

08/15/12-MFCL/Ombud/HCS

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

PRINTED: 08/10/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/03/2012
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NAME OF PROVIDER OR SUPPLIER WOODLAND CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 310 FOURTH STREET WOODLAND, WA 98674
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Woodland Convalescent Center on 07/24/12, 07/25/12, 07/26/12, 07/27/12, 07/30/12, 07/31/12, 08/1/12, 08/2/12, and 08/03/12. A sample of ---40 residents was selected from a census of 90. The sample included 48 current residents and the records of 13 former and/or discharged residents.</p> <p>The survey was conducted by: Elizabeth Frost, M.S.N., R.N. Katherine Ander, M.N., R.N. Darryl Luyt, M.N., R.N. Jeri Jones, B.S.N., R.N. Christine Kubiak, M.S.N., R.N.</p> <p>Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, District 3, Unit C P.O. Box 45819 Olympia, Washington 98504-5819</p> <p>Telephone: 360-664-8420 Fax: 360-664-8451</p> <p><i>Jane Jones</i> Residential Care Services Date</p>	F 000	<p>Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.</p> <p>The facility would also like to note that staff commentary quoted by the survey team was consistently inaccurate and some statements were taken out of the context in which they were communicated. The facility feels this is an important consideration since many of the stated quotes reflect negatively on facility intent, knowledge, and concern for quality resident care and services.</p> <p style="text-align: center;">RECEIVED AUG 31 2012 DSHS/ADSA/RCS</p>	
F 156 SS=C	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and</p>	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Candy Jones</i>	TITLE <i>Administrative</i>	(X6) DATE 8/27/12
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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 156	<p>Continued From page 1</p> <p>responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section</p>	F 156	<p>F 156 CFR 483.10(b)(5)-(10)(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES SS=C</p> <p>AFFECTED and POTENTIALLY AFFECTED RESIDENT(S) The facility had recently refurbished the resident's living room area where many of the required postings were located. Upon completion of this project the postings were not all moved to their new location. Although the required information is additionally provided in the resident admission handbook, the noted Medicare/Medicaid information posting and the addresses for the advocacy groups were missing from the public notification area during the survey process. Residents admitting to the facility initially received all notification information required by this regulation. All current facility residents and/or legal representatives will be provided with a written notice of the missing information and directive as to where important resident notices are located and who to contact for additional assistance.</p> <p>SYSTEMIC CHANGES- The facility's current policy supports the criteria established by this regulation, therefore, changes will be made in the area of increased Quality Assurance Program monitoring, including quarterly auditing of required postings and continued annual review of the resident admission packet contents. Education and awareness will be provided ongoing to the resident population and family members as well.</p> <p style="text-align: right;">Cont.</p>	

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F 156	<p>Continued From page 2</p> <p>1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p>	F 156	<p>QUALITY ASSURANCE MONITORING-</p> <p>The Continuous Quality Improvement Team will audit, review and revise as necessary policies/procedures to ensure acceptable thresholds are met on an on-going basis.</p> <p>Plan of Correction date: 8/20/2012</p> <p>Correction Assurance Manager: Candy Hayes, Administrator</p>	

