

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

PRINTED: 07/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505435	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/25/2014
NAME OF PROVIDER OR SUPPLIER TACOMA LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1301 N HIGHLANDS PARKWAY TACOMA, WA 98406	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Tacoma Lutheran Home on 6/16/14, 6/17/14, 6/18/14, 6/19/14, 6/20/14, 6/23/14, 6/24/14, and 6/25/14. A sample of 56 residents was selected from a census of 152. The sample included 48 current residents and the records of 8 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>Marilyn Edwards RN, MN Ruth Futch, RN, BSN, MBA Candice Mohar, PhD, RN, MS, MSN, APFNS Michelle Scollard, RN, BSN Johnathan Berliner, RN, MN, CPG Tammey Thompson, RN, BSN</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, District 3, Unit A P O Box 45819 MS: N27-24 Olympia, Washington, 98504-5819</p> <p>Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p> 7/8/14 Signature Date</p>	F 000		

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DSHS-ADSA
RCS-REGION 5

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Michelle Scollard / CEO	(X6) DATE 7/18/14
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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 154 SS=D	<p>483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS</p> <p>The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.</p> <p>The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to obtain an informed consent for 2 of 6 current sampled residents (#236 & #196) reviewed in Stage 2 for unnecessary medications. This failure placed residents and/or the residents' legal representative at risk of not being fully informed of the risks and benefits of psychotropic medications prior to the administration of medications.</p> <p>Findings include: The facility policy and procedure titled "The Process of Informed Consent" with a review date of 6/14 directed the staff to document in the medical record the informed consent process or a form may be used when significant risk is involved.</p> <p>RESIDENT #236 Resident #236 was admitted [REDACTED] 14 with diagnoses to include Alzheimer's and anxiety. According to the Minimum Data Set (MDS), an assessment tool, dated 4/28/14 the resident was</p>	F 154	<p>F-154, SS=D, INFORMED OF HEALTH STATUS, CARE, & TREATMENTS</p> <p><i>How will the facility correct the deficiency as it relates to the resident?</i> The use of the prescribed psychoactive medications were reviewed with Resident #236's legal representative, and afterwards with the approval of this legal representative, supporting documentation of the informed consent originally received upon initiation of Ativan and Celexa order for resident was completed on 7/11/14.</p> <p>Resident #196 passed away on [REDACTED] 14, leaving no opportunity to correct matters in this case.</p> <p><i>How the facility will act to protect residents in similar situations?</i> <i>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</i> To ensure that Residents are fully informed in advance about care and treatment and any changes in their care, the system of processing new physician orders will be revised. The notation of the order will be documented using the electronic physician order progress note, which will require the nurse to fill in the</p>	
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F 154	<p>Continued From page 2</p> <p>severely impaired with decision making skills.</p> <p>The Resident started Ativan, an anti-anxiety medication, on 4/22/14. The Ativan dosage and/or frequency changed on 4/25/14 and 6/5/14.</p> <p>The Resident started Celexa (an anti-depressant) on 5/7/14. The Celexa dosage was increased on 5/22/14.</p> <p>There was no documentation in Resident #236's medical record indicating informed consent was given indicating the risk and benefits and/or alternative treatment prior to these medications being initiated and/or changed.</p> <p>In an interview on 6/20/14 at 9:15 a.m., Staff B stated informed consents for medications were done when medications were initiated. The Licensed Nurse (LN) documented informed consent was given by initialing the bottom of the telephone order or fax indicating who was updated of the order change. The LN was expected to educate the family or resident of medication changes by using the medication informed consent book.</p> <p>RESIDENT #196 Resident #196 was admitted [REDACTED] 2014 with diagnoses to include anxiety and dementia. The MDS, dated 4/11/14, the resident was severely impaired with decision making skills.</p> <p>A review of the May and June 2014 physician orders revealed Resident #196 was on the following medications: Ativan as needed for anxiety, Zyprexa (an anti-psychotic) daily, Depakote Sprinkles (a mood stabilizer) daily and Cymbalta daily.</p>	F 154	<p>date, time informed consent was received to proceed with new physician orders, who gave consent, a listing of the indication and benefits of the medication/treatment and the risks related to proceeding with the ordered medication/ treatment.</p> <p>Nursing staff in-services will be conducted on the revised system of processing physician orders to ensure that it is correctly implemented and that this does not recur.</p> <p><i>How the facility plans to monitor its performance to make sure that solutions are sustained.</i> Unit Managers will monitor compliance with the revised physician order documentation and the new physician order progress note which contains required fields for charting receipt of informed consent from resident and/or legal representative on behalf of the resident monthly with Medication Recapitulation for the next 3 months. The results on this audit will be provided to Nursing Administration for follow-up with individuals who fail to demonstrate retention of corrected practice. Education, corrected practice, and initiation of monitoring process will be completed on or before 8/8/14.</p>	
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F 154	Continued From page 3 There was no documentation in Resident #196's medical record indicating informed consent was given indicating the risk and benefits and/or alternative treatment prior to these medications being initiated and/or changed. In an interview on 6/20/14 at 12:45 p.m., Staff S stated prior to initiating or changing a psychotropic medication, the LN obtained approval from the resident and/or responsible party. Staff S was asked to verify Resident #196's responsible party was notified of the initiation and changes of the psychotropic medications. Staff S was not able to verify this was done.	F 154		
F 159 SS=B	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of \$50 in an interest-bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest	F 159	F-159 SS=B, FACILITY MANAGEMENT OF PERSONAL FUNDS <i>How will the nursing home correct the deficiency as it relates to the residents?</i> The facility converted the existing checking account that contained resident trust funds from a non-interest bearing account to one that paid interest. The effective date of this move was July 1, 2014. The facility will retroactively post interest to the affected resident's accounts back to March 1, 2014 or the date the resident account was established, whichever is later. The current interest rate on the interest bearing checking account will be used to calculate interest for each individual account.	

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F 159	<p>Continued From page 4 bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to deposit resident personal funds (trust funds) in an interest bearing account and credit interest earned for Medicare recipients with balances in excess of \$100.00 or for Non-Medicare recipients with balances of \$50.00 or more. Failure to deposit resident personal funds in an interest bearing account</p>	F 159	<p><i>How the nursing home will act to protect residents in similar situations?</i> As of July 1, 2014, the facility deposits resident personal funds (trust funds) in an interest bearing account and credit interest earned for Medicare recipients with balances in excess of \$100.00 or for Non-Medicare recipients with balances of \$50.00 or more.</p> <p><i>What measures will be put into place or what systematic changes will you make to ensure that the deficient practice does not recur?</i> This issue was the result of a change in banking relationships and as such was isolated in nature.</p> <p><i>How will the nursing home plan to monitor its performance to make sure that the solution is maintained?</i> The Chief Financial Officer will review the resident trust funds on a quarterly basis and assure that interest is posted to each resident's account.</p>	

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F 159	<p>Continued From page 5</p> <p>affected 14 out 29 Sampled Medicare Residents (#s 1, 2, 8, 10, 12, 23, 26, 37, 58, 89, 104, 115, 184, & 339) and 11 out of 18 Sampled Non-Medicare Residents (#s 5, 28, 32, 121, 127, 139, 158, 181, 219, 240 & 361) during April 2014 and/or May 2014 of the 56 residents who were included in the Stage 2 review. This prevented residents from receiving potential accrued interest to their personal accounts held in trust by the facility.</p> <p>Findings include:</p> <p>On 6/20/14 beginning 9:07 a.m., during review of business office resident trust fund procedures, Staff K provided a list of residents in the facility that had trust accounts and corresponding balances as of 6/20/14. Staff K also provided bank statements for the trust account for March 2014; April 2014 and May 2014. Ending balances in the trust account between March 2014 and May 2014 ranged between \$23,810.12 and \$25,903.65.</p> <p>At this time, Staff K reported the facility computer system could compute the amount of interest paid on each resident's trust account automatically. When asked if the facility posted interest for any of the residents who had trust accounts (Medicare beneficiaries with balances in excess of \$100.00 and Non-Medicare beneficiaries with Balances in excess of \$50.00), Staff K reported, when the facility switched banks in April 2013 or May 2013, resident trust funds were deposited in a checking account that did not bear interest. Staff K confirmed residents with trust funds did not receive interest posted to their accounts.</p>	F 159		

