

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505291</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>RIVERVIEW LUTHERAN CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1841 EAST UPRIVER DRIVE SPOKANE, WA 99207</b>
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F 000 INITIAL COMMENTS

This report is the result of an unannounced Quality Indicator Survey conducted at Riverview Lutheran Care Center on 5/19/14, 5/20/14, 5/21/14, 5/22/14, 5/23/14, 5/27/14 and 5/28/14. A sample of 32 residents was selected from a census of 67. The sample included 27 current residents and the records of 5 former and/or discharged residents.

The survey was conducted by:

Linda Loffredo, R.N., B.S.N.  
Lisa Harting, R.N., B.S.N.  
Colleen Daniels, R.N., B.S.N.  
Jessica Wolfrum, R.N., B.S.N.  
Jessica Dingwall, M.S.W.  
Kathleen Robl, R.N., B.S.N.

The survey team is from:

Department of Social & Health Services  
Aging & Long-Term Support Administration  
Division of Residential Care Services District 1,  
Unit A  
316 West Boone Avenue, Suite 170  
Spokane, Washington 99201

Telephone: (509) 323-7302  
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Residential Care Services Date 6/10/14

F 000

Riverview Lutheran Care Center takes great pride in providing a quality environment for residents and their families. We take each and every comment seriously and respond quickly and appropriately to these concerns.

The completion of this plan of correction is done to comply with requirements of Medicare/Medicaid certification. The completion of this form in no way implies agreement with or implies admission to any and all liability to the allegations found within in this document.

**RECEIVED**

JUN 16 2014

DSHS ADSA RCS  
SPOKANE WA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE  	TITLE  <u>Administrator</u>	(X6) DATE  <u>6/16/2014</u>
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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 observation, interview, and record review, it was determined the facility failed to inform 1 of 7 residents (#150) prior to starting a</p>	F 157	<p>F157</p> <p>The completion of this plan of correction is done to comply with requirements of Medicare/Medicaid certification. The completion of this form in no way implies agreement with or implies admission to any and all liability to the allegations found with in this document.</p> <p>1. This facility corrected this deficiency as it relates to this resident by discontinuing and changing the medication to one the resident requested on 5/11/14. The nursing home will protect other residents in similar situations by inserviceing all licensed nurses as it relates to medication changes. This will include having the charge RN notify resident or POA of medication changes. The charge RN will get residents who have decisional capacity to sign consents</p>	7/7/14
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F 157	<p>Continued From page 2</p> <p>new medication; and failed to notify the physician timely regarding sleep problems for 1 of 7 (#37) residents in a sample of 32. Findings include:</p> <p>1. Per record review, Resident #150 was admitted for specialized rehabilitation services after [redacted] surgery. The resident had no memory or decision-making problems.</p> <p>Review of the resident's record revealed on 5/7/14 the facility obtained physician orders for [redacted] an [redacted] medication, and administered 2 doses to the resident on 5/8 and 5/9/14. On 5/10/14 and 5/11/14, the resident refused the medication.</p> <p>Additional record review revealed the facility did not discuss the risk/benefits of [redacted] with the resident until 5/13/14, when he declined the medication in writing on the medication consent form.</p> <p>On 5/20/14 at 2:25 p.m., the resident stated one morning he looked carefully at his morning medications and thought there were more pills than there should be. That was when he found out staff was giving him [redacted] without first informing him. He refused the [redacted] and obtained an order for a different [redacted] when he visited his doctor.</p> <p>In an interview on 5/27/14 at 2:15 p.m., Staff #K confirmed the resident should have been informed and given consent before taking [redacted]</p> <p>2. Per record review, Resident #37 had diagnoses including heart and breathing problems. The resident had no memory problems, and had mood problems including difficulty sleeping.</p> <p>During interview with the resident on 05/20/2014 at 09:22 a.m., Staff #M came in the</p>	F 157	<p>for antidepressants or psychotropic medications prior to being administered. Riverview will monitor this correction by checking medication consents during our weekly mental wellness meeting. This corrective action will be completed by 7/7/14. The Director of Nursing Services will be responsible to ensure the correction.</p> <p>2. This facility has corrected this deficiency as it relates to this resident by moving the resident to a private room. This setting has resulted in improved sleep without a pharmacological intervention. To protect residents in similar situations all staff will be inserviced on communicating resident needs and requests. Riverview will continue to use the IPC book as a communication tool between our staff to our Doctor. This facility will continue to monitor sleep issues with our weekly mental</p>	
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F 157	Continued From page 3 resident's room to administer medications. The resident asked Staff #M about an order for Melatonin, an over-the-counter supplement often prescribed for sleep. Staff #M stated she would talk to the charge nurse about contacting the physician. When the interview resumed, the resident stated about 10 days ago, staff talked about obtaining a physician order for Melatonin and she didn't have an order for it yet. During interviews on 5/23/14 at 11 a.m. and 5/27/14 at 2:15 p.m., Staff #K was informed of the resident's request for information about Melatonin. Staff #K stated the mental wellness committee reviewed the resident's medication regimen on 5/5/14 and recommended Melatonin at that time. There was no information to indicate the recommendation was ever discussed with the physician. In addition, Staff #K confirmed there was no information to indicate staff followed up with the resident about ongoing sleeping problems until 5/23/14 when the facility started to monitor the resident's sleep pattern.	F 157	wellness meeting. These meetings will also serve to monitor our communication protocol to ensure our practice is sustained. This corrective action will be completed by 7/7/14. The Director of Nursing Services will be responsible to ensure the correction.		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS  The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.  Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  Except as provided in paragraph (e)(3) of this	F 164	F164  The completion of this plan of correction is done to comply with requirements of Medicare/Medicaid certification. The completion of this form in no way implies agreement with or implies admission to any and	7/7/14	