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F 156	<p>Continued From page 3</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to post the required Medicare/Medicaid information and addresses for advocacy groups and state survey agency. This violated the rights of 61 residents and/or legal representatives residing in the facility.</p> <p>Findings include:</p> <p>Tour of the facility 7/27/12 at 8:20 a.m. found required Medicare and Medicaid information was not displayed in any of the common areas or on bulletin boards posting information for families and residents. Names and telephone numbers of advocacy groups and the state survey agency were posted, but not addresses.</p> <p>On 7/27/12 at 9:50 a.m. The facility administrator reviewed resident postings and agreed that required Medicare and Medicaid information was not there.</p> <p>The Administrator stated Medicare and Medicaid information was formerly posted on the family bulletin board and the resident council board. She stated the facility recently remodeled and the</p>	F 156		
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F 156	Continued From page 4 required information was not currently posted or available.	F 156	F 226 CFR 483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, SS=E		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to implement policies to thoroughly investigate incidents to rule out abuse and/or neglect and protect residents and prevent further incidents in accordance with state law and 42 CFR 483.13 (c)(3) for 6 of 13 current sampled residents (#s 30, 34, 28, 25, 21 & 55) and 1 of 1 former sampled resident (#71) reviewed for unwitnessed incidents and investigations. This failure placed the residents at risk for for abuse and/or neglect due to lack of thorough investigations. Findings include: The facility's "Incident/Accident Policy & (and) Procedure" dated 5/10/10 documented, "An incident investigation is filled out for the following reasons: A. Allegations of abuse, neglect, negligent treatment by staff, family or other residents, B. Falls with or without injury, C. Found injuries- i.e. bruises, skin tears, lacerations,	F 226	AFFECTED RESIDENTS- The facility will take the following action to correct the deficiency as it relates to the following residents: Resident #30- Resident was set-up with alarms due to previous witnessed occasions of spontaneous movement placing resident at risk of falls from bed and wheelchair. To establish resident safety as a priority; markings for bed alarm alignment, additional staff training; including skill demonstration for alarm use will be conducted by the Rehab Supervisor. An assessment will be conducted to evaluate the resident's movements while in bed, including a review of comfort medication administration (the RCM). If the resident's current condition demonstrates significant decreased mobility, the bed alarms will be removed. Other options to ensure resident safety have been considered and they were determined to be too restrictive. Previous investigation documents and findings will be re-reviewed to rule out mistreatment, neglect, and abuse. <i>Cont.</i>		

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F 226	<p>Continued From page 5</p> <p>deformities, D. Elopements for : a. Residents that have never eloped before, b. Residents that cannot be redirected back in to the facility (greater than 10 minutes), c. Multiple elopements for any resident that results in greater difficulty in redirecting back into the building, and E. All resident to resident altercations."</p> <p>The policy and procedure documented, "A plan to prevent re-occurrence must be initiated at the time of the incident."</p> <p><Resident #30></p> <p>Record review found Resident #30 was admitted to the facility [redacted] with [redacted]. The resident's annual Minimum Data Set (MDS - an assessment tool) dated 6/4/12, identified the resident had no falls in the past year.</p> <p>Resident #30's Care Area Assessment (CAA) dated 6/4/12, documented staff provided frequent visual checks and the resident had a laser alarm located at the foot of her bed. The CAA detailed specific details of how the alarm was to be set.</p> <p>Resident #30's care plan dated 6/27/12, was amended 6/29/12 to discontinue the laser alarm and add a pull string alarm attached to the resident when in bed on position bar next to wall. The care plan identified that Resident #30 had a seat belt with alarm when in wheelchair, staff was to release every hour for repositioning and toileting.</p> <p>Multiple observations over 8 days of survey (7/24, 7/25, 7/26, 7/27, 7/30, 7/31, 8/1, 8/2) revealed</p>	F 226	<p><u>Resident #34</u>-There is no clear indication of when the resident's lower dentures were initially missing. It clearly could have been after the incident of 7/21/12. There have been repeated documented incidents where the resident has reported items missing and after an expeditious search the missing item is found tucked away in a sock or under the resident's mattress, etc. The resident has not been an accurate historian of events. A report was made on 7/24/12 to the Social Service Designee and the resident could not accurately pinpoint when they were first missing. The Rehab Supervisor reviewed the resident during a meal and did not note any difficulty with chewing or missing lower dentures. The resident's meals were in compliance with the diet texture order. The resident has been scheduled for a SLP evaluation to evaluate concerns with eating, swallowing, and diet texture. The findings of this incident already ruled out mistreatment, neglect, and abuse. Clarification of findings will be documented.</p> <p>An appointment has been made to initiate the process for replacing the resident's lower denture.</p> <p><u>Resident #28</u>-A review of the resident's current ADL status and customary routine will be reviewed to determine safety measures that may need to be put into place. The CNA who first noticed the skin tear will be interviewed to determine facts surrounding incident. A review of any previous incidents similar to this event will be reviewed to assess any patterns of occurrence. Additional staff interviews will be conducted as necessary to evaluate resident safety and to determine whether mistreatment, neglect, and abuse can be ruled out.</p>	