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F 159	<p>Continued From page 6</p> <p>Records provided by Staff K indicated on 6/20/14, 12 out of 27 Medicare beneficiaries who had trust accounts had balances in excess of \$100.00. On 6/20/14, 10 out of 21 Non-Medicare beneficiaries with trust accounts had balances in excess of \$50.00 in their accounts.</p> <p>On 6/25/14 at 2:30 p.m. Staff L confirmed resident trust funds were not deposited in an interest bearing account. Staff L also reported a concern if resident trust funds were deposited in an interest bearing checking account, monthly fees would exceed the amount of interest earned with an average balance of \$30,000. Staff L provided additional information to identify trust fund balances for residents during April 2014 and May 2014. The facility identified which residents were Medicare and Non-Medicare recipients.</p> <p>Fourteen Sampled Medicare recipients with trust account balances greater than \$100.00 included several residents with balances greater than \$1000.00:</p> <ol style="list-style-type: none"> 1. Resident #10 had a balance of \$1770.26 as of 4/30/14; \$1727.54 as of 5/31/14 and \$1784.82 as of 6/20/14. 2. Resident #104 had a balance of \$1391.70 as of 4/30/14; \$1448.98 as of 5/31/14 and \$1506.26 as of 6/20/14. 3. Resident #339 had a balance of \$1320.49 as of 4/30/14; \$1354.49 as of 5/31/14 and \$1349.49 as of 6/20/14. <p>Eleven Sampled Residents who were Non-Medicare recipients had trust account balances that ranged between \$50.50 a month up</p>	F 159			

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F 159	Continued From page 7 to \$500.00 a month during April 2014 and May 2014. Bank statements provided by the facility identified the bank did not post interest to the resident trust account or prorate interest to individual resident trust balances during the months of March 2014, April 2014 or May 2014.	F 159			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	F-278, SS=D, ASSESSMENT ACCURACY/COORDINATION/CERTIFIED <i>How will the facility correct the deficiency as it relates to the resident?</i> The diagnosis of depression and diabetes was added to Resident #217's diagnoses list. Modifications to correct these item coding errors for this resident's Minimum Data Sets (MDS's) dated 2/20/14 and 5/5/14 was completed on 7/11/14 adding these diagnoses to the assessments. <i>How the facility will act to protect residents in similar situations?</i> Staff GG will receive a written reminder regarding his/her responsibility to certify the accuracy of his/her portion of the assessments completed on all residents that he/she is assigned to.		

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F 278	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure the Minimum Data Set (MDS), a comprehensive assessment tool, accurately reflected health conditions for 1 of 28 current Sampled Resident (# 217) reviewed in Stage 2 for assessment accuracy. This failure prevented the facility from ensuring qualified staff members accurately identified, treated and/or prevented decline in residents' physical and/or mental health status. Findings include: RESIDENT #217 Resident #217 was initially admitted to the facility from the hospital on [REDACTED] 12 with multiple medical diagnoses including seizures, high blood pressure and stroke with left-sided weakness. On 11/6/12, the physician's note indicated the resident had depression based on an assessment and the resident's statements of being depressed most of her life with attempted self-harm twice. On 1/15/13, the records indicated an onset of anxiety, depression, personality disorder and cognitive decline. On 10/17/13, the resident was started on oral medication (Metformin) twice daily for diabetes. Review of the Social Services (SS) note dated 2/10/14, the resident had dysthymia	F 278	<i>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</i> Although item coding error of this type could negatively affect care planning and the facility error rate, this incident is considered isolated. The facility had a 0.00% error rate on of our recent Case-Mix Accuracy Review conducted 6/27/14 to 7/8/14 in which 24 residents were sampled out of 153 of the facility census during audit. <i>How the facility plans to monitor its performance to make sure that solutions are sustained.</i> The DNS or Nursing Administrative designee will conduct a 10% audit of each MDS nurse's assessments for the next 3 months. The results on this audit will be provided to the Quality Assurance Committee. Education, corrected practice, and initiation of monitoring process will be completed on or before 8/8/14.	

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F 278	Continued From page 9 [chronic/long-standing depression] and borderline personality disorder. Review of several comprehensive assessments completed for the resident since admission and the MDS' for 2/20/14 and 5/5/14, failed to indicate diagnoses of depression or diabetes. Noted in the records and confirmed during interview with the resident on 6/20/14 at 2:00 p.m., she acknowledged being diabetic and having long-standing/chronic depression and feels the anti-depression medication does not help her. The assessments further indicated she had lost interest in normal activities, frequently tearful, feels low self-esteem and usually feels down. During interview with the Staff E on 6/24/14 at 10:00 a.m., it was learned no diagnoses of mental health problems had been documented on the MDS' for the resident since admission.	F 278	F-280, SS=D, RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP <i>How will the facility correct the deficiency as it relates to the resident?</i> Resident #217 was offered time to discuss all concerns with SW and nursing. She will have an upcoming care conference within the month and staff will ensure that the resident has 5 days advanced notification of care conference date and time. The resident will have opportunity for input into who will be invited to the care conference per her preferences. Social Services and Nursing will document the resident's concerns and what actions will be taken to address them following the care conference. Resident #24 had a scheduled care conference on 06/25/14 which he participated in along with his family. His concerns as well as his family's concerns have been clearly documented in his record with what steps would be taken to address them.		
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,	F 280			

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F 280	<p>Continued From page 10</p> <p>and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to involve 2 of 3 Sampled Residents (#s 217 & 24) reviewed in Stage 2 for participation in the plan of care. Failure to ensure residents and appropriate qualified team members were afforded the opportunity to discuss care and treatment during the care planning process, created the potential of not meeting residents' care and treatment needs.</p> <p>Findings include:</p> <p>RESIDENT #217 Resident #217 was admitted to the facility in 2012 with multiple medical conditions including a recent stroke. She was alert, oriented, made all of her own care decisions and could clearly communicate her needs. The resident was assessed in 2013 with depression, diabetes and was placed on a restorative toileting program to maintain/improve her urinary continence.</p> <p>On 6/20/14 at 1:30 p.m., during interview, the resident stated she was asked to come to care conferences "on-the-fly" and described the Social Services (SS) staff member asking her one day, and without notice, if she was up for a care</p>	F 280	<p><i>How the facility will act to protect residents in similar situations?</i> Social Services Staff will ensure that residents have at least 5 days prior notification of scheduled care conferences. Resident's preferences for attending their care conference will be documented in the medical record. Social Services and Nursing staff will document a summary of resident's concerns following care conferences and the steps that will be taken to address them.</p> <p><i>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</i> Social Services Staff will review the process for care conference scheduling and charting requirements.</p> <p><i>How the facility plans to monitor its performance to make sure that solutions are sustained.</i> The Director of Social Services or designee will conduct a random audit of residents scheduled for care conferences to ensure that charting and notification process meet standards for the next 3 months. The results on this audit will be provided to the Quality Assurance Committee. Education, corrected practice, and initiation of monitoring process will be completed on or before 8/8/14.</p>		

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F 280	<p>Continued From page 11</p> <p>planning conference meeting right then at 10:00 a.m. She agreed and met with the weekend nurse and SS. She stated she does not really participate in the conferences but listens to what they [staff] tell her has been decided.</p> <p>When asked if issues discussed in the conferences included her fall in January 2014, statements made by caregivers regarding her weight in April 2014 and how she feels about not being toileted to prevent urinary incontinence and refusing a medication because it caused her to toilet too often, she said "No" because she is afraid to bring up care issues, "I don't want to get anyone in trouble." She stated she was not asked, nor aware, of others she might like to attend the conferences such as the restorative aides, physician and/or dietitian to help in the process of planning her care and treatment related to her care needs.</p> <p>During interview with SS and resident at 2:30 p.m., SS stated facility residents/family members previously had been notified of care conferences by letter but now notification is in person or by phone calls. When informed of the documentation regarding the resident's fall resulting in being transferred by one aide instead of two; statements by staff members in front of her regarding difficulty moving her in bed and toileting her because of her size/weight and if care planning changes were discussed such as her toileting needs, depression or diabetes, she said she was not aware of these issues coming up during care conferences.</p> <p>Review of care conference summaries provided by SS on 6/24/14 indicated a conference on 3/19/14 and the restorative programs [including</p>	F 280			

