

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

PRINTED: 11/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/30/2012
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NAME OF PROVIDER OR SUPPLIER CAROLINE KLINE GALLAND HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 7500 SEWARD PARK AVENUE SOUTH SEATTLE, WA 98118
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Caroline Kline Galland Home on October 22, 23, 24, 25, 26, 28, 29 and 30, 2012. A Stage II sample of 45 current residents was selected from a census of 188. In addition, the closed records of 8 discharged residents were reviewed.</p> <p>The survey was conducted by: Susan Abrisz, MSW Marilyn Ferguson-Wolf, MA, RD, CD Janet Thorson-Mador, RN, MSN</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging & Disability Services Administration Residential Care Services, Region 2 Unit E 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388 Telephone: (253) 234-6004 Fax: (253) 395-5070</p> <p><i>[Signature]</i> Residential Care Services Date</p>	F 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 12/31/2012
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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 000	Continued From page 1	F 000		
F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide care and services in a manner which enhanced resident dignity. Instances observed included: for Resident #475, one of two sample residents, and random observations of Resident #93, urinary catheter bags were not covered when residents were in public areas.</p> <p>For Resident #94, who was observed during medication administration, staff gave the resident an injectable medication while she was seated in a public dining room. For Residents #258, 70, 63, 77 and 97 and approximately sixty other residents, the facility posted private dietary information for these residents in a public dining area. These failures created the potential to detract from the residents' quality of life.</p> <p>Findings include: UNCOVERED CATHETER BAGS: RESIDENT #475: Resident was recently admitted with multiple medical conditions necessitating use of a urinary catheter. During observations on 10/22/12 at</p>	F 241	<p>Kline Galland is committed to providing an environment in which each resident is comfortable, safe and secure. Kline Galland's mission is to enhance the quality of life of our residents to preserve their dignity by providing a caring environment.</p> <p>In respect to residents #475, #93 and #94, these deficiencies were corrected on the day (during survey) this was brought to our attention by immediately covering the urinary catheter bag, counseling a nurse one to one about protecting resident's privacy when administering injection and by covering up dietary information.</p> <p>All urinary catheter bags were inspected to ensure they have a cover and this does not occur to other residents in similar situation. All dining areas were inspected immediately to ensure that the private dietary information is protected.</p> <p>The Staff Development Coordinator will conduct a series of in-services for professional staff on importance of promoting resident care in a manner and in an environment that maintains or enhances resident's dignity and respect.</p>	<p>10/22- 10/30/12</p> <p>10/30/12</p> <p>12/14/12</p>