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F 226	<p>Continued From page 6</p> <p>Resident #30 seated in a tilt-in-space wheelchair with very little spontaneous movement or interaction. An alarm was noted on the bed and on the seat belt.</p> <p>Review of progress notes found 3 documented non injury falls from bed (6/20/12, 6/28/12, and 7/10/12).</p> <p>Review of incident reports for all 3 falls found that the alarm was not set correctly on 6/20/12 and 6/28/12. The 7/10/12 incident report documented, "adjust alarm and check." Staff inservices on correct alarm placement were done 6/21/12 and 6/29/12. The incident for 7/10/12 did not identify if the alarm was working or had been set correctly with no further follow up to determine if staff was using the alarm equipment properly or if other measures were considered.</p> <p>The 6/20/12 incident report documented "roll her towards wall and keep on side with a pillow" with the added comment "good idea." Restricting the resident's mobility is not an acceptable measure to prevent falls.</p> <p><Resident #34></p> <p>Record review found that Resident #34 was admitted to the facility [redacted] with [redacted]. The resident's MDS significant change assessment dated 2/12/12, identified that the resident had some cognitive impairment. The assessment identified no difficulty with swallowing, nutritional status or dental status.</p>	F 226	<p>Resident #25- Resident is care planned to be independent for mobility while in her electric wheelchair. Even though the resident has [redacted] she understands her limitations and moves about slowly and cautiously in her chair. The resident indicated that she simply moved to close to her bed while maneuvering her chair. The findings of this incident on 6/21/12 already ruled out mistreatment, neglect, and abuse. Clarification of findings will be documented. The incident reported on 7/4/12 will be reviewed for additional fact finding. The CNA's who were present during the transfer will be interviewed to determine facts surrounding incident. A review of any previous incidents in Hoyer transfers similar to this event will be reviewed to assess any patterns of occurrence. If indicated, a skill demonstration will be conducted to assess the staff's knowledge and ability to conduct a safe Hoyer transfer. Additional staff interviews and a second interview with the resident will be conducted as necessary to evaluate resident safety and to determine whether mistreatment, neglect, and abuse can be ruled out.</p> <p>Resident #21- The facts surrounding both the 4/20 and 7/12/12 incidents will be reviewed to determine what the resident was doing prior and during the non-injury falls. This information will be compared to the resident's current ADL status and customary routine to determine safety measures that may need to be put into place to prevent reoccurrence and to rule out abuse and neglect.</p> <p style="text-align: right;">Cont.</p>	
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F 226	<p>Continued From page 7</p> <p>Resident #34's CAA identified that the resident was on a regular diet. The resident's Care Plan dated 6/28/12, identified difficulty chewing/swallowing certain foods. The resident was to have no corn or peas. Staff was to cue the resident to sit in upright position, slow pace and small bites.</p> <p>On 07/24/12, Resident #34 reported, "They lost track of my lower dentures. Probably laid on table and knocked into the garbage. One-two weeks ago ... It is pretty hard to chew with no lower dentures." The resident stated he reported the missing denture to the Social Services Director (SSD).</p> <p>On 8/2/12, SSD confirmed that Resident #34's lower dentures were reported missing for a few weeks on 7/24/12 and were not found.</p> <p>An incident report dated 7/21/12 at 8:00 p.m. documented Resident #34 began coughing and stated that he had something "right here" pointing to his lung area. The resident continued to cough until he coughed up an "old Navy" bean. Staff documented, "Bean did look old," Staff documented the resident was much improved after spitting/coughing up the bean.</p> <p>Review of the facility investigation found that staff monitored the resident for choking, but did not investigate all of the circumstances related to the bean choking event, including if or how the resident's dentition contributed to coughing up a whole bean.