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F 280	<p>Continued From page 12 toileting] were continued although identified on the comprehensive assessment for toileting as "no improvement."</p> <p>Review of the care conference participation documentation and care plan last reviewed on 5/12/14 failed to reflect the resident's inclusion or interdisciplinary team's involvement related to necessary revisions to the care plan to better meet her current health care needs.</p> <p>See F 278 and F 315.</p> <p>RESIDENT #24 Resident #24 admitted to the facility on [REDACTED] 14 with diagnoses that included a form of anemia, a heart condition and depression.</p> <p>An admission nursing note dated [REDACTED] 14 documented the resident admitted alert and oriented to person, place and time and became confused with change. The note documented the resident could make day to day decisions and family would make medical decision.</p> <p>A Social Service Note dated 2/26/14 documented the resident had cognitive impairment and moderate impairment with decision making requiring cues and supervision. The note indicated the resident responsible for self and relied on family to assist with decisions.</p> <p>Resident #24's medical record contained a document dated 10/25/13 designating power of attorney for financial and health care decisions to two family members.</p> <p>On 6/16/14 at 3:57 p.m. Resident #24 reported a concern staff might not inform him/her in advance</p>	F 280		
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F 280	Continued From page 13 if the physician changed a medication. During an observation on 6/23/14 at 11:14 a.m., Resident #24 sat in room engaged in conversation with a visitor. On 6/23/14 at 2:28 p.m. the resident sat in his room conversing with the surveyor and reported he did not recall ever attending a care conference with staff but would like to attend one to discuss care with staff when scheduled. On 6/23/14 at 10:58 a.m. Staff H provided a copy of a document that identified the facility conducted a care conference on 3/18/14 at 9:30 a.m. The form indicated attendees included a nurse, social worker and two family members. Staff H confirmed the form did not indicate Resident #24 attended the care conference. Staff H also reported residents could attend care conferences also even when family members were present. When asked if staff asked Resident #24 if he/she wanted to attend the conference, Staff H reported social service staff "would do that." On 6/23/14 at 11:05 a.m. Social Service Staff F reported and confirmed the resident was not provided with an opportunity to attend the conference and staff did not explain the results of the conference to the resident after the meeting.	F 280			
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to	F 285	F-285, SS=D, PASRR REQUIREMENTS FOR MI & MR <i>How will the facility correct the deficiency as it relates to the resident?</i> Resident #248 had a correction to her Pre-Admission Screening and Resident Review (PASRR) on 02/05/14 invalidating the need for a Level II screen due to resident having a primary diagnosis of Dementia. This resident received Mental Health (MH) services initiated on 07/30/13 and provided by Good Sam Behavioral Health (GSBH). Resident # 197 had his PASRR corrected on 03/05/14 [redacted] days after admission. This PASRR was invalidated due to a primary diagnosis of dementia and no need for level II screening was indicated.		

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F 285	<p>Continued From page 14</p> <p>the maximum extent practicable to avoid duplicative testing and effort.</p> <p>A nursing facility must not admit, on or after January 1, 1989, any new residents with:</p> <p>(i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission;</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>For purposes of this section:</p> <p>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).</p> <p>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.</p>	F 285	<p><i>How the facility will act to protect residents in similar situations?</i></p> <p>Social Services Staff will ensure that PASRRs are corrected and updated following MH evaluations as well as upon admission, quarterly and upon change of condition.</p> <p><i>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</i></p> <p>Social Services Staff will review the PASRR process and the procedure for review and correction of PASRRs .</p> <p><i>How the facility plans to monitor its performance to make sure that solutions are sustained.</i></p> <p>The Director of Social Services or designee will conduct random audits of PASRRs to ensure compliance with the regulations for the next three months. The results on this audit will be provided to the Quality Assurance Committee. Education, corrected practice, and initiation of monitoring process will be completed on or before 8/8/14.</p>	
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F 285	<p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR) assessments were accurately completed for 2 of 5 current Sampled Residents (#s 197 & 248) reviewed in Stage 2 for PASRR completion. Failure to ensure PASRR's were done and/or accurately completed prior to admission placed residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet their mental health [MH] care needs.</p> <p>Findings include:</p> <p>1) Resident #248 was admitted to the facility from the hospital on [REDACTED] 13 with multiple medical conditions including major depression and delusional disorders. The hospital completed the PASRR on 7/13/13 without identification of these conditions. The facility reviewed and corrected the PASRR on 2/5/14.</p> <p>2) Resident #197 was admitted to the facility from the hospital on [REDACTED] 14 with multiple medical diagnoses including anxiety and depression. The facility completed the PASRR after admission on 3/5/14.</p> <p>During interview with Social Service Staff F on 6/24/14 at 10:00 a.m. and Staff B on 6/25/14 at 3:30 p.m., it was learned the facility was having difficulty getting PASRR screens completed and when a PASRR was provided, the facility had to re-do them because they were frequently</p>	F 285		

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F 285 F 309 SS=D	Continued From page 16 inaccurate. 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 that the facility failed to thoroughly assess all factors related to incidents for 2 of 4 Sampled Residents (#s 19 & 67) reviewed for either accidents and/or skin conditions of the 30 residents who were included in the Stage 2 review. This had the potential for staff to not be able to determine if current care plans needed to be revised to prevent or reduce likelihood of further reoccurrence and/or injury. Findings include: RESIDENT #19 An admission assessment dated 4/10/14 identified Resident #19 admitted to the facility on [REDACTED] 14 with diagnoses that included dementia, kidney disease and arthritis. The assessment identified the resident was not steady to transfer without physical assistance and used a walker and a wheelchair. A Significant Change assessment dated 5/15/14	F 285 F 309	F-309, SS=D, PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING <i>How will the facility correct the deficiency as it relates to the resident?</i> This report doesn't include any details of how the expectations were not met according to the regulations as they relate to resident #67. However, after interview with the surveyor on 6/24/14, this resident's transfers with the Sit-to-Stand lift were evaluated by the Assistant Director of Nursing and the assigned Unit Manager. It was determined that the resident would require two-person assist with the use of this device. Therefore, this device was discontinued and resident care guidelines and the care plan were updated instructing the nursing assistants to use the Mechanical Hoyer Lift with Resident #67, as the resident is no longer combative with care. Based on the finding for Resident #19, the Resident care guidelines for the nursing aide staff was updated on 6/19/14 to reflect the need to encourage resident to wear both the arm and leg protectors, and to encourage the resident to allow staff to assist with all transfers from the wheelchair to ensure that the leg rests are removed prior to transfers. Resident is able to transfer safely with one person extensive assist and no longer attempts to self-transfer.	

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F 309	<p>Continued From page 17</p> <p>identified the resident received oxygen therapy and hospice services.</p> <p>Treatment records for May 2014 identified staff administered oxygen through a nasal cannula to maintain oxygen levels greater than 92%. Staff documented oxygen levels were checked every shift, three times a day.</p> <p>The facility initiated a care plan (#42) on 4/14/14 related to potential/actual impairment to skin integrity. The care plan identified on 5/1/14 the resident had actual bruises and an abrasion to the right hip and skin tear to the right wrist.</p> <p>An Activities of Daily Living care plan initiated 4/14/14 identified Resident #19 required extensive staff participation with transfers. Resident Care Guidelines for nursing aide staff to follow dated "4/3" identified for staff to pivot transfer the resident with one person assistance using a gait belt.</p> <p>On 6/17/14 at 10:11 a.m. Resident #19 sat in a wheelchair and wore clothing that exposed both lower legs. A large bandage covered the resident's right lower leg and protective sleeves covered both arms. The resident reported he/she did not know what happened to his/her leg.</p> <p>On 6/19/14 at 9:22 a.m. Staff TT prepared to change the dressing on the resident's leg. Approximately 14 steri-strips covered a long narrow wound that measured approximately 10 inches long. A dried scab covered the lower portion of the wound. A shorter upper section of the wound closest to the knee remained opened and measured approximately one inch wide.</p>	F 309	<p><i>How the facility will act to protect residents in similar situations?</i></p> <p>The registered nurse who wrote the incident report involving Resident #19 will receive a reminder to fully assess any resident in a similar situation at the time of the incident, to take a full set of vital signs after an incident (including oxygen saturations), observe the technique used to transfer the resident, and the environment to identify any potential staff teaching needs or environmental factors that could impact resident safety. Staff education on these safety measures will be conducted with the remaining nursing staff as well.</p> <p>Secondly, Staff J will receive a reminder due to her failure to initiate a new incident report when notified on 5/15/14 of the change in the wound at the right lower extremity by the Medication/Treatment nurse. The reminder will include the need to properly report the changes in care needs to the Attending Physician for updates with the treatment regimen as needed. Staff education will be conducted to remind staff that a new incident report is required when a significant change occurs at an existing site to ensure resident safety.</p>		

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F 309	<p>Continued From page 18</p> <p>An incident report provided to the surveyor by Staff B on 6/19/14 at 12:30 p.m. Staff B reported the resident had very fragile skin. The incident report documented on 5/4/14, when staff assisted Resident #19 to bed, the resident verbalized pain in the right leg and staff noted some blood. The report identified the resident had a 5 cm by 2.5 cm crescent shaped skin tear to the right lower leg.</p> <p>The report indicated the resident "either leg hit the w/c (wheelchair) during transfer or the bed" and noted the injury reasonably related and origin of injury established.</p> <p>A summary statement documented Resident #19 was weak at the time of the injury and Staff WW picked up the resident's legs to position the resident in bed to prevent sliding. "It is reasonable that the w/c (wheelchair) was not far enough away when (staff) lifted" the resident's legs and "may have bumped" the resident's skin. An environment assessment section of the report identified the resident's wheelchair contributed to the injury.</p> <p>No evidence was found in the record staff observed how Staff WW transferred the resident to ensure leg rests were removed prior to transfer and if staff followed the plan of care. The record did not contain evidence how the wheelchair contributed to the injury or if staff examined the wheelchair, bed or environment to rule out potential unprotected edges that may have contributed to the injury.</p> <p>The record did not contain evidence staff assessed the resident following transfer and discovery of the leg skin tear for a change in vital</p>	F 309	<p><i>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</i></p> <p>This isolated occurrence will not require system alteration.</p> <p><i>How the facility plans to monitor its performance to make sure that solutions are sustained.</i></p> <p>Nursing Administration will audit the incident reports summaries thoroughly to ensure that they include a full assessment of resident status at the time of an incident involving transfers and vital signs after an injury. Nursing Administration will also ensure that the summaries include an evaluation of how a resident's environment may have the potential to contribute to resident injury. Education, corrected practice, and initiation of monitoring process will be completed on or before 8/8/14.</p>		