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

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F 164	<p>Continued From page 4 section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to protect personal privacy for 1 of 1 residents (#142) in a sample of 32 by not consistently providing female care givers during personal cares. Findings include:</p> <p>Resident #142 had diagnoses that included [REDACTED] 3 Per record review, the resident was alert and oriented and able to make her needs known. She required extensive assistance with activities of daily living (ADL's). During an interview on 5/19/14 at 2:45 p.m., Resident #142 was asked if staff provided privacy when working with her. She stated she had requested female care givers only but sometimes ended up with males because the facility didn't have enough staff. In a follow up interview on 5/27/14, she preferred female care givers because she didn't like the idea of a man</p>	F 164	<p>all liability to the allegations found with in this document.</p> <p>This facility has corrected this deficiency as it relates to this resident by educating direct care staff and updating care plans to reflect resident request. To protect residents in similar situations, this facility will continue to place caregiver preferences and requests on the census sheet as well as the care plan. To ensure staff is following these requests, we will conduct resident interviews and do random hall observations will be conducted for four weeks. This corrective action will be completed by 7/7/14. The Director of Nursing Services will be responsible to ensure the correction.</p>	
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F 164 Continued From page 5 dressing her.  
Per review of the resident's plan of care, there was nothing documented about the resident's preference for female care givers.  
During an interview on 5/28/14 at 9:44 a.m., Staff #1 stated that if a resident wanted to have female care givers only then the facility accommodated that. He stated that an assessment would be done to find out specifically what care they only want females for, such as toileting or dressing, and it was then put on the resident's care plan.

F 241 SS=E 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  
The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to promote dignity related to dining services for 2 of 32 sample residents (#76, #142) and potentially all residents who received hall trays in the east and south halls. This failure had the potential to negatively impact the residents' quality of life. Findings include:

During observation of lunch on 5/9/14 at 12:08 p.m., 5 residents residing in the east and south halls in the facility were served lunch in their rooms. Each resident's meal was served on a tray with plastic utensils, and plastic dishware for desserts and salads.