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F 241	<p>Continued From page 2</p> <p>12:00 p.m. in the dining area and 10/25/12 at 10:00 a.m., in the unit's day room, the catheter bag was hanging under the wheelchair without a cover. On 10/29/12 at 7:48 a.m., the resident's catheter bag and some of the urinary tubing was lying on the resident's wheelchair foot rest. On all occasions the urine inside the bag was clearly visible to other residents and visitors.</p> <p>In an interview with the charge nurse, Staff J, on 10/29/12 at 8:27 a.m., she said "Urinary catheter bags should be covered for privacy."</p> <p>RESIDENT #93: Resident #93 required the use of a urinary catheter. On the following occasions the urinary catheter bag was uncovered beneath the resident's wheelchair in the dining area of the unit: 10/24/12 at 8:17 a.m. until 9:00 a.m.; 10/25/12 at 8:25 a.m. until 9:35 a.m.; 10/26/12 at 7:40 a.m. and at 10:15 until 11:15 a.m.</p> <p>In an interview with the charge nurse, Staff I, on 10/26/12 at 11:15 a.m. she reported "The staff are trained to put some kind of cover over the urinary catheter bag, a blue catheter bag or a pillow case if the blue bag is not available." When the nursing assistant who had provided the resident with a shower was asked about covering the catheter bag, he reported, "There aren't any blue bags available."</p> <p>MEDICATION ADMINISTRATION: RESIDENT #94 On 10/24/12 at 8:00 a.m., during medication administration, it was observed that the medication nurse, Staff K, walked up to Resident</p>	F 241	<p>Random QA checks will be performed regularly on medication pass by Nursing Administration, managing catheter bag, and protecting resident private dietary information to ensure resident dignity and respect.</p>	<p>10/30/12 and on-going</p>
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F 241	<p>Continued From page 3</p> <p>#94, lifted her shirt and injected medication into her abdomen. The resident was seated at the dining room table with other residents around the table next to her.</p> <p>POSTING RESIDENT INFORMATION IN PUBLIC AREAS:</p> <p>On 10/22/12, during observations of the noon meal in the third floor main dining room, resident information, including first and last names, and private medical information such as prescribed diets and dietary restrictions were taped to the top of the tables used by residents at each meal. This information remained on the tables throughout the day, where it was visible to other residents, staff or visitors. For Residents #258, 70, 63, 77 and 97 and approximately 60 other residents, the medical/ dietary information taped to the tables included their specific diet, as well as "fluid restriction", "sodium restriction", or "lactose intolerant".</p> <p>On 10/30/12 at 9:25 a.m., during an interview with the Dietary Manager (Staff D), she was asked about the decision to tape resident information to tables in this dining room. She stated the information had previously been present on cards at each table. She said approximately two weeks previously, staff decided to tape the information to the tables because some cards were getting lost. When asked if this plan to have personal information about resident diets posted where other residents or visitors could see them had been discussed with administrative staff, she said it had not. At 9:40 a.m. on 10/30/12, during a discussion with the Director of Nursing (Staff B), she said she was not aware of the system of taping resident names and personal</p>	F 241		
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F 241	Continued From page 4 medical/dietary information to tables in the main dining room. She said she was aware of requirements related to resident dignity including not posting care information in areas visible to the public.	F 241		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248	The Caroline Kline Galland Home is committed to providing a comprehensive activity program for its residents. The Kline Galland Home employs qualified activity staff under the supervision of a qualified activity director. In respect to resident #98 and resident #29, re-conducted comprehensive assessment and updated care plan to reflect offering activities in resident room when activities refused by resident by Activity Director. All resident comprehensive activity care plan documentation will be reviewed and updated in regards to offering room activities when activities refused by resident by Resident Life Care staff. Activity Director will provide an in-service to entire activity staff on importance of providing a comprehensive activity program including activities in rooms when activities refused by residents.	10/30/12 12/14/12 and on-going 12/14/12
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a program of activities to meet the needs of Resident #98, one of three sample residents who needed staff assistance to provide a program of individualized activities. This failure placed her at risk for social isolation and a diminished quality of life. Findings include: Resident #98 was admitted on [REDACTED] 11 with care needs related to dementia with impaired mobility, impaired swallowing (dysphagia) and impaired speech (aphasia). According to her Minimum Data Set (MDS) assessment dated 9/16/12, she had difficulty with her memory and her ability to communicate with staff. She was totally dependent on staff for all aspects of her care. She was unable to walk and according to an interview with a Licensed Nurse (Staff E) on 10/29/12, Resident #98 was very resistant to			

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F 248	Continued From page 5 being out of bed or leaving her room. In a recent "Life Services Comprehensive Initial Assessment" dated 10/16/12, a Recreational Therapist (Staff E) documented Resident #98 had no "behavior concerns" or any pattern of refusing care or activities. The stated goal for this resident was "out daily in social environment to activities of choice/ interest". There were not goals related to providing in-room activities for this resident who reportedly chose to stay in bed. Interventions listed to address these goals included " Escort to social environment- sit in lounge" and "Enjoys watching TV / listen to music- assist as needed" and "Support family visits". Review of her current care plan, dated 10/12/12, under the problem of "Alteration in mood and behavior" identified interventions including - "one to one with staff as needed"; "Invite/ escort to act of choice", and "Offer to get out of bed daily...(res refuses)". When observed on 10/23/12 at 7:40 a.m., 9:58 a.m., 11:02 a.m. and 1:43 p.m., Resident #98 was observed in bed, asleep, being fed via a feeding tube. She did not awaken when her name was called. The room was dark, with the curtains drawn and the lights off. Other than a TV which remained off, there were no items observed which might provide sensory stimulation for this resident. At 3:10 p.m. on 10/23/12, Resident #98 was awake in bed. She talked briefly, but didn't know where she was. Since 7:10 a.m., there were no observations of staff offering or providing any in-room activity for her. Similar observations of a lack of in room activities	F 248	Activity Director will conduct a focused quarterly evaluation which will assess a resident's recent activities in light of comprehensive goals established in the comprehensive assessment including in room activities.	12/14/12 and on-going
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F 248	<p>Continued From page 6</p> <p>were made on 10/24/12 at 8:40 a.m. and 11:05 a.m. when the resident remained in bed but was not provided with music, TV or any other in-room activity. On 10/26/12 at 8:05 a.m., 9:55 a.m., 11:05 a.m., 11:55 a.m. and 1:00 p.m. Resident #98 was again observed to be in bed, in a darkened room, with no music or other diversion provided. During the morning of 10/29/12, Resident #29 was again observed in her room, in bed with no activities provided.</p> <p>In contrast, on one of the five days she was observed, (10/25/12) at 9:38 a.m. and noon, Resident #98 had classical music playing in her room. She was awake at noon, and when asked if she enjoyed the music, she replied, "Oh, yes...".</p> <p>On 10/29/12 at 11:10 a.m., a Recreational Therapist (Staff F) was interviewed. When asked about the types of activities provided for Resident #98, she replied, "I try to make sure she has music on", and said the resident liked certain kinds of music. When asked about family support or visits, Staff F said Resident #98 had no family, then said she had visits from people in her church three or four times a month. During a discussion of the observed lack of in-room activities for Resident #98 on 10/23/12, 10/24/12, 10/26 and 10/29/12, Staff F said she tried to check residents by doing brief visits. She was not aware of the lack of in-room activities observed on the above dates and was not able to show any activities had been offered or refused on those days.</p> <p>When asked about her system for documenting when activities such as music or social visits were offered and either accepted or refused by</p>	F 248		