</p> <p>On 8/2/12, Licensed Nurse (LN) #2 (who was the rehabilitation care manager) stated that she</p>	F 226	<p>Resident #55- The facts surrounding the 3/23/12 incident were reviewed to determine what the resident was doing prior and during the non-injury falls. There was sufficient information to prepare an administrative analysis summary which ruled out abuse or neglect. Additional safety measures were put into place to prevent additional falls.</p> <p>Resident #71- The Resident successfully discharged to a Memory Care Facility on [REDACTED]. The resident became increasingly more active as her medical condition(s) improved and she regained strength. Initially she did not recognize her surroundings or remember why she was in a rehab facility so she would comment that she had to get home with attempts to leave the building. Eventually, she was communicating she just wanted to go outdoors for some fresh air. The facility had care planned to take resident outdoors for walks throughout the day. The facility policy requires an incident report to be completed for either an elopement where the resident cannot be redirected back into the building after 10 minutes or for multiple elopements where redirecting the resident is becoming more difficult. The resident was always easily redirectable. The two unusual occurrences, 6/14/12 and 7/8/12 will be reviewed for the purpose of improving investigative policy, procedure, and training.</p> <p>RESIDENT IDENTIFICATION PROCESS- The Administrator and DNS will review all resident incident reports for residents <u>not included</u> in the Census Sample and all incidents recorded from the end of survey, up to the implementation of the revised policies/procedures to ensure new process is followed.</p>	
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F 226	<p>Continued From page 8</p> <p>reviewed the incident on 7/23/12 (2 days after the event) and did not note any difficulties with the resident's chewing. The LN documented that Resident #34 declined a speech therapy evaluation. The LN stated that she did not notice that Resident #34's teeth were gone at the time and did not know when his teeth went missing. LN #2 said, "Usually we do look in the mouth when determining choke risk."</p> <p><Resident #28></p> <p>Resident #28 was admitted to the facility on [REDACTED] with diagnoses to include [REDACTED]. The resident's MDS dated 6/15/12 indicated the resident had memory problems and was severely impaired with daily decision-making skills.</p> <p>A facility investigative report dated 7/20/12 at 6:50 a.m., documented the resident sustained a skin tear on her right leg from either the waistband of her pants or her hand. According to the report, the licensed nurse documented, "called to personal bathroom by CNA (Certified Nursing Assistant) ..." The facility's investigative report did not have a statement from the CNA who witnessed the incident or an administrative summary analysis of the incident. The report did not document if abuse and neglect were ruled out.</p> <p><Resident #25></p> <p>a) Resident #25 was admitted to the facility on [REDACTED] with diagnoses to include [REDACTED]. The resident's MDS dated 6/12/12 indicated the resident was able to make her own daily</p>	F 226	<p>SYSTEMIC CHANGES- The facility will implement revised procedures for reporting and investigation, including changes for: * Providing more clarity to staff when to initiate an incident report; * Expanding investigative process for optimal fact gathering; and * More comprehensive administrative summary analysis of an incident. This revised process will support the means to implement plans and revisions to care and services that will protect the resident from reoccurrence and assist in detecting agency reportable occurrences.</p> <p>QUALITY ASSURANCE MONITORING- Resident incident reports will be reviewed by the interdisciplinary team daily to evaluate completeness and to revise care plan and approaches to maintain resident safety. Additionally, resident incident statistical data and incidents involving: * repeated occurrence * abuse or neglect * hospitalization; or * triggered during facility QA process (mimics QIS process) will be presented to the Continuous Quality Improvement Team for review by the Director of Nursing. The Quality Assurance team will revise as necessary policies/procedures to ensure regulatory compliance and resident safety. <i>Plan of Correction date: 9/16/2012</i> <i>Correction Assurance Manager:</i> Candy Hayes, Administrator</p>		