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F 309	Continued From page 19 signs (blood pressure, pulse and respirations) or drop in oxygen level. Failure to fully assess resident status at the time of the incident, how the transfer occurred and the environment had the potential for staff to not be able to determine if the resident's plan of care should be changed to attempt to reduce the risk of re-occurrence.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure the resident was given appropriate treatment and services through the restorative program to maintain or improve his/her abilities for 1 of 3 Sampled Residents (#8) reviewed for range of motion of the 30 residents who were included in the Stage 2 review. This failure placed the resident at risk for functional decline in the left hand to not achieve or maintain the highest practicable outcome. Findings include: The Annual MDS Assessment dated 1/3/14 listed several care needs for Resident #8 related to contracture of hand joint, arthritis, Aphasia, [REDACTED] Hemiplegia, and anxiety disorder.	F 311	F-311, SS=D, TREAT/SERVICES TO IMPROVE/MAINTAIN ADLS <i>How will the facility correct the deficiency as it relates to the resident?</i> On 7/14/14 the restorative plan for resident #8 will be updated to include what time/s and/or shift staff should apply the palm protector (palm guard). The documentation will be corrected to reflect the number of hours a day that Resident #8 wears the palm guard and if applicable the times when the resident declined to wear it. Resident #8's program will be reassessed to ascertain whether it would be appropriate to add a wrist splint as listed as a goal in the plan of care of if the program goals should be revised due to the resident's history of refusing to wear assistive devices on this extremity, i.e. the palm guard.	

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F 311	<p>Continued From page 20</p> <p>Review of the MDS assessment dated 1/3/14, 3/25/14 and 5/3/14 Special Treatments and Programs revealed the "Restorative Nursing Program" was for passive and active ROM with no splint or brace device in use.</p> <p>Continued review recorded the Functional Status for Resident #8 as extensive assistance with transfers, locomotion on and off unit, eating, toilet use and personal hygiene with physical assistance of 1-2 person(s). Total dependence (full staff performance), needed for bed mobility with 2+ person physical assistance with functional limitation in range of motion related to impairment on both sides of upper (shoulder, elbow, wrist, hand) and lower (hip, knee, ankle, foot) extremities.</p> <p>Review of the Care Plan dated/initiated 1/9/14 records, "Palm protector on 2 hours daily, increase to 4 hours in next 30 days 6 times/week each occasion. When tolerate palm protector 4 hours daily, will add a washcloth or roll to increase finger extension. Will re-evaluate on quarterly assessment to try adding wrist support/splint once patient used to wearing hand splint." The care plan did not identify what time/s and/or shift staff should apply the palm protector (palm guard).</p> <p>On 6/17/14 at 10:50 a.m. Staff FF said Resident #8 receives ROM, hand massage and cleaning daily - 6 days a week. Staff FF confirmed the resident was to wear a hand splint and demonstrated use of the device and how to be worn. Staff FF said the resident "does not like to wear the splint and often refuses." Resident #8 confirmed with shaking of head that does not like to wear.</p>	F 311	<p><i>How the facility will act to protect residents in similar situations?</i> Staff R and Staff GG will receive reminders and training on the importance of accurately writing restorative programs and thoroughly reviewing them with each MDS cycle to ensure appropriate plans and resident participation with their programs are charted by the nursing assistants and restorative aides. They will be reminded to report any declinations from the residents that they are working with to ensure that the programs properly evaluated and revised if necessary.</p> <p><i>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</i> This isolated occurrence will not require a system alteration.</p> <p><i>How the facility plans to monitor its performance to make sure that solutions are sustained.</i> The Health Records Supervisor will conduct a random audit of restorative programs for completion and evaluation of resident participation by the assigned nurse over the next 3 months. The DNS or designee will ensure that any identified issues are corrected, and produce a summary report for the Quality Assurance Committee of this audit after the quarter is completed. Education, corrected practice, and initiation of monitoring process will be completed on or before 8/8/14.</p>	

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F 311	<p>Continued From page 21</p> <p>Immediately following the interview with Staff FF, Staff EE reviewed the restorative schedule log for Resident #8, and confirmed the resident did not like to wear splint (palm guard) and "refused most of the time." Staff EE reported documentation of Restorative activity was found in the computer under the "task tab".</p> <p>Review of the Restorative documentation under the "task tab" in the computer for 6/1/14-6/23/14 for Resident #8 documented the resident wore the palm guard. Restorative docmentation did not identify how many hours a day the resident wore the palm guard or if and when the resident declined to wear it.</p> <p>On 6/20/14 at 9:48 a.m. Resident #8 was observed to have bilateral hand contractures with no splint device on left hand and again the same on 6/23/14 at 10:25 a.m. The resident was able to verbalize/show (raised 4 fingers on right hand) that wears splints on hands 4 hours a day. S/he said wears "sometimes". Resident was not able to verbalize when those times were or how long.</p> <p>A review of the Progress Notes for "Nursing Maintenance/Restorative Program Updates" on 6/20/14 at 10:38 a.m. recorded the resident continued passive range of motion (ROM) and gentle stretch of left upper extremity that were done 6 times a week for approximately 15 minutes and wear palm guard up to 4 hours a day.</p> <p>Although Staff FF and Staff EE reported Resident #8 often refused to wear the palm guard, documentation did not reflect reported history of refusals. Further review of chart notes did not</p>	F 311		

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F 311	Continued From page 22 reveal documentation of staff interventions when the resident refused to wear the palm guard or reassessment to evaluate possible decline of finger extension due to frequent refusals. The record did not contain evidence staff reassessed Resident #8 for possible addition of a wrist splint as indicated in the care plan dated 1/9/14.	F 311			
F 315 SS=D	<p>These failures placed the resident at risk for functional decline in ROM of the extremity and to not obtain/maintain the highest possible level of function and well-being.</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain urinary status at the highest practicable level for 2 of 4 Sampled Residents (#s 195 & 217) reviewed for urinary incontinence of the 30 residents who were included in the Stage 2 review. This failure had the potential to diminish restoration of normal bladder function and increased risk for development of urinary tract infections.</p>	F 315	<p>F-315, SS=D, NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p><i>How will the facility correct the deficiency as it relates to the resident?</i> Resident #195's and Resident #217's candidacy for a toileting program were assessed on 7/14/14. A scheduled toileting program was initiated for Resident #195. Resident #217's toileting program was revised without the need to change this resident's room during the survey, which eliminated the resident's concern about the timing of the nursing assistants' break times on the current hall. This program was discussed with the resident who consented to the times outlined in the new schedule.</p> <p><i>How the facility will act to protect residents in similar situations?</i> Staff GG, the MDS Coordinator, will receive a reminder to alert the Unit Manager when she identifies a decline in a resident's urinary status.</p>		

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F 315	<p>Continued From page 23</p> <p>Findings include:</p> <p>RESIDENT #195 Resident #195 was admitted [REDACTED] 2014 with diagnoses to include dementia.</p> <p>The Minimal Data Set (MDS), and assessment tool, dated 1/09/14, indicated the resident had severe cognitive impairment and frequently incontinent of urine. A quarterly MDS, dated 4/10/14 identified Resident #195 was always incontinent of urine, which indicated a decline. The Care Area Assessment, dated January 2014, stated Resident #195 will be referred to the Unit Manager for a possible toileting program.</p> <p>A review of Resident #195 medical record was done. There was no evidence of a possible toileting program being initiated for Resident #195.</p> <p>Resident #195's care plan, with a review date of 6/8/14, was reviewed. The goal was to decrease "frequency of urinary incontinence from frequently to occasionally."</p> <p>In an interview on 6/23/14 at 10:45 a.m., Staff GG was asked regarding what the normal process was when a resident was identified with urinary incontinence or had a decline in their status. Staff GG stated she refers to the appropriate Unit Manager to assess for the possibility of a toileting program and/or to assess the resident's urinary function. If a toileting program was indicated, the Unit Manager would alert her and she would put the program in place. When Staff GG was asked what was done for Resident #195's urinary status, Staff GG stated she was referred to the Unit</p>	F 315	<p><i>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</i></p> <p>This isolated occurrence will not require a system alteration.</p> <p><i>How the facility plans to monitor its performance to make sure that solutions are sustained.</i></p> <p>The Health Records Supervisor will conduct a random audit of the bladder and bowel assessments for all residents assigned to Staff GG during the next quarter to ensure initiation of the assessments occurred. The DNS or designee will ensure that any identified issues are corrected, and produce a summary report for the Quality Assurance Committee of this audit after the quarter is completed. Education, corrected practice, and initiation of monitoring process will be completed on or before 8/8/14.</p>		