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F 248	Continued From page 7 residents, Staff F said she didn't have a system for documenting when activities were offered/ provided to residents, or when activities were refused by Resident #98, or other dependent residents.	F 248		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250	Kline Galland is committed to providing social service to meet all resident's needs. The Social Services staff works closely with medical and nursing team on daily basis to identify and address medically related social service needs. In regard to resident #80, social services together with Dentist reviewed his dental care needs with resident, family and nurse practitioner, and reflected it to his care plan. Social Service's staff and Charge Nurse will review resident care plans to ensure addressing medically related social service needs, particularly on dental care needs. Director of Social Services will in-service social service staff on the importance of identifying and addressing residents medically-related to social service needs.	11/30/12 11/30/12 and on-going 12/14/12
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide social services to Resident #80, one of two residents reviewed for dental services. This had the potential to prolong dental and psychosocial discomfort for the resident. Findings include: Resident #80 was admitted with care needs including bipolar disorder and a history of cancer. His most recent annual MDS Assessment dated 08/11/12 indicated he had no cognitive impairment. The assessment also reported that he had no dental issues or mouth pain, and had not received any as-needed pain medication for any reason during that quarter. The care plan dated 09/23/12 for Alteration in Comfort: Pain included chronic pain of both ankles and right foot pain. It included the			

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F 250	<p>Continued From page 8</p> <p>interventions to assess and manage pain, and medicate for pain prior to performing activities of daily living or participating in the rehabilitation program. It did not include oral/dental pain.</p> <p>The Mood and Behavior care plan dated 12/22/12 included that the resident had depression, insomnia and anxiety, with signs including inability to sleep and depressed mood.</p> <p>A dental treatment record note of 01/11/12 included examination results and recommendations that tooth #11 "hurts when [he] sucks air in. #11 tooth no longer attached to crown. Only root remains... needs extraction of root #11. Will send treatment plan to social worker to help him find an oral surgeon that takes his insurance."</p> <p>A social services note dated 02/06/12 documented that the social worker, Staff L, had spoken to the dentist that day about the resident's need to have an upper root extracted that was blocked by his dental bridge. "It is causing resident significant discomfort. She gave me some clinic possibilities, of which I'm following up." The social worker documented further that she contacted the resident's daughter by phone on 02/08/12, and left her a voice mail on 04/14/12 "to find out if she followed up on her father's dental problem."</p> <p>On 10/19/12 the nurse practitioner (ARNP) wrote an order for Oxycodone, a narcotic, for the resident to take every evening routinely at 10 p.m., for pain. In the progress note dated 10/19/12, the ARNP documented the following: "Last week made statements to his wife and</p>	F 250	<p>Nursing Administration and Social Services team will monitor and conduct overall review of all residents medically related social services needs on an on-going basis and at the quarterly care conference and will document corrective plan, if any and quarterly as part of the quality assurance process.</p>	11/30/12 and on-going
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F 250	<p>Continued From page 9</p> <p>family that 'life isn't worth living anymore'... He admits to feeling very down last week and does admit that he had thought about suicide due to a financial issue surrounding some work needing to be done on his teeth/bridge. Has had mouth pain for a while and his bridge needs to be fixed. He reports it will cost thousands of dollars that he does not and will not have and insurance will not cover the associated costs. We bumped up his Citalopram (an anti-depressant) back to 30 mg." The ARNP also noted, "Tooth pain--will schedule Oxycodone 5 mg at 10 p.m. at his request due to increased tooth pain when lying down."</p> <p>In an interview on 10/23/12 at 2:42 p.m., the resident stated "sometimes my teeth hurt," and pointed to his left upper teeth.</p> <p>In an interview on 10/25/12 at 11:43 a.m., Staff M, the charge nurse, stated "He's doing good with Oxycodone. It makes him more comfortable at night." She said he had been having a toothache.</p> <p>On 10/29/12 at 2:50 p.m., Staff L said that the resident had been "bothered quite a few months by the tooth." She said the resident had had a dental appointment but it was canceled because he was sick, and the resident's daughter had not rescheduled it. She said the family had lost the dental referral, and also that the daughter was "very proactive." Staff L said she had just "tossed my notes in the shredder" about her communications with the resident's daughter.</p> <p>When asked about the progress on the resident's dental issues, Staff L said, "It has taken way too long." She said that she was going to follow up again with several resources and with the</p>	F 250		