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F 226	<p>Continued From page 9 decisions and had no memory problems.</p> <p>A facility investigative report dated 6/18/12 at 8:05 p.m., documented the resident bumped her right knee into the end of the bed while she maneuvered her electric wheelchair. The report did not indicate if abuse and neglect were ruled out.</p> <p>b) A facility investigative report dated 7/4/12 with blank spaces for the time and witness indicated the resident bumped her left shin during a hooyer lift. The report did not include statements from the staff assisting with the hooyer lift transfer. The report did not document an administrative summary analysis of the incident or if abuse and neglect were ruled out.</p> <p><Resident #21></p> <p>Resident #21 was admitted to the facility on [REDACTED] with [REDACTED]. Her MDS dated 6/12/12, indicated the resident was moderately impaired in daily decision-making skills and had memory problems.</p> <p>Two facility investigative reports dated 4/20/12 at 4:15 p.m., and 7/12/12 at 12:30 a.m., documented the resident had non-injury, unwitnessed falls in her room. The reports did not document an administrative summary analysis of the incident or if abuse and neglect were ruled out.</p> <p><Resident #55></p> <p>Resident #55 was re-admitted to the facility on</p>	F 226		
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F 226	<p>Continued From page 10</p> <p>██████ after an unwitnessed fall in the facility on ██████ resulting in a right hip fracture. Medical diagnoses included ██████</p> <p>The facility's investigative report dated 3/23/12 at 2:20 p.m. documented the resident had an unwitnessed fall in her room. The resident was transferred to the hospital. The resident's record documented she sustained a right hip fracture. The facility investigative report did not indicate if abuse and neglect were ruled out.</p> <p><Former Resident #71></p> <p>Former Resident #71 was admitted on ██████ from the hospital with diagnoses to include a history of falls and dementia.</p> <p>Resident #71 was discharged on ██████ unavailable for interview and observations.</p> <p>The resident's MDS dated 1/11/12 documented the resident was severely impaired for daily decision making skills with disorganized thinking and inattention behaviors. The MDS identified the resident had daily wandering behavior without placing the resident at risk for exiting to the outside of the facility</p> <p>The quarterly MDS dated 5/07/12, documented the resident exhibited wandering behaviors placing her at significant risk for getting to a potentially dangerous place.</p>	F 226		
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F 226	<p>Continued From page 11</p> <p>The resident's "Alteration in Cognition" care plan with a printed date of 3/22/12 was updated 5/8/12. Interventions included 1) resident unsafe to be left alone outside 2) take the resident out for walks daily 2 to 3 times weather permitting, must be supervised.</p> <p>According to the facility's documentation, the resident had 14 unwitnessed incidences of exiting the facility between 3/25/12 and 7/27/12 with only one documented facility investigation report dated 6/14/12. The report documented the resident "climbed out window...headed up town." The facility did not notify the appropriate State Agency.</p> <p>The resident's record revealed the resident exited the facility unsupervised on 7/8/12 "made it all the way to stop sign at end of the road." The resident walked off of the facility's property reaching the main business road. The facility did not initiate an investigation, record the incident on the reporting log or notify the appropriate State Agency.</p> <p>On 8/01/12 at 4:00 p.m., the Director of Nursing Service (DNS) said the purpose of doing an investigation was to determine if abuse or neglect of a resident had occurred.</p> <p>On 8/02/12 at 10:05 a.m., the DNS and the Administrator reviewed the resident's nursing progress note, dated 6/17/12, with the surveyor. The note documented Resident #71 was found in the front parking lot at the beginning of the next block away from the facility.</p> <p>The Administrator said the nurse on duty should have completed a resident incident report/investigation to rule out abuse or neglect</p>	F 226			