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F 315	<p>Continued From page 24</p> <p>Manager in January 2014 and did not receive any communication back from the Unit manager regarding the progress of the toileting program. When asked what was done related to the urinary decline the Resident experienced in April 2014, Staff GG stated she referred it to the Unit Manager.</p> <p>In an interview at 11:51 a.m., Staff Q was not able to locate any information regarding the trial toileting program in January 2014 being attempted.</p> <p>In an interview at 12:00 p.m., Staff J stated she did not receive a referral from Staff GG in April 2014.</p> <p>The facility failed to comprehensively assess or maintain Resident #195's urinary function. There was no evidence the facility attempted a toileting program, or adequately assess the Resident's urinary status when a decline was identified.</p> <p>RESIDENT #217</p> <p>Resident #217 was admitted in [REDACTED] 12 for rehabilitation following a stroke and left-sided weakness. The resident was alert, oriented and able to make all of her own care decisions and could clearly communicate her needs. Review of the comprehensive assessments and documentation, completed in November 2013, February and May 2014, indicated the resident was on a restorative toileting program to maintain urinary continence.</p> <p>The restorative maintenance toileting care plan, initiated on 7/20/12 and last reviewed on 5/12/14, remained unchanged and indicated: "Offer to</p>	F 315		

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F 315	<p>Continued From page 25</p> <p>toilet upon rising and every two hours during waking hours. Assist to the bathroom. Stand by while she grabs the bar to stand ... " The plan failed to identify toileting times most helpful to the resident and if the times were implemented. The assessments indicated "no improvement" of urinary incontinence and "continue the plan."</p> <p>On 6/20/14 at 1:30 p.m., during interview and observation of the resident's toileting program, she was assisted by two nursing aides (NAs) to use a mechanical lift [sit-to-stand] to transfer to the toilet. The resident stated she was able to ambulate/stand until a fall in January 2014. She frequently complained of being incontinent because of the lack of assistance to toilet when she needed. She stated she stopped taking a medication because she had to use the bathroom too often as noted on a fax to the physician on 5/22/14 requesting the medication be discontinued. She also stated there continued to be issues with the NAs who do not like helping her as often as necessary because of her size/weight.</p> <p>Review of the nursing notes (NN) and additional records dated 4/11/14: "Resident alleges that when NA's were taking care of her ...one of them complained the resident was too heavy/big to move around in bed or get her up to the commode ...". A note dated 4/21/14 indicated: "Restorative therapy ordered but they are reluctant to start it because of the possibility of hurting themselves...".</p> <p>The NN's for January 2014 indicated the resident was being toileted by one NA to use the bedside commode and incurred a fall. A June 2014 note indicated continued complaints regarding the</p>	F 315		

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F 315	Continued From page 26 NA's not getting her up and not toileting her in a timely manner. Staff notes dated 6/18/14 and 6/19/14 proposed a hall change and that one NA might delay her break in order to toilet the resident when needed. The care directive indicated to use "heavy wetter" briefs at night and did not mention the times for toileting that may be most helpful to the resident to maintain urinary continence/restore as much bladder function as possible. Without accurate comprehensive and revised care plans for maintaining the resident's urinary continence, the resident continued to be at risk for decline and diminished quality of life.	F 315		
F 325 SS=D	See F 280. 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 provide comprehensive nutritional services for 1	F 325	F-325, SS=D, MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE <i>How will the facility correct the deficiency as it relates to the resident?</i> Resident's care guidelines were updated on 7/16/14 to include current level of feeding assistance. The resident #248 continues to require extensive assistance with feeding, including hand over hand, prompting, cuing and reminding. Dietary assessment was completed on 6/25/14 with recommendations to provide small cups at meals. Another dietary assessment was completed on 7/8/14 once the resident was admitted to hospice services. At that time, the resident's dietary goals were updated as weight maintenance was no longer an appropriate goal. New resident's dietary goal is oral intake for pleasure and as tolerated. The definition of extensive assistance with feeding was clarified with staff BB and does not include 1:1 feeding throughout mealtime.	

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F 325	<p>Continued From page 27 of 3 Sampled Residents (#248) who had specific dietary intake needs and continued weight loss of the 30 residents who were included in the Stage 2 review. This failure placed the resident at risk for poor nutrition and continued weight loss.</p> <p>Findings include:</p> <p>The Minimum Data Set (MDS - an assessment tool) Quarterly Assessment dated 4/9/14 lists diagnosis to include non-dementia Alzheimer's, depression, memory loss, general muscle weakness, dehydration, and delusional disorder.</p> <p>Further record review reports Resident #248's functional status with meals as extensive assist with eating requiring one (1) person physical assist. Dental issues were not identified in the assessment.</p> <p>The Resident Care Guidelines for nursing aids to follow, located in the closet of the residents room, dated last reviewed 1/16/14 lists the resident's Eating/Feeding needs as "set-up and verbal cueing". The guidelines did not reflecting the current assessment change on 4/9/14 the resident required extensive assist with eating.</p> <p>Review of Resident # 248 Care Plan dated 7/24/13 records the resident had nutritional problems related to diet restrictions, mechanical soft, poor appetite and weight loss. The goal was to maintain adequate nutritional status as evidenced by maintaining weight within 118+/- 5% ... and consuming at least 75% of all meals daily. One intervention was to report significant weight loss: 3 pounds in 1 week.</p>	F 325	<p><i>How the facility will act to protect residents in similar situations?</i> Staff RR and DD will receive reminders regarding the need to refer to residents' care guidelines to determine the level of assistance needed for feeding residents. A reminder will also be provided for the Speech Therapist who failed to document that resident #248 was assessed prior downgrading the diet. Per policy, when referred by physician/nursing, the registered dietitian will complete thorough dietary assessment as appropriate.</p> <p><i>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</i> While this was an isolated occurrence, the facility will revise the residents' care guidelines form to reflect levels of eating/feeding assistance in a detailed manner by August 8th, 2014.</p>	
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F 325	<p>Continued From page 28</p> <p>DIET/WEIGHT HISTORY</p> <p>On 5/19/14 nursing requested a speech therapist evaluate and treat the resident for refusing to chew or eat any food but would drink liquids. The request also stated the resident currently did not accept a mechanical soft diet and was losing weight.</p> <p>On 5/22/14 the speech therapist wrote a telephone physician order for the following: "discharge order for speech therapy evaluation and treatment. May try diet texture downgrade first 2° (secondary to) pts (patients) cognitive status and lack of dentition; if agreeable-nursing/dietitian."</p> <p>A dietary Note on 5/23/14 documents "received RN consult for possible downgrade of diet texture 2/2 resident refuses to chew foods but will drink. SLP evaluation recommended diet downgrade. Wt down 6% x 3 months, po intake 0-25% most meals."</p> <p>On 5/23/14 dietary staff wrote a physician telephone order to change and downgrade Resident #248 to a "full liquid plus diet". The resident's record did not contain documented report of the speech therapist's assessment.</p> <p>On 6/20/14 at 9:07 a.m., Staff BB reviewed the resident's record and reported the resident was started on a full liquid diet on 5/23/14. S/he explained the assessment recorded the resident refused solids, and with the recommendation of speech therapy was placed on full liquid plus diet (plus=designed to provide adequate nutritional needs). Staff DD added, Resident #248 was also</p>	F 325	<p><i>How the facility plans to monitor its performance to make sure that solutions are sustained.</i></p> <p>The registered dietitian or designee will audit a random sample of residents' charts to ensure that care guidelines for eating/feeding are consistent with residents' care plans. The registered dietitian or designee will ensure that any identified inconsistencies are promptly corrected, and will present the results of the audit at the Quality Assurance Committee at the end of this quarter. Education, corrected practice, and initiation of monitoring process will be completed on or before 8/8/14.</p>	
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F 325	<p>Continued From page 29</p> <p>offered ice cream twice a day and Resource 2.0 (240kcal (kilocalorie)/10g (grams) of protein per 120 ml (milliliters) three times a day with medication pass.</p> <p>On 6/24/14 at 10:18 a.m., Staff XX did not locate documentation to why the speech therapist recommended a change to a full liquid diet. When asked if it was standard practice to make a recommendation without conducting an assessment Staff XX said " No ".</p> <p>Review of Resident # 248's weight record identified the resident experienced a downward weight loss trend since admission on [REDACTED] 13. At the time of admission the resident weighed 115 pounds. On 5/14/14, the weight at the time of the request for the change to a full liquid diet, the resident weighed 105.6 pounds.</p> <p>A review of the Weight Summary dated 6/25/14 revealed the resident ' weight continued to trend downward to 96.4 on 6/25/14. Also recorded on the Weight Summery was a calculated weight change (104.2 on 5/28/14 and 96.4 on 6/25/14) of 7.5%, a weight change of greater than 5% in a one month period that meets the regulatory criteria of severe weight loss.</p> <p>DINING OBSERVATIONS</p> <p>On 6/20/14 during observations between 7:00 - 8:00 a.m., Resident #248 received intermittent assistance of Staff VV and Staff UU to eat breakfast. The resident drank approximately 75% of meal and did not refuse assistance.</p> <p>Resident #248 was observed to need 1:1 assistance with her meal. Both Staff VV and Staff</p>	F 325		