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F 250	Continued From page 10 resident's daughter to arrange for dental care for the resident.	F 250		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and/or revise comprehensive care plans for Residents #96, 13, 147 and 98, four of 48 sample residents. Failure to establish plans that accurately reflected assessed care needs related to incontinence care, oral care, pressure ulcers and activities, placed residents at risk to receive less than adequate care.	F 279	Kline Galland is committed to providing comprehensive care plan by an interdisciplinary team which develops reviews and revises the plans on an on-going basis. Residents' comprehensive care plans are established on admission and are reviewed and revised with each change of condition in addition to formal review quarterly basis. Resident #96 no longer resides in KGH. In regards to resident #13, #147 and #98, the charge nurse revised the comprehensive care plan and documented the current resident's condition and needs; Resident #13 has been frequently refusing his dental and oral care offered by dentist and nursing staff. However, Charge Nurse reviewed his comprehensive dental and oral care plan, and updated the care plan to reflect his current status dental/oral care needs and intervention. Resident #147 is actively involved in planning her own care plan together with entire clinical team and she demonstrates her understanding of the risk and benefits of interventions placed for her care to prevent pressure ulcers and to heal	

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F 279	<p>Continued From page 11</p> <p>Findings include:</p> <p>RESIDENT #96: The resident was admitted to the facility in [REDACTED] 12. The resident's admission assessment Minimum Data Set (MDS) dated 06/23/12, indicated the resident was alert, oriented, required extensive assistance from one staff member for most activities of daily living (ADL's) and was continent of her urinary function. The Care Area Assessment completed on 06/25/12, identified "resident continent of bladder with good self-control; resident able to get to the bathroom in time for proper voiding; no care plan because she is continent."</p> <p>The 90 day MDS, dated 09/16/12, noted the resident required limited assistance of one staff member for ADL's and was occasionally incontinent of urine (less than 7 times).</p> <p>In review of the Facility "Bowel and Bladder Record" the incontinent episodes increased. During the month of July she was incontinent a total of five times and in August she was incontinent multiple times per day for 25 days. The record also showed during the month of September, she was incontinent every day</p> <p>An "Incontinent Assessment" was completed on 09/16/12. The assessment identified, "Functional Incontinence due to dementia, impaired and decreased mobility". The nursing diagnosis was identified as "Possible functional incontinence". The form included a section titled "Identify Incontinence Management Program". No program was identified for this resident.</p>	F 279	<p>ulcers. While honoring resident's choice and preference, Staff will continue to educate and work with resident to minimize risk of developing pressure ulcers. Resident #98, the activity care plan was reviewed and updated by Activity Director and reflected all of her activity needs including possible refusal of activities.</p> <p>Charge Nurses multidisciplinary team will review comprehensive resident care plans, pertaining to oral/dental care, individualized toileting program and activity needs to reflect current status of the resident needs.</p> <p>Nursing Administration and Activity Director will provide an in-service to all interdisciplinary team on the importance of developing, reviewing and documenting resident comprehensive care plan, reflecting the current status of resident condition and needs.</p> <p>As part of the quality assurance process, the Nursing Administration will conduct random audit of care plans at quarterly care conference and they will document findings and corrective actions.</p>	<p>11/30/12</p> <p>11/30/12 and on-going</p> <p>12/14/12</p> <p>11/30/12 and on-going</p>
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F 279	Continued From page 12 In review of the above information with the charge nurse, Staff H, on 10/29/12 at 11:19 a.m., she indicted, "The resident liked to be out of her room and could not always get back to the bathroom in time to be continent." The Nurse indicated a plan of care should have been developed to address her incontinence. Refer to 483.25 (d) F-315 Urinary Incontinence for more details RESIDENT #13: Resident #13 was admitted with care needs related to multiple sclerosis and psychiatric diagnoses with behavioral issues. According to the medical record, he had infection of his gums, and discontinued his own dental hygiene care in 2005 for reasons not specified in the medical record. A dental hygiene note dated 05/17/2005 documented "He has many natural teeth with severe generalized acute and chronic gum infection. His daily care . . . is still not adequate to control infection. . . I am not certain he is able to completely understand the risk of no care but I explained as best possible . . . Nurses should monitor for pain , swelling, fever and refer to [the dentist] as needed." The hygienist did not give a reason for the refusal, or any alternatives offered, but wrote "I respect his frustration and difficulty tolerating care." The MDS assessments dated 05/18/12 and 08/11/12 documented the resident had no rejection of care. His oral/dental status was not assessed because "Unable to assess." He had no documented pain, and no use of as-needed pain medication or non-pharmacological pain	F 279		