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F 226 Continued From page 12 when the resident went missing.

The Administrator said the staff did not complete investigation reports for every elopement. The Administrator stated the staff did not feel the resident was "missing" when she would sometimes go out for "fresh air" by herself. The Administrator said the resident was not to go out of the facility on her own.

The facility did not rule out abuse or neglect for 14 of the 15 incidents of the resident exiting the building unsupervised when the staff did not initiate an investigation.

Refer to F-323

F 241 SS=E 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to promote dining room experiences that respected resident dignity in 2 of 2 dining rooms and failed to promote care that enhanced dignity for 1 of 5 residents (#52) reviewed for dignity. These failures potentially diminished resident quality of life.

Findings include:

F 226

F 241 CFR 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY SS=E

AFFECTED RESIDENTS-
Resident #52- The resident was evaluated daily for mental anguish and allowed an opportunity for counsel to discuss the incident of miscommunication. The resident was willing to discuss his feelings until he felt that the issue was resolved. The staff member was counseled and retrained for the proper procedures to take in identifying an odorous situation that needs resolved. The resident's care plan will be reviewed and revised to improve resident hygiene as the resident is willing to comply.
Resident #15, 5, 13, 16, 17, 70, 51, 10, 37, 30 (Dining Room Services)- Multiple residents are potentially impacted by the method in which services are provided during dining. The complete policy and procedure for Dining Services, if followed, is successful in services being provided with respect and dignity. The facility's dining room policy and procedure had recently been revised (June 2012). The Quality Assurance Team recognizes that the revised procedures need to be immediately reviewed. During this transitional time a manager will be available at all meals to ensure that the residents identified and any other potentially affected residents are offered services in a respectful and dignified manner, ensuring that minimally, all areas listed below are followed by dining room staff:

Cont

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F 241

Continued From page 13

Resident #52 was admitted to the facility with [REDACTED]. According to the Minimum Data Set (MDS- a standardized assessment tool) annual assessment dated 5/9/12, Resident #52 used a wheelchair for mobility. The MDS identified Resident #52 was frequently incontinent of urine, cognitively intact and rejected care 1 to 3 days out of 7.

Resident #52's Care Area Assessment (CAA) dated 5/11/12 identified he required staff assist with toileting and had a chronic issue with foul odor and urine leakage.

The resident's care plan dated 6/28/12, identified measures to manage odor, incontinence and skin care.

On 7/19/12, progress notes documented an incident where the Resident Care Manager (RCM) checked on the resident when she noted an odor in the room. The RCM documented she walked over to Resident #52 and started sniffing to see if she could find the odor. The RCM documented when she explained to Resident #52 she was looking for a bad odor, the resident became upset.

On 07/25/2012 at 11:30 a.m., a mix of body and urine odor was noted in Resident #52's room. The odor became stronger when the resident shifted in his wheelchair.

Resident #52 stated, "Yesterday they said I stunk." The resident stated a staff person told him he smelled. "I didn't like it. I told them why don't

F 241

*Residents requiring hands on assistance with eating will be (confidentially) identified and staff will provide timely and complete service so meals are provided at appropriate temperatures.

*Resident and staff assisting will be properly positioned at the table for safety, comfort, and dignity.

*Staff will promptly offer the resident an alternative if they consume less than 25% and they will alert the resident's LN.

* Staff will speak and converse with residents in a dignified manner and will refrain from using terms of endearment.

SYSTEMIC CHANGES-

1) Current dining room procedure will be reviewed for possible revisions and to assess whether there are sufficient numbers of certified staff to meet the current resident population needs. If additional staff are needed, the facility will initiate the Paid Feeding Assistant Program. Staff training will be conducted to ensure all staff assigned to provide resident assistance are thoroughly trained.

2) If concerns arise that relate in any manner to unpleasant environmental odors, identification and/or detection process will be conducted discretely, without residents being present during the process. Nursing staff will be re-trained on reporting resident hygiene concerns for necessary care plan revisions.