F 164

F 241

F241

The completion of this plan of correction is done to comply with requirements of Medicare/Medicaid certification. The completion of this form in no way implies agreement with or implies admission to any and all liability to the allegations found with in this document.

This facility corrected this deficiency as it relates to these residents by providing metal silverware and ceramic plates on all room trays this correction was made immediately 5/28/14. To protect residents in

7/7/14 MLE

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F 241	<p>Continued From page 6</p> <p>On 5/19/14 at 12:22 p.m., Resident #76 stated she ate all her meals in her room and was always served plastic utensils. She stated she did not know why she did not receive silverware but thought it was a "waste."</p> <p>On 5/21/14 at 8:47 a.m., Resident #142 was observed eating breakfast in her room using the plastic utensils that had been provided on her meal tray.</p> <p>On 5/23/14 at 12:13 p.m., Resident #142 was observed sitting in her room eating lunch using the plastic utensils from her tray. When asked about the plastic utensils she stated, "I hate them". When asked if she could cut her food with the knife she stated, "Not really, but I find a way to make it work".</p> <p>On 5/27/14 at 3:35 p.m., Staff #J, the Dietary Manager, stated it was the facility's routine practice to use disposable plastic utensils on room trays. He stated they used to use real silverware but were now using the plastic utensils because they came pre-wrapped and it kept them covered while being transported from the kitchen to the residents' rooms.</p>	F 241	<p>similar situations this facility will in service all dietary staff on the practice of using metal silverware for all room trays. The Dietary manager will audit room trays for four weeks to ensure staff is following procedure. This corrective action will be completed by 7/7/14. The Director of Nursing Services will be responsible to ensure the correction.</p>	
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p>	F 279	<p>F279</p> <p>The completion of this plan of correction is done to comply with requirements of Medicare/Medicaid certification. The completion of this</p>	7/2/14

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F 279

Continued From page 7

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).

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, and record review, it was determined the facility failed to develop and implement a comprehensive care plan for bilateral hand splints for 1 of 2 (#155) residents reviewed for range of motion in a sample of 32. Findings include:

Per record review, Resident #155 had bilateral wrist fractures which originally needed bilateral casts and then had been transitioned to a brace/splint to maintain stabilization. The resident had used a wheelchair and a platform walker for mobility. Resident #155 needed assistance with her daily cares and occasionally experienced pain due to her injury.

Per the resident's care plan dated 5/15/14, instructions under dressing had been to "please gently move my arms because the casts are heavy." This was the only reference in regards to the casts in the resident's care plan.

Per record review on 5/20/14, the resident had an order from the doctor to wear the new wrist braces/splints except when eating, during hygiene, with physical therapy and at night.

On 5/21/14, a progress note referred to the braces/splints being placed on wrists.

F 279

form in no way implies agreement with or implies admission to any and all liability to the allegations found with in this document.

The facility corrected this deficiency as it relates to this resident by updating the care plan to reflect current splint application directions. To protect other residents in similar situations Riverview will notify the therapy department via email and hard copy of any order changes that would affect a resident's care plan. Our internal care plan auditor will also be notified of requested changes to care plan in order to monitor and ensure the necessary changes have been made. The facility will inservice staff, including the therapy department on the new procedure. This corrective action will be completed by 7/7/14. The Director of Nursing Services will