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F 279	<p>Continued From page 13 interventions.</p> <p>The Personal Hygiene care plan dated 05/26/2003 and last updated 05/30/2012 did not contain information about dental care or monitoring.</p> <p>The Resistance with Care plan dated 03/23/2005 included that the resident refused dental hygiene among other services, and interventions included "Monitor for signs of discomfort and fever," not specific to dental. There were no interventions specific to assessing/monitoring the oral cavity or providing routine mouth care on the care plan or TAR (treatment administration record). Interventions included giving medication, talking to the resident before care, leaving him when he was angry and coming back in 10 minutes to offer the care again. They did not include assessing the reason for the refusal or offering alternatives.</p> <p>The care documentation flow sheets used by the NACs (Certified Nursing Assistants) included no directions for providing oral care, including no information on how often the resident was to be offered oral care and what kind of oral care, or monitoring of the oral cavity. Each day the NACs signed off a box that said "I read the resident's plan of care and provided the care as indicated."</p> <p>In a telephone interview on 10/24/2012 at 10:31 a.m., the resident's representative stated that oral care was the the resident's main problem at the facility. "He has horrible smelly teeth. I don't know how successful they are with it. It's a big health care issue we've been struggling with for a long time." She noted that the resident had a history of refusing care, and said "I know he has</p>	F 279		

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F 279	<p>Continued From page 14</p> <p>painful gums. He won't go to a dentist because of pain. They try to sedate him. They used to give him Ativan before dental work but then they quit." Painful gums were not noted in the MDS assessment or plan of care.</p> <p>At 10/25/12 at 9:37 a.m., the resident was observed lying in his bed apparently asleep, with his mouth open. There was a foul smell coming from his mouth and it was noticeable from several feet away.</p> <p>On 10/25/12 at 11:23 a.m., the charge nurse, Staff M, said about the resident's oral care "He's very moody, resistant. He really doesn't want to be helped. Most of the time he says 'Get out of here'." When asked to look at the nursing mood and behavior flow sheet that documented resistance to care on a total of three days between September 1 and October 25, 2012, she said "Sometimes he agrees."</p> <p>In an interview about oral care on 10/26/12 at 9:30 a.m., Staff O, an NAC, stated that provision of oral care was not charted separately from other ADLs (Activities of Daily Living) for the resident. He said that there was no way to know how often the resident got oral care or when he refused. He said that the resident did what he wanted when he wanted, and he sometimes refused interventions.</p> <p>In an observation on 10/26/12 at 12:00 p.m., Staff P, an NAC, gave the resident a toothbrush at his bathroom sink and asked him to brush his teeth. He was able to do so effectively, and did not refuse. She said "It depends on his mood."</p>	F 279		

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F 279	<p>Continued From page 15</p> <p>No staff person interviewed gave a possible reason, including pain, for the resident's refusal of oral care. Assessing the reason for the refusal and/or offering alternatives was not included in the care plan.</p> <p>RESIDENT #147: Resident #147 was admitted with care needs related to Multiple Sclerosis with mobility impairment and contractures of both hands. She had heart disease which put her at risk of swelling of her lower extremities. She was dependent upon staff for repositioning, but was able to get around the facility once she was up in her electric wheelchair. She had no history of pressure ulcers when she was admitted to the facility on 01/11/2012. She developed a pressure ulcer on her left buttock region that progressed to a Stage IV ulcer.</p> <p>The facility's initial skin assessment dated 01/11/12 described a "dusky/cyanotic blanchable" area that was circled on a diagram at the site of the lower buttocks.</p> <p>The admission MDS assessment included the Care Area Assessment (CAA) of "Pressure Ulcers" dated 01/18/2012: "No pressure ulcer at present but remains at risk due to her decreased mobility and not sleeping in bed. She uses reclining sofa to sleep and not able to change her position. She declines to be checked or change position when asleep. Staff will monitor skin daily during care."</p> <p>The care plan originating on [REDACTED] 12 included "Risk for Skin Breakdown" exhibited by dry skin, unable to reposition self, edema, sleeps in a</p>	F 279		

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F 279	<p>Continued From page 16</p> <p>recliner and "uses wheelchair 24/7 per preference." This was modified in a handwritten, undated, unsigned note on the care plan, "Up in wheelchair for 12-15 hours."</p> <p>Interventions in the care plan included monitoring of skin weekly by the licensed nurse, and application of topical cream to the buttocks every shift and as needed. Information was included that "Resident refused to use bed and to be repositioned. Prefers to use recliner when sleeping or resting. Sitting on her motorized wheelchair at daytime." There was no information in the care plan regarding pressure redistribution when sitting up in the wheelchair, or evaluation/monitoring of the sitting surface. Refusal of repositioning did not specify what repositioning was offered in what device, the reason for the refusal, or any alternatives offered.</p> <p>The nursing assistant care directives used from admission until the resident went to the hospital on 02/23/12 included the directions to "report any skin issues to the licensed nurse." In addition, "Resident refused to use bed and to be repositioned. Prefers to use recliner when sleeping or resting. Sitting on her motorized wheelchair at daytime. Calmoseptine to bottom every shift and as needed." There was no information on the directives for NACs about pressure redistribution in the chair during the day, including what was offered, provided or declined.</p> <p>Nursing notes described "redness on resident's buttocks and hips, blanchable," on 02/19/2012 and on 02/21/12 a rash on the thighs, bottom and back. On 02/22/12 it was noted she "prefers to be up in the chair," and that her urinary bag was</p>	F 279		