QUALITY ASSURANCE MONITORING-

As part of the Quality Assurance Team's new monitoring program; a dining room service protocol review will be conducted quarterly. This process will also include resident/family interview sessions which will detect any concerns regarding dignity and respect. Identified concerns will be addressed by the Quality Assurance Team as discovered.

Plan of Correction date: 9/16/12
Correction Assurance Manager:
Candy Hayes, Administrator

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F 241	<p>Continued From page 14</p> <p>you get a vehicle and take me home, but I have no place to go. If I could walk I'd leave." On re-interview 7/30/12 at 2:21 p.m., Resident #52 recalled the incident.</p> <p>On 7/31/12 at 11:30 a.m., the RCM stated that when she noted a bad odor in Resident #52's room, "I was sniffing, trying to find where the odor was coming from. I bent down behind (Resident #52's) wheelchair and I smelled something. I told him "(---) there is something in here that does not smell good, I'm trying to find out where it is. "I did not say "you stink."</p> <p>On 7/31/12 at 5:40 p.m., the Administrator stated staff were trying to pinpoint a source of odor in the vicinity of Resident #52's room. According to the Administrator the preference would be to wait until the resident was out of the room.</p> <p><Dining observations></p> <p>On 8/02/12, record review of the facility "Dining Room Service Tips for Success Policy," found the following documentation for resident dining services: "Maintaining nutritional status is critical to keeping our residents healthy so provide top notch customer service. Ensure resident is positioned properly. Offer choice-food alternates if not interested in served meal. Immediately report to the Licensed Nurse any resident who consumes 25% or less of their meal. This should be a five star dining experience!!!"</p> <p>On 8/02/12 at 10:05 a.m., the Administrator said the facility had a daily schedule for assigned</p>	F 241			

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F 241	<p>Continued From page 15</p> <p>managers to be in attendance in both dining rooms at each meal, 7 days a week. The manager duties included, "Ensuring all staff are performing duties as described and monitoring the dining process for all residents" as noted in the Dining Room Policy.</p> <p><7/24/12 lunch observation in the large dining room></p> <p>At 11:45 a.m., Resident #15 was served a plate of food that sat in front of her for over 30 minutes. The resident made minimal attempts to eat. The food was then taken away with no offer of assistance or food replacement.</p> <p>At 12:30 p.m., NAC #3 said, "she can feed herself if she likes the food otherwise she just spits it out." Multiple observations of Resident #15 in the dining room from 7/24/12 to 8/02/12, found she could not adequately feed herself.</p> <p>Resident #5 sat at her table with no food. She took a spoon and attempted to scrape off a picture of a penguin taped to the table top in front of her for over 20 minutes.</p> <p>At 12:20 p.m., a nursing assistant (NAC) stood over Residents #37 and #30 and assisted to feed them their lunch.</p> <p>NAC #13 was heard to call various residents, multiple times "Honey" and "Babe" during the mealtime.</p> <p>One randomly observed resident said she needed to go the bathroom. A nursing assistant sitting next to her stated, "I have to stay in here."</p>	F 241		
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F 241	<p>Continued From page 16</p> <p>You go to your room and turn on the light for help." The resident did not appear able to take herself out and remained at the table. Approximately 15 minutes later another staff removed the resident from the dining room.</p> <p>Resident #16 was observed to wheel herself out of the dining room at around 12:45 p.m. The resident had a catheter bag in an outer bag that dragged on the floor with exposed catheter tubing.</p> <p><7/27/12 breakfast observation in the large dining room></p> <p>At 7:15 a.m., 9 residents were observed in the large dining room with full water glasses sitting on the tables in front of them. There was no observation of an assigned facility manager in the dining room during the meal.</p> <p>At 7:35 a.m., Resident #49 was served a plate of food. The plate sat uncovered from 7:35 a.m. to 8:00 a.m. The plate of food consisted of a cut up waffle and bacon. At 8:00 a.m. NAC #11 sat down to assist Resident #49 to eat. NAC #11 immediately left and came back 5 minutes later to resume assisting the resident. The plate of food was not observed to be reheated after sitting open for 30 minutes. Other residents were brought into the dining room over the course of the meal.</p> <p>Resident #17 was observed to sit for 25 minutes with a food tray in front of her. She received no assistance with her meal during that time. The</p>	F 241		
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F 241	<p>Continued From page 17</p> <p>resident was not able to pick up her utensils to feed herself.</p> <p>At 8:13 a.m., NAC #2 opened up Resident #17's plate to assist her to eat. After starting to assist Resident #17, NAC #2 was observed to go outside and drink a beverage. No staff took over assisting the resident to eat when the NAC left for a break. NAC #2 returned after approximately 7 to 10 minutes and resumed assisting Resident #17. NAC #2 stood over Resident #17 while feeding her in the dining room.</p> <p>By this time, Resident #17's tablemate (Resident # 5) had completed her breakfast. During the 25 minutes, after Resident #5 had eaten her food, she took her spoon and attempted to scrape off a picture of a penguin that was taped to the table in front of her. No one assisted her to stop the behavior or offer her more food.</p> <p>Resident #70 was served a plate of food around 7:40 a.m. The plate was uncovered for 20 minutes while the resident attempted to use utensils with very jerky hand movements. She was unable to guide the utensils to pick up her food. At 8:06 a.m., Resident #70 began picking up food with her right hand. Resident #70 then spilled most of her scrambled eggs on the table and ate the eggs directly off the table. No staff was observed to offer her any assistance to redirect her from eating her eggs off the table or get her fresh eggs on a plate.</p> <p>A randomly observed resident sitting next to Resident #70 sat with an open plate of food in front of her for 25 minutes with no assistance until 8:10 a.m. At that time, a nursing assistant sat</p>	F 241			