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F 279	<p>Continued From page 8</p> <p>During an interview on 5/22/14 at 11:00 a.m., Staff #C reported the splints had to be on 24/7 which included wearing the braces/splint at night with an exception to have them off while being bathed.</p> <p>On 5/23/14 at 1:00 p.m., Staff #A reported the therapist would be responsible for updating the care plan for any therapy changes.</p> <p>On 5/27/14 at 9:00 a.m., Resident #155 was sitting slouched in her manual wheelchair near the nurses station. The resident did not have any wrist splints on at this time and her wrists were observed not in alignment and bent when she moved them. Shortly after at 9:30 a.m., the resident had a splint on her left wrist but not her right wrist.</p> <p>Staff #E stated on 5/27/14 at 9:30 a.m., he was not sure what the splint schedule was and asked to look at the care plan posted inside the resident's closet door. After he looked at the care plan he stated there was no instructions or schedule for the wrist splints.</p> <p>During an interview with Staff #F on 5/27/14 at 9:52 a.m., she stated the resident did not have a schedule for the wrist splints and believed the splints could be off with cares, bathing and at night.</p> <p>Staff #B stated on 5/27/14 at 11:20 a.m., the resident should wear the splints all the time with exception to be off during bathing, hygiene, and skin care. Staff #B stated the splints needed to be on during the night per the doctor's orders. Staff # B stated the therapy staff communicates with the nursing staff by making changes to the care plan and the care plan is posted inside the residents closet door for reference.</p> <p>The resident's care plan was not accurate or updated since it still referenced casts on the resident's wrists. The resident had the casts</p>	F 279	be responsible to ensure the correction.	
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F 279	Continued From page 9 removed and braces/splints applied on 5/20/14. The care plan did not have any objectives or interventions in regards to the bilateral wrist braces/splints which caused the staff to provide inconsistent care which could potentially interfere with the progress for the resident and increase the resident's pain level.	F 279		
F 309 SS=D	<b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  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 interview and record review, it was determined the facility failed to provide necessary care and services for 1 of 2 (#80) residents reviewed for dialysis management in a sample of 32. Findings include:  Resident #80 had diagnoses that included diabetes and end stage renal disease. Per record review, the resident went to dialysis (process to filter blood to maintain kidney function) three days a week at an outside facility. Per review of the resident's treatment record, it directed staff to remove the resident's dressing over the fistula (connection of an artery to a vein for access during dialysis) and to monitor the site for signs and symptoms of infection upon returning from dialysis.	F 309	F309  The completion of this plan of correction is done to comply with requirements of Medicare/Medicaid certification. The completion of this form in no way implies agreement with or implies admission to any and all liability to the allegations found with in this document.  The facility corrected this deficiency as it relates to this resident by immediately (5/27/14) creating a post dialysis policy and procedure. A batch order was created to ensure that the assessments are completed. All	7/7/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505291</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
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F 309 Continued From page 10

Per review of the resident's plan of care, there was no care plan directives on monitoring the fistula on the days he did not attend dialysis.

On 5/20/14 at 3:00 p.m., the resident was interviewed but was unable to answer questions about his fistula.

Per interview on 5/27/14 at 2:40 p.m., Staff #R stated that the dressing was taken off the fistula when the resident returned from dialysis.

On 5/28/14 at 9:20 a.m., Staff #H stated she removed the resident's dressing after dialysis and checked the fistula at that time. She stated nothing was done with the fistula on non dialysis days.

On 5/28/14 at 10:00 a.m., Staff #O stated the fistula was supposed to be checked each shift and that would be documented in the progress notes. Per record review, no documentation was found in regards to checking the fistula.

The facility failed to consistently monitor the resident's fistula which placed him at risk for complications which could include bleeding and/or clotting of the fistula site.

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.

F 309

licensed nurses will be inserviced on the policy and procedure. The batch orders were created to ensure that assessments will not be missed by licensed nurses for future dialysis patients. This corrective action will be completed by 7/7/14. The Director of Nursing Services will be responsible to ensure the correction.