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F 279	<p>Continued From page 17 leaking and she was wet with urine.</p> <p>The resident was hospitalized between [REDACTED] 12 and [REDACTED] 12 for "sepsis due to cellulitis along her buttocks and posterior thighs " according to a hospital discharge note dated [REDACTED] 12. According to this note, "It was felt that perhaps a faulty wheelchair cushion may have caused the initial area of skin breakdown and this was evaluated by our PT (physical therapist) and should be further evaluated by the SNF PT while she is sitting in her wheelchair." An MD order dated [REDACTED] 12 stated "Roho cushion in wheelchair, and restorative checks daily during restorative program." The MD note included "It was felt her skin on buttocks and thighs was compromised due to sub-optimal cushioning in her wheelchair." The provider prescribed barrier cream to the resident's buttocks, and that the resident was to have an evaluation with seating specialists at the hospital's rehab facility for adjustments to her wheelchair.</p> <p>The care plan dated 02/29/12 for "Risk for Skin Breakdown" included the handwritten, undated, unsigned interventions "Roho cushion to wheelchair," and "Overlay mattress Step 1: check proper inflation and functioning." The MD order for the mattress overlay was dated 06/15/12, several months after the care plan's original date. The recliner for sleeping was crossed off the care plan, but this change was not dated. No pressure relief or repositioning interventions for when the resident was up in her wheelchair were on the care plan. A physical therapy note of 03/14/12 noted that the resident slept in a recliner chair and had a "Tilt-n-Space" wheelchair "for pressure relief," without</p>	F 279		

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F 279	<p>Continued From page 18 recommendations on its use.</p> <p>In an interview on 10/23/12 at 11:48 a.m., the resident stated that "I'm stuck in bed a lot due to a healing pressure ulcer." She was sitting up in her motorized wheelchair at that time, working on her computer. She said that she "sometimes" tipped her wheelchair back to relieve pressure. When she was asked how often she did this, and for how long, she was not able to specify. She said it was not documented by staff.</p> <p>In an interview on 10/25/12 at 11:35 a.m., Staff M, the charge nurse, said "She does do her power chair tilt back at least every two hours. We just kind of remind her." Staff were not documenting the tilt-backs.</p> <p>On 10/26/12 at 1:30 p.m. the resident was observed during a dressing change to the Stage IV pressure ulcer. The clinical coordinator, Staff C, told the resident that the depth of the wound was not improving. During the dressing change, Staff C asked the resident "Are you doing your tilt-backs?" The resident said yes, but she sometimes forgot.</p> <p>On 10/29/12 at 1:00 p.m., the resident was observed to be lying on the air mattress. When asked if she was tilting back in her wheelchair, she said that she was. When asked how often and for how long, she said it was maybe about two hours total between 4:00 and 9:00 p.m. When asked if staff were monitoring this, she said no.</p> <p>Refer to 483.25(c) F 314 Pressure Sores for more details. <i>Deleted Bennett Nov 11/20/12</i></p>	F 279		
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F 279	<p>Continued From page 19</p> <p>RESIDENT #98: Resident #98 was admitted on [REDACTED] 11 with care needs related to dementia with impaired mobility, and impaired speech (aphasia). According to her Minimum Data Set (MDS) assessment dated 9/16/12, she had difficulty with her memory and her ability to communicate with staff. This MDS also identified listening to music as an activity she enjoyed. According to an interview with a Licensed Nurse (Staff E) on 10/29/12, Resident #98 was very resistant to being out of bed or leaving her room.</p> <p>In a "Life Services Comprehensive Initial Assessment" dated 10/16/12, a Recreational Therapist (Staff F) documented Resident #98 had no "behavior concerns" or any pattern of refusing care or activities. The stated goal for this resident was "out daily in social environment to activities of choice/ interest". Interventions listed to address these goals included "Escort to social environment- sit in lounge" and "Enjoys watching TV / listen to music- assist as needed" and "Support family visits". There were no goals related to providing in-room activities for this resident who reportedly chose to stay in bed and refused/ resisted efforts by staff to help her spend time out of bed.</p> <p>Review of her current care plan, dated 10/12/12, under the problem of "Alteration in mood and behavior" identified interventions including - "one to one with staff as needed"; "Invite/ escort to act of choice". " Offer to get out of bed daily... (res refuses)".</p> <p>When observed on 10/23, 24, 26 and 29/12,</p>	F 279			

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F 279 Continued From page 20
Resident #98 was observed to remain in her room in bed. She was not provided with activities such as music or TV on 4 of 5 days when her care was observed. (Refer to F248- Activities- for additional documentation).