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F 325	<p>Continued From page 30</p> <p>UU helped the resident during the meal. When not being helped, the resident sat in her chair at the table and made no attempt to perform eating on her own. The meal had several liquids, and a Resource drink. With assistance of staff, the resident ate about 75% of meal.</p> <p>During an interview on 6/20/14 at 9:07 a.m., Staff BB, said the resident's intake had been 25-50% the last few days, sometimes less than that. S/he was provided extensive assist with meals and explained extensive assist was hand over hand guidance and extensive support such as cutting food to bit size or cueing for chewing or swallowing. This was the same as 1:1 assistance with the expectation there would be a person who stays with the resident throughout the meal.</p> <p>On 6/24/14 during observations between 7:00 - 8:00 a.m., Resident #248 was observed sitting at the dining room table with eyes closed. At 7:07 a.m. Staff UU began assisting the resident with holding a cup of juice and the resident drank without assistance. When offered hot cereal the resident took a spoon full, moved it around on tongue in mouth before swallowing. When offered another spoonful, the resident shook head "no", and would not open his/her mouth. The resident's tray contained 2 smaller cups of juice and 2 larger cups of health shake.</p> <p>Staff UU handed the resident a large cup with health shake, then left to assist another resident. Resident #248 made several attempts to lift and drink liquids on own. S/he was able to lift the small juice cups, but had difficulty tilting the larger cups of health shake to her mouth to drink. At 7:22 a.m. and multiple times after, Staff UU, placing the health shakes in hand before leaving</p>	F 325			

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F 325	<p>Continued From page 31 again to assist another resident. Each time the resident had difficulty tilting the larger cup of health shake to her mouth.</p> <p>At 7:33 a.m. Staff DD sat with Resident #248 and offered health shake, and supported the cup to help the resident to drink. While staff supported the cup the resident was able to drink some of the health shake, encouraged and assisted him/her to drink. With continuous assistance from Staff DD, Resident #248 consumed most of the liquids on the tray.</p> <p>At 7:45 a.m. when asked how staff knew how much assistance residents needed during meals, Staff RR reported residents are observed to know how to assist them. Residents were observed for feeding difficulties, sounds, cough and notify the nurse if issues were identified. Staff RR further explained 2-3 staff were assigned to the dining room, one person for every 4 residents.</p> <p>At 7:55 Staff DD reported Resident # 248 drank almost 2 health shakes, juice, and water. She stated she was surprised at how awake the resident was during the meal. The resident's level of assist was varied. When she was asked how she knows level of assist for residents, she said it is by knowing the resident and looking around the room. There was no documentation to guide persons not familiar with residents about level of assist needed. Neither staff reported the need to review the resident's care plans or resident care guidelines for directions to identify how much assistance Resident # 248 needed during dining.</p> <p>RE-ASSESSMENTS</p> <p>A dietary assessment dated 6/25/14 indicated the</p>	F 325		
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F 325	<p>Continued From page 32</p> <p>residents food consumption varied between 0-50% with each meal. The Summary of the Nutritional Diagnosis reported: "Inadequate oral intake related to PO <50% at most meals as evidenced by significant weight loss 12% x 180days."</p> <p>The speech evaluation was discontinued without documentation to identify the resident was assessed before downgrading the diet.</p> <p>The record did not contain evidence staff timely reassessed to determine all factors that may have limited the resident's oral intake such as amount of assistance needed from staff to attempt to increase the resident's intake or if smaller cup size would encourage the resident to self-feed more successfully.</p> <p>Resident #248 was identified by the facility to have dietary intake needs and a gradual weight loss trend followed by weekly weights. Though the resident was identified to require extensive assistance during the last three quarterly assessments, staff were unaware of the level of assistance the resident required for meals. The care plan did not reflect the amount of assistance staff should provide during meals.</p> <p>Review of the records did not contain a thorough, detailed documentation to fully and clearly understand the various aspects of Resident #248's care. On 5/21/14 staff recommended a hospice referral due to the resident's declining status.</p> <p>Failure to timely assess, monitor and reassess, and/or to consistently provide the care planned level of assistance with meals to ensure the</p>	F 325		
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F 325	Continued From page 33 resident received adequate intake, had the potential to place Resident #248 at risk for continued weight loss and declining health status.	F 325	F-329, SS=D, DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS <i>How will the facility correct the deficiency as it relates to the resident?</i> Resident #143's medication regimen will be reviewed by the facility's pharmacy consultant for recommendations related to this resident's drug regimen. Any recommendations from the pharmacist will be reported to the attending physician and to the resident's legal representative. Implementation of the recommendation will begin once informed consent has been granted by the resident's legal representative. The Unit Manager for the Dementia Unit will update Resident #143's monthly psychoactive monitors. <i>How the facility will act to protect residents in similar situations?</i> The Unit Manager will review/update the monthly psychoactive monitors for all other residents on the Dementia Unit, where this problem was identified. <i>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</i> This isolated occurrence will not require a system alteration.		
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure staff adequately monitored and considered gradual dose reductions of medications for 1 of 6	F 329			

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F 329	<p>Continued From page 34</p> <p>Sampled Residents (#143) reviewed for unnecessary medications of the 30 residents who were included in the Stage 2 review. This potentially placed the resident at risk for receiving unnecessary medications.</p> <p>Findings include:</p> <p>The facility's policy and procedure for Anti-psychotic medications, dated "4/13", and anti-anxiety medications, dated "6/14", directed the License Nurse (LN) to evaluate the effectiveness of the psychoactive medication by using the "Monthly Psychoactive Monitoring Summary" form. The goal was to attempt gradual dose reductions, unless contraindicated, on these medications.</p> <p>Resident #143 was admitted to the facility [REDACTED] 2012 with diagnoses of depression, anxiety and dementia.</p> <p>Resident #143 received the following psychotropic medications: Clonazepam (used for anxiety) 0.5 mg (milligrams) three times daily for generalized anxiety and dysthymic disorder (a depressive mood disorder), Celexa (an anti-depressant) 30 mg for depression and Seroquel (an anti-psychotic) 25 mg in the morning and 75 mg at bedtime for dementia with behavioral disturbance. The behavioral disturbances were described as screaming out, fear of being alone, delusional about bathroom needs, and combative and/or refusing activities of daily living needs.</p> <p>A review of the May 2014 and June 2014 behavioral flow sheet indicated the Resident was being monitored daily for yelling/screaming and</p>	F 329	<p><i>How the facility plans to monitor its performance to make sure that solutions are sustained.</i></p> <p>The DNS or designee will conduct a random audit of the monthly psychoactive reviews for all Units in the facility during the next quarter to ensure that the monitors are updated according to facility policy. The DNS or designee will ensure that any identified issues are corrected, and a summary report will be shared with the Quality Assurance Committee after the quarter is completed. Education, corrected practice, and initiation of monitoring process will be completed on or before 8/8/14.</p>	

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F 329	<p>Continued From page 35</p> <p>being restless. There is documentation on the May behavioral sheet the resident was yelling/screaming one time and was restless once in June. There was no evidence Resident #143's other behaviors described above were being monitored.</p> <p>Resident 143's record was reviewed for evidence of psychoactive medication monitoring. There was no evidence of any monitoring for the last nine months or attempts at possible dosage reductions for the Seroquel and Clonazepam..</p> <p>In an interview on 6/20/14 at 12:12 p.m., Staff CC stated Resident 143's psychotropic medications were discussed at the quarterly care conference. Staff CC was asked about the monthly monitoring as outlined in the facility's policy and procedure. Staff CC confirmed Resident 143 had not had a monthly review monitoring the effectiveness of the psychoactive medications.</p> <p>Three care conferences (3/2014, 1/2014 and 10/2013) were reviewed. The care conferences only discussed what medications Resident #143 was receiving, and lacked sufficient monitoring of the medications.</p> <p>There was no evidence the facility monitored the use of the Seroquel and Clonazepam towards therapeutic goals, monitored targeted behaviors, assessment of interventions which were effective in meeting the residents mood and behavioral needs. Nor was there evidence of a gradual dose reduction for these two medications placing this resident at potential risk for receiving unnecessary medications.</p>	F 329			
F 334	483.25(n) INFLUENZA AND PNEUMOCOCCAL	F 334			