F 325

F325

The completion of this plan of correction is done to comply with requirements of Medicare/Medicaid certification. The completion of this form in no way implies agreement

7/7/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505291</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
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F 325	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to develop and implement interventions to maintain nutritional parameters for 1 of 3(#13) residents reviewed for nutrition in a sample of 32. This failure created the potential for poor nutritional management and unplanned weight loss. Findings include:</p> <p>Resident #13 was admitted on <b>1</b> 13 weighing <b>3</b> lbs. Per the nutritional assessment completed on 12/11/13 the resident's acceptable body weight was <b>3</b> lbs. Her calculated body mass index (BMI) was 21.8, this was determined to be at the low end of acceptable. Resident #13 was placed on a regular diet with a goal to maintain a weight between <b>3</b> lbs.</p> <p>Per record review on 1/2/14 Resident #13 weighed <b>3</b> lbs ( a five pound or 4.4% loss).</p> <p>Per record review the nutritional committee met on 2/5/14, due to Resident #13's weight loss of 5 lbs in 2 weeks. Resident #13's weight was <b>3</b> lbs ( a ten pound or 8.9% loss in one month). The committee determined the resident was to remain on a general diet with an intervention of calorie dense features added to meals ( adding additional calories to meals). Her weight goal remained <b>3</b> lbs.</p> <p>On 2/26/14 Resident #13 weighed <b>3</b> lbs, a 12 lb decease in less than 3 months. No changes were made to her diet and no additional interventions were put into place.</p> <p>Per record review between 3/6/14 and 5/8/14 the resident lost an additional 4 lbs. The nutrition committee met on 3/7/14 and determined Resident # 13 had a decrease in</p>	F 325	<p>with or implies admission to any and all liability to the allegations found with in this document.</p> <p>The facility corrected this deficiency as it relates to this resident by adding second stage intervention of high protein shakes to meals and snacks. The Medical Director was notified of weight loss, and the care plan was updated to reflect the resident's new weight goal. To protect residents in similar situations dietary staff will be inserviced on documentation of supplements accepted at meals, and on documentation of other interventions that are offered. To ensure that this issues does not recur, there will be random audits of dietary staff regarding the accuracy of their meal monitoring by the dietary manager. Riverview will monitor its performance and sustain solutions through audits of weight loss/poor</p>		

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F 325	Continued From page 12 appetite but no additional interventions were put into place. On 5/8/14 Resident #13 weighted <b>3</b> lbs. On 5/22/14, the nutrition committee determined the resident was continuing to feed herself and her weight was trending down. Per interview on 5/20/14 at 10:30 a.m., Resident #13 stated she had no concerns with the taste of the facility food. Resident #13 was observed on 5/22/14 during lunch service in the main independent dining room. She slowly ate approximately 50-75% of her meal with encouragement. During an interview on 5/27/14 at 3:10 p.m., Staff #N stated Resident #13 is at her ideal body weight at <b>3</b> lbs, she had been meaning to change her assessment but had not done it. Staff #J stated if a resident eats less than 50 % of their meal they receive a supplement and it is documented. During the interview Resident # 13's meal monitor was reviewed and it was confirmed no supplements had been consumed by resident. The facility failed to ensure interventions were in place to maintain this resident's nutritional well-being and created the potential for poor nutritional management and unplanned weight loss.	F 325	appetite and documentation at weekly nutrition committee meetings with multiple disciplines. This corrective action will be completed by 7/7/14. The Director of Nursing Services will be responsible to ensure the correction.	
F 431 SS=E	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.	F 431	F431  The completion of this plan of correction is done to comply with requirements of Medicare/Medicaid certification. The completion of this	7/7/14

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F 431	<p>Continued From page 13</p> <p>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.</p> <p>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.</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 medication carts were consistently locked when unattended by licensed nurses in 4 of 5 resident halls. Failure to consistently secure medications potentially allowed residents and visitors of the facility access to potentially harmful medications. Findings include:  On 5/19/14 at 11:20a.m., the medication cart was unlocked and unattended in the west hall. At</p>	F 431	<p>form in no way implies agreement with or implies admission to any and all liability to the allegations found with in this document.</p> <p>The facility corrected this deficiency by educating all licensed nurses on the importance of drug storage as it relates to resident and visitor safety. Licensed nurses directly involved were counseled with disciplinary action. The facility will conduct random hall observation to ensure staff is following the standard of practice. This corrective action will be completed by 7/7/14. The Director of Nursing Services will be responsible to ensure the correction.</p>		