F 279

On 10/29/12 at 11:10 am, a Recreational Therapist (Staff F) was interviewed about Resident #98's care plan for activities. When asked about family visits, Staff F said Resident #98 had no family, even though the care plan said "support family visits". Staff F said Resident #98 had visits from her church 3 to 4 times a month, but these were not addressed in the care plan. The issue of possible refusal of activities was had not been addressed or revised in her care plan.

F 315
SS=D 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER

F 315

Kline Galland is committed to safeguarding the health and well-being of each resident through an individualized toileting program, to prevent catheter use, UTI and to restore bladder.

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

Resident #96 no longer resides in KGH. To ensure similar occurrence does not happen, Charge Nurse will ensure that every resident's toileting program is individualized based on resident comprehensive assessment of urinary history at admission and at condition change to put appropriate interventions in place.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to provide appropriate treatment and services for Resident #96, one of one residents evaluated for urinary continence of 48 residents in Stage 2. Failure to thoroughly assess, provide

11/30/12
and on-going

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/30/2012
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NAME OF PROVIDER OR SUPPLIER CAROLINE KLINE GALLAND HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 7500 SEWARD PARK AVENUE SOUTH SEATTLE, WA 98118
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F 315	Continued From page 21 assistance with toileting and to generate an individualized toileting program, placed the resident at risk for deterioration of her urinary function. Findings include: RESIDENT #96: The resident was admitted to the facility in [REDACTED] 12. The resident's admission Minimum Data Set (MDS) assessment dated 06/23/12, indicated the resident was alert, oriented, required extensive assistance from one staff member for most activities of daily living (ADL's) and was continent of her urinary function. The Care Area Assessment completed on 06/25/12, stated "resident continent of bladder with good self-control; resident able to get to the bathroom in time for proper voiding; no care plan because she is continent." The 90 day MDS, dated 09/16/12, noted the resident required limited assistance of one staff member for ADL's and was occasionally incontinent of urine (less than 7 times in the past 7 days). In a physician note dated 08/08/12, the following was recorded. Resident #96 reported that she had "...concerns over her kidneys and reported increased urinary frequency and 'difficulty holding my urine'..." The physician noted this as new concerns for the resident. The resident was referred to the Gerontological Psychological group in August to evaluate her medical condition as it related to behaviors, dementia and depression. They suggested a new medication to be started, if she was free of any urinary tract infections. This medication, Aricept	F 315	Nursing Administration and Charge Nurse will conduct random QA of care plan on toileting program at quarterly conference to ensure that appropriate interventions are in place to address resident incontinent status, needing individualized toileting program.	12/14/12 and on-going
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F 315	<p>Continued From page 22 (a medication used to treat Dementia) was started on 08/14/12.</p> <p>In review of the Facility "Bowel and Bladder Record" the incontinent episodes increased. In July she was incontinent five times on five different days. In August, the monitor showed the resident was incontinent 13 times during the day shift and during the afternoon/evening shift; she was incontinent 1 to 3 times on 25 days of the month. During the month of September, she was incontinent of her urine every day of the month.</p> <p>An "Incontinent Assessment" was completed on 09/16/12. The assessment identified, "Functional Incontinence due to dementia, impaired and decreased mobility". The nursing diagnosis was identified as "Possible functional incontinence". The assessment did not address the increased frequency of incontinence episodes, the new medication started in mid-August, the resident's 2 urinary tract infections on 06/30 and 08/29/12, or any consideration of the resident's mobility status.</p> <p>The "Incontinent Assessment" form included a section titled "Identify incontinence management program", with choices of "Resident is not a candidate for bladder retraining" or "Scheduled toileting program" or "Check and Change program" or "Resident is appropriate for Prompted Voiding Assessment". There was nothing identified for a management plan for this resident.</p> <p>In an interview with the charge nurse, Staff H, on 10/29/12 at 11:19 a.m., she indicated, "The resident liked to be out of her room, would refuse to be toileted when staff offered, and could not</p>	F 315		
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F 315	Continued From page 23 always get back to the bathroom in time to be continent." There was no documented evidence a pattern of increased refusals of assistance and/or additional interventions to assist the resident to return to prior continent status were addressed.	F 315		
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.	F 329	Kline Galland is committed to providing highest quality of clinical care, including prevention of unnecessary drug use. The clinical team includes experienced nurses, physicians, nurse practitioners, social workers, pharmacists and other consultants. In respect to resident #80, a clear documentation was put in place to support clinical rationale for no GDR based on reviews done by physician who reviewed its use with the clinical team, resident and family. To ensure residents are free from unnecessary medication use, Charge Nurse will continue to review resident medication use, especially on GDR needs in timely manner, together with pharmacy consultant, attending physician or Nurse Practitioner, resident and/or DPOA. The team will document clinical rationales for its use.	11/30/12 11/30/12 and on-going

