I will leave them and keep checking back to make sure he takes them".</p> <p>Failure to keep medications locked and supervised at all times placed residents at risk for potential injury/accidents related to the improper ingestion of medications.</p>	F 431		
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