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F 334 SS=B	<p>Continued From page 36 IMMUNIZATIONS</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is</p>	F 334	<p>F-334, SS=B, INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</p> <p><i>How will the facility correct the deficiency as it relates to the resident?</i> For every resident named (2, 12, 76 & 125) documentation of informed consent will be completed in the resident's record.</p> <p><i>How the facility will act to protect residents in similar situations?</i> Audits of all other resident's charts will be done and missing documentation for informed consent received during the previous flu season will be completed.</p> <p><i>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</i> Education will be given to all Unit Managers & Unit Coordinators regarding their responsibility to document when informed consent is received, education given including the Vaccine Information Statement and person giving the consent and relationship if not the resident.</p>	
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F 334	<p>Continued From page 37</p> <p>medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to provide documented evidence staff provided education of risks and benefits prior to administration of flu vaccines for 4 of 6 Sampled Residents (#s 2, 12, 76 & 125) who received the vaccine. This had the potential to place these residents or their surrogate decision makers from having information necessary to make an informed choice to determine if they wanted to accept or</p>	F 334	<p><i>How the facility plans to monitor its performance to make sure that solutions are sustained.</i></p> <p>Infection Control nurse or designee will audit informed consent and resident/family education given during flu season and quarterly for compliance. Education, corrected practice, and initiation of monitoring process will be completed on or before 8/8/2014.</p>	
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F 334	<p>Continued From page 38 decline the vaccine.</p> <p>Findings include:</p> <p>On 6/19/14 at 2:19 p.m. Staff O reported residents were provided flu immunizations during the past flu season beginning 10/1/13 through 3/31/14. Staff O reported residents or surrogate decision makers were given a Flu Vaccine Information Statement (VIS) sheet obtained from the CDC (Centers for Disease Control and Prevention.) Vaccine VIS sheets educate regarding flu symptoms, potential complications of the flu, when individuals should not get the vaccine, risks and types of vaccine reactions and specific potential side effects and benefits associated with the vaccine.</p> <p>Staff O also reported staff documented in resident computerized records when they provide a copy of the VIS and educate regarding risks and benefits associated with the vaccine.</p> <p>RESIDENT #12 Resident #12 resided in the facility during the previous flu season. Resident diagnoses indicated in the most recent quarterly assessment dated 6/14/13 included cancer, anemia, a heart condition and diabetes.</p> <p>The assessment also identified the resident had impaired vision and required large print to read and had the ability to understand others. Computer records indicated staff obtained consent and administered the vaccine on 10/10/13.</p> <p>Resident #12's medical record did not contain evidence staff provided the VIS sheet in a large</p>	F 334		
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F 334	<p>Continued From page 39 print format and verbally discussed potential benefits and side effects prior to administering the flu vaccine.</p> <p>On 6/24/13 at 7:33 a.m. with Staff O and at 9:57 a.m. with Staff B, both confirmed and reported staff did not document they provided education to the resident or family prior to administering the flu vaccine.</p> <p>RESIDENT #2 Resident #2 admitted to the facility on [REDACTED] 12. The resident's record indicated staff administered the flu vaccine on 10/13/14. The immunization record did not indicate staff discussed risks and benefits with the resident before administering the vaccine.</p> <p>On 6/19/14 at 3:28 p.m. Staff O reported the risks and benefits would be documented in the progress notes if not documented on the immunization form. Progress notes documented staff administered the vaccine and did not identify staff first provided education materials or explained risks and benefits before they administered the vaccine.</p> <p>RESIDENT #76 Resident #76 resided in the facility during the previous flu season and had multiple chronic medical conditions that included decreased mobility and cognitive decline. The resident's record documented staff administered the flu vaccine on 10/10/13.</p> <p>On 6/20/14 at approximately 2:15 p.m. Staff B provided a copy of immunization records and confirmed it did not contain evidence staff provided education of risks and benefits prior to</p>	F 334		

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F 334	<p>Continued From page 40 administering the flu vaccine.</p> <p>On 6/20/14 at 2:16 p.m. Staff J reported Resident #76 was unable to make informed decisions on own and a family member would have been contacted regarding education prior to administering the vaccine. The resident's record did not contain evidence staff provided education to the family member.</p> <p>The facility Policy and Procedure titled "Influenza Vaccination" stated "prior to the vaccination, the resident (or resident's legal representative) will be provided information and education regarding the benefits and potential side effects of the influenza vaccine."</p> <p>On 6/24/14 at 7:33 a.m. Staff O reported staff needed further training regarding how to document provision of education provided prior to administration of flu vaccines.</p> <p>RESIDENT #125 Resident #125 received the influenza vaccine on 10/10/13.</p> <p>There was no documentation in the medical record indicating the Vaccine Information Sheet was given to the resident and/or healthcare decision maker discussing the risk and benefits of the vaccine.</p> <p>In an interview on 6/20/14 at 9:15 a.m., Staff B stated on 10/4/13 the Unit Manager gave the informed consent to the family but did not "check" the box in the computerized medical record indicating the consent was given. There was no other supporting documentation in the medical</p>	F 334		
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F 334	Continued From page 41	F 334			
F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>F-441, SS=E, INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p><i>How will the facility correct the deficiency as it relates to the resident?</i> Every staff member named (C, D, JJ, HH & NN) will be educated, counseled with a written warning and care observed for compliance.</p> <p><i>How the facility will act to protect residents in similar situations?</i></p> <p><i>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</i> Education will be given to all nursing staff regarding their responsibility for hand washing before and after direct contact with each resident during mealtimes including washing hands before meals, after direct contact with residents, in-between residents when feeding them, wearing gloves when preparing meal trays involving touching food items or taking lids off cup. Will continue yearly education related to proper hand washing procedures.</p>		

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F 441	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure 5 of 10 staff (Staff # C, D, JJ, HH, & NN) washed hands according to accepted professional standards before and after direct contact with each resident. This failure placed residents at risk of infection. Findings include: PACIFIC DINING ROOM On 6/19/14 between 7:00 a.m. and 8:10 a.m. during Pacific dining room observations, 10 residents were seated at three tables and noted to be dependent on Nursing Assistant (NA) C and D to help them with some or all of their meals. Nursing Assistant C was observed to deliver trays, cut resident food, feed residents, assist one resident who was coughing, replace clothing protectors, take trays to the hall cart, return and touch residents at two of the three tables without performing hand washing. Both NA C and D continued to rotate tables, wipe residents' faces, assist with food/drinking cups and use residents' utensils without hand washing between direct resident contact when moving from table to table/ resident to resident. ALPINE DINING ROOM Observations were made of the noon meal in the Alpine dining room on 6/16/14 from 11:45 a.m. until 12:15 p.m. At 11:47 a.m., Staff JJ assisted a female resident with her positioning by moving the wheelchair	F 441	<i>How the facility plans to monitor its performance to make sure that solutions are sustained.</i> Unit managers and Unit coordinators will monitor mealtimes for staff compliance. Infection Control nurse will monitor staff during infection control rounds for proper hand washing before and after direct contact with each resident. Audit results will be reviewed by QA committee to assess the need for further problem solving. Education, corrected practice, and initiation of monitoring process will be completed on or before 8/8/2014.	