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F 329	Continued From page 25 There was no clinically pertinent rationale for continuing the medication without attempting the recommended GDR. Review of the record revealed that a GDR had not been attempted, and no record of the family's having refused a GDR of Olanzapine was present in the chart. In an interview on 10/30/12 at 10 a.m., Staff B stated "the family does not sign anything directly" if they do not want a resident to have a GDR. She said a family might "feel it would not be a good idea" to take a resident off a medication. She added that "All of our GDR recommendations come out of pharmacy consultation. If you see them, it's happening."	F 329		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility	F 514	Kline Galland Policy affirms that we maintain clinical records on each resident that are complete, accurately documented and readily accessible and systematically organized. In respect to resident #286, he was discharged from KGH at the time of survey. In regards to resident #98 and #127, documentation on provision of care related to activities were reviewed and updated to reflect outcomes.	11/30/12

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F 514	Continued From page 26 failed to maintain clinical records for each resident which were complete and accurately documented. For Resident #286, the facility failed to document if the response to pain medication experienced by the resident was effective. For Residents #98 and 127, and other non-sample residents who were dependent on staff to provide activities and monitor progress towards recreational goals, the facility failed to document provision of activities in a manner which showed planned interventions were being carried out. Failure to consistently document provision of care, and related outcomes did not ensure staff monitored, evaluated and revised resident care when needed. Findings include: RESIDENT #286: Resident #286 was admitted with care needs related to cancer in [REDACTED] 12. He survived for [REDACTED] days in the facility. Review of his closed record revealed he received Tramadol for pain on 5/17, 20, 21, 22, 23, 25, 26 and 28, 2012, for general abdominal pain. After administration of the medication, no information on whether or not the medication was effective was charted by the RN in the "Result" section for any of these administrations. Morphine was given periodically on all the days between 5/17/12 and 5/29/12. The reason was "Pain" in whole body, torso, upper extremities, stomach. No pain result was charted on any of these administrations in the "result" section except on 5/19/12 it said "helped." The documentation did not reveal the resident's pain level, and whether or not the pain medication	F 514	Charge Nurse will review all documentation on response to pain medication in resident MAR (Medication Administration Record), and Activity Staff will include related outcomes to activities in their documentation, to maintain resident clinical records that are complete and accurate. Nursing Administration and Activity Director will schedule an in-service to staff on importance of maintaining accurate and complete resident clinical records on all residents. Random QA will be conducted on regular basis by Clinical coordinator and Activity Director as part of Quality Assurance process to ensure correction.	11/30/12 and on-going 12/14/12 11/30/12 and on-going
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F 514	<p>Continued From page 27</p> <p>administered was adequate to meet his pain needs.</p> <p>Observations of prn pain medication administration for Resident #108 on 10/25/12 at 4:19 p.m. by Staff N revealed that nurses were consistently monitoring the results of narcotic prn medication after this resident had taken the medication. The staff member verified in the record that all doses administered had a corresponding follow-up pain level result based on resident response.</p> <p>RESIDENTS #98 and 127: Resident #98 was admitted on [REDACTED] 11 with care needs related to dementia with impaired mobility. According to an interview with a Licensed Nurse (Staff E) on 10/29/12, Resident #98 was very resistant to being out of bed or leaving her room.</p> <p>In a recent "Life Services Comprehensive Initial Assessment" dated 10/16/12, completed by a Recreational Therapist, (Staff F), she documented Resident #98 had no "behavior concerns" or any pattern of refusing care or activities. There were no goals were included for provision of in-room activities for this resident who reportedly chose to stay in bed and refused/resisted efforts by staff to help her spend time out of bed.</p> <p>On 10/29/12 at 11:10 am, Staff F was interviewed about provision of activities for Resident #98. The lack of observed in-room activities was discussed. When asked for documentation of how often staff met with Resident #98 for one to one visits, or to offer other activities, Staff F said she did not document one-to-one contacts with</p>	F 514		
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F 514	Continued From page 28 residents and did not document when activities were offered for any resident, or if activities were refused or accepted by a resident. Without such information, consistent provision of activities, and /or progress toward recreational goals could not be monitored over time for residents who were dependent on staff to provide them with activities. Similar findings were also discussed regarding Resident #127, who was observed to remain asleep in her room except for meals.	F 514			

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