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

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F 431 Continued From page 14  
11:26 a.m., Staff #F walked up to the unlocked cart opened it and removed medication and walked away leaving it again unlocked and unattended. Staff #F was alerted by the surveyor and the cart was then locked. Staff #F confirmed medication carts should not be left unlocked while unattended.  
Again at 2:27 p.m., in the west hall a medication cart was unlocked and unattended, Staff #G was informed, he locked it and stated it should not have been left unlocked.  
On 5/20/14 at 8:47 a.m., a medication cart was unlocked outside of the main dining room Staff #F was in the dining room administering medications unable to see the cart. Staff #F returned to the cart and confirmed it was left unlocked and unattended.  
On 5/22/14 at 7:00 p.m., the medication cart in the 100 hall was unlocked with no staff in sight. Staff #Q returned from inside a resident's room and confirmed the cart should not have been unlocked and left unattended.  
On 5/28/14 at 8:30 a.m., in the 100 hall a medication cart was observed unlocked and unattended, Staff #G was alerted and locked the cart. Staff #G stated it was Staff #H's cart.  
At 8:34 a.m., 4 minutes later the same cart was again found unlocked and unattended, Staff #G was alerted and locked the cart confirming it had again been left unlocked and unattended.  
At 9:05 a.m., a medication cart in the west hall was unlocked and unattended. Staff #H was informed and confirmed it was left unlocked. Again in the west hall at 12:30p.m., the medication cart was observed unlocked and unattended, Staff #I walked by and locked the cart.

F 431

F 514 483.75(l)(1) RES

F 514

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505291</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/28/2014</b>
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F 514 SS=D	<p>Continued From page 15</p> <p><b>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</b></p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain a complete and accurately documented clinical record for 1 of 5 residents (#76) reviewed for unnecessary medication in a sample of 32. Findings include:</p> <p>Resident #76 had diagnoses including cancer and diabetes. Per record review, the resident was receiving comfort care and made choices about her daily care.</p> <p>Review of the resident's medication orders revealed physician orders for checking blood sugars 4 times per day, daily long-acting insulin, short-acting insulin before meals, and additional short-acting insulin sliding scale dosage for high blood sugar readings.</p> <p>Per record review, in May 2014 the resident had increased periods of sleepiness, ate little at some meals, and refused some medications,</p>	F 514	<p>F514</p> <p>The completion of this plan of correction is done to comply with requirements of Medicare/Medicaid certification. The completion of this form in no way implies agreement with or implies admission to any and all liability to the allegations found with in this document.</p> <p>This facility corrected this deficiency as it relates to this resident by updating and modifying the resident's medication order to collect the necessary data. This was the only resident with the electronic data discrepancy. To protect other residents in similar situations, licensed nurses who enter orders into the electronic medication administration record have been inserviced to ensure</p>	7/7/14
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F 514	<p>Continued From page 16 including insulin.</p> <p>During observation of medication pass with Staff #P on 5/22/14 at 8:40 a.m., the resident accepted blood sugar testing with much encouragement. The resident's blood sugar was elevated, so Staff #O administered both long-acting and 2 doses of short-acting insulin.</p> <p>Review of the Resident's May 2014 Medication Administration Record (MAR) revealed the blood glucose result was documented on the MAR but the dosage of the short-acting sliding scale insulin was not documented, either on 5/22/14 or for any other sliding scale doses administered in May 2014.</p> <p>On 5/22/14 at 12:20 p.m., Staff #O was informed of the lack of documentation. After review, Staff #O confirmed the insulin dosage was not documented and the accuracy of diabetic medication services was not maintained.</p>	F 514	<p>the orders are correctly transcribed. The medical record department will audit the diabetic orders and data to ensure that the solution is sustained. This corrective action will be completed by 7/7/14. The Director of Nursing Services is responsible to ensure the correction.</p>	