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F 441	Continued From page 43 away from the table, removed both foot rests and positioned the resident back up to the table. Staff JJ then did the same action to a male resident. Staff JJ, without washing her hands, retrieved a tray and removed the lids of the cups, touching the cup rims with her bare hands and delivered the tray to a male resident. Staff JJ was then observed, with the same contaminated hands, assisting a female resident with her lunch tray by touching the resident's sandwich, placing the sandwich in the resident's left hand and rubbing the resident's back. Staff JJ then proceeded, with the same contaminated hands, retrieve another tray, removed the cup lids while touching the cup rims. At 11:58 a.m., Staff JJ washed her hands. Similar observations were made on 6/20/14 from 7:52 - 8:12 a.m. with Staff HH. In an interview on 6/20/14 at 11:04 a.m., Staff HH was asked regarding what is her process when she touches resident while serving food. Staff HH stated she would wash her hands after she touched a resident. Staff HH was made aware this was not done during the breakfast observation. HALL On 6/16/14 at 11:48 a.m., Staff NN was observed delivering the hall trays on the 700 hall. Staff NN removed a tray off of the cart, picked a glove up off of the floor and walked into another resident's room to throw the used glove away. Staff NN, with contaminated hands, proceeded to another resident's room to deliver the food tray and then was observed to wash his/her hands.	F 441			
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	F 463			

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F 463	Continued From page 44 The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to implement a system to systematically and routinely check call lights in each resident's room and bathroom to ensure call light malfunctions were timely identified. As a result, the facility failed to identify call lights for 3 Sampled Residents (#s 67, 96 & 142) and in 1 of 3 Nursing Units (Alpine Unit) was fully functional. Failure to have a consistently functional communication system had the potential to place residents, staff and visitors at risk to not receive timely assistance when needed. Findings include: ALPINE UNIT A call light check was done on the Alpine unit on 6/16/14 from 4:00 - 4:30 p.m. Room 1101-1, the resident was not in the room. The call light was wrapped around the light fixture above the bed, wedged behind the dresser, was not accessible and unable to activate. Room 1102-2, the resident was not in the room. The call light lit outside of the resident's room (above the doorway), but there was no sound in the hall or at the nursing station.	F 463	F-463, SS=D, RESIDENT CALL SYSTEM – ROOMS/TOILET/BATH <i>How will the facility correct the deficiency as it relates to the resident?</i> Call light buttons will be provided and placed within reach for every resident, excluding those on the Alpine Unit. There, the call lights will remain coiled above the beds and staff will be trained to use the call light if they need assistance. The call light system has been repaired and reprogrammed so that all call lights in resident rooms/toilets/baths are fully operational. <i>How the facility will act to protect residents in similar situations?</i> All call lights in the facility will be checked to determine they are operating properly. All staff in the Nursing, Housekeeping, and Therapy departments will be instructed to check for accessible placement of call light buttons for each resident when entering and departing from resident rooms/toilets/baths. <i>Measures the facility will take or the systems it will alter to ensure that the problem does not recur.</i> Maintenance staff will daily check the Nurse Station monitor panel for service or error messages. Nursing staff will be instructed to report call light malfunctions on maintenance logs to request service.	

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F 463	<p>Continued From page 45</p> <p>Room 1108-2, the resident was not in the room. The call light was coiled up, hanging down from the wall, and not accessible to the resident. The call light lit outside of the resident room, but did not sound at the nursing station.</p> <p>Resident 179's did not have a call light available next to his/her bed to be used.</p> <p>In an interview at 4:04 p.m., Staff QQ was asked about Resident #179's call light. Staff QQ stated the Resident had a bed alarm would sound if the Resident needed assistance.</p> <p>Similar findings were found in the remaining 14 resident rooms.</p> <p>In an interview at 4:15 p.m., Staff OO stated most of the residents do not use their call lights to ask for assist. Staff OO further stated, the emergency bathroom call lights do make an audible noise, but not the call lights in the resident rooms.</p> <p>In an interview at 4:45 p.m., Staff KK was asked how he/she asked for help when there was no accessible call light in the resident's room. Staff KK replied he/she would call out for help, if he/she was not able to leave the resident unattended.</p> <p>In an interview at 5:20 pm, Staff PP stated when a call light was activated, it would sound at the nursing station (and pointed to a call light monitor sitting on the nursing desk). The surveyor activated a call light and went back to the nursing station, there was no audible sound noted.</p> <p>At 5:49 p.m., Staff PP alerted the surveyor the</p>	F 463	<p><i>How the facility plans to monitor its performance to make sure that solutions are sustained.</i></p> <p>The Environmental Services Director or designee will conduct a complete audit of all nurse call lights to create a base line. Random audits will be conducted monthly. The results of audits during the next three months will be provided to the Quality Assurance Committee. Education, corrected practice, and initiation of monitoring process will be completed on or before 8/8/14.</p>	
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F 463	<p>Continued From page 46</p> <p>call light monitoring system in the Alpine unit was unplugged and was plugged back in and was working properly.</p> <p>RESIDENT # 96 On 6/16/14 at 5:45 p.m., Resident #96 was not in the room. The surveyor activated the call light and the bathroom emergency light. The call light did not sound or register at the nursing station, but did light outside of the Resident's room.</p> <p>RESIDENT #142 On 6/16/14 at 5:45 p.m., Resident #142 was not in the room. The surveyor activated the call light and the bathroom emergency light. The call light did not sound or register at the nursing station, but did light outside of the Resident's room.</p> <p>On 6/20/14 at 8:32 a.m., Resident #96 and #142's call lights and bathroom emergency light were checked. All three call lights did light outside of the resident's room, but did not sound or register at the nursing station. It was observed the call light system at the Ocean nursing station read "service" was required, and was not registering any call lights throughout the facility.</p> <p>At 8:27 a.m., Staff J alerted the maintenance department of the call light system not registering at the Ocean nurses station.</p> <p>In an interview on 6/23/14 at 8:00 a.m., Staff P was asked about the call light system. Staff P stated he/she was not aware of Resident #67 call light not working prior to 6/16/14, but has since fixed the call light when made aware on 6/16/14. Staff P was aware Resident #96 and #142's call lights were not sounding or registering at the Ocean nursing station for about a month. Staff P</p>	F 463		
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F 463	<p>Continued From page 47</p> <p>stated the call lights in this room did not work due to the facility was changing call lights systems. Staff P was asked how he/she was made aware of a resident's call light was not working. Staff P responded, there was no system in place to check the call lights on a routine basis, but staff would notify him/her of any call light concerns.</p> <p>In an interview at 10:00 a.m., Staff J stated the current call light system did not alert the staff if a call light was not functioning properly. Staff J was asked what he/she does when there is a call light concern. Staff J responded, he/she is alerted by the staff or through his/her own observation, and if there was a concern he/she notified Staff P right away.</p> <p>RESIDENT #67</p> <p>On 6/19/14 at 8:32 Resident #67 sat in a wheelchair in room with legs on footrests facing the bed. The resident's call light cord lay on the floor behind the bed out of reach. The resident's eyes were closed and did not respond when spoken to. Staff were not present in the room at this time.</p> <p>On 6/16/14 at 4:10 p.m. Resident #67 sat in a wheelchair with a call light placed on the resident's lap. The resident did not respond when asked if he/she could use the call light. When the surveyor attempted to activate the call light it did not register a light outside the room door or make an audible sound at the nursing station.</p> <p>During a second attempt to activate Resident #67's call light on 6/16/14 at 5:10 p.m., again it did not activate outside the room door or make an audible tone at the nursing station.</p> <p>At this time, Staff U confirmed Resident #67 did</p>	F 463		
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F 463	<p>Continued From page 48</p> <p>not use the call light. Staff U also reported when residents could not use their call lights staff conducted visual checks every 15 minutes and anticipated their needs.</p> <p>On 6/16/14 at approximately 6:25 p.m. the survey team reported concerns related to call lights not functioning to Staff B before leaving the facility.</p> <p>On 6/17/14 at 1:52 p.m. the resident lay in bed with the call light clipped to a blanket that covered the resident. The call light did not function during an attempt to activate it.</p> <p>On 6/20/14 at 8:00 a.m. Maintenance Staff P stated he did not know previously Resident #67's call light did not work. Staff P reported an outside company had been notified to complete repair to the call light system and the resident's call light now signaled at the nursing station but the repair company still needed to reprogram the call light system.</p> <p>6/20/14 at 8:20 a.m. Resident #67 lay in bed with call light draped on the covers across the foot of bed. The resident's call light did not light up outside the room door. Staff T entered the room at this time and moved the call light within the resident's reach.</p> <p>On 6/24/14 at 9:33 a.m. Staff A reported call lights that did not register a light outside the room door or signal an audible tone needed to be manually identified and reported. Staff A did not know how long Resident #67's call light did not work.</p> <p>Later that morning at approximately 10:30 a.m., Administrative Staff A reported the facility obtained assistance from an outside company to</p>	F 463		

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F 463	<p>Continued From page 49</p> <p>repair reported call light concerns and further work was need to repair Resident #67's room call light.</p> <p>On 6/24/14 at 9:00 a.m. Staff Q reported nursing staff did not conduct routine maintenance checks on call lights and thought "someone should." When asked how nursing staff knew if a call light did not work, Staff Q reported the signal and visual digital pad at the nursing station would maintain an audible tone and not turn off.</p> <p>On 6/24/14 at 9:07 a.m. Maintenance Staff P reported staff needed to actually push the call light to activate it in order to know if it did not work. Staff P reported call light malfunctions did not register at the nursing station and maintenance relied on nursing to "pay attention to that.</p> <p>Staff P reported routine maintenance checks were not conducted on call lights addressed concerns only when reported by staff and work orders were requested.</p> <p>On 6/24/14 at 9:33 a.m. Staff A reported nursing staff were advised to note call light malfunctions on maintenance logs to request service.</p>	F 463			