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F 241	<p>Continued From page 18</p> <p>down between Resident #70 and the other resident briefly. The NAC then got up and left the two residents who still required feeding assistance.</p> <p>Approximately 10 minutes later, the NAC returned and began cuing Resident #70 in how to use her fork. This was 30 minutes after the plate of food had been served. An NAC warmed Resident #70's plate of food, including orange slices that were originally served as a cold dish.</p> <p>At 7:45 a.m., Resident #51 sat at her table with 3 cups of liquid in front of her for 40 minutes. No one assisted or cued her during the breakfast meal. Two other residents at the table needed assistance to eat or pick up their beverage glasses but did not receive any assistance. One resident spilled food onto her clothing protector. The resident was observed to take her fork and eat off the clothing protector.</p> <p>By 8:23 a.m., multiple residents were falling asleep at their tables with over 75% of food remaining on their plates.</p> <p>During this time NAC #6 walked in and out of the dining room and around the room but did not assist any resident to eat their food. NAC #6 was observed to place a fork at the plate of one randomly observed resident. NAC #6 stated out loud, "She's not able to use the fork." NAC #6 walked away while the resident began to pick up her food with her hands. NAC #6 made no attempt to assist or verbally cue the resident to eat her breakfast with the fork.</p> <p>At 8:50 a.m., a randomly observed resident was</p>	F 241		
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F 241	<p>Continued From page 19</p> <p>approached and moved by NAC #6. NAC #6 began to move the resident's wheelchair without telling the resident she was going to move her. The resident appeared startled and waved one hand in the air as NAC #6 wheeled her from the room.</p> <p>At 8:45 a.m. Resident #10 was brought to the dining room. NAC #11 stood over her while feeding the resident her breakfast. NAC #12 stood over Resident #37 and #30 while assisting them to eat their breakfast.</p> <p>On 8/02/12, at 10:05 a.m., the DNS stated the nursing assistants were to sit in chairs next to residents that required feeding assistance. The DNS said the NACs could stand and feed Resident #37 only because he was so tall.</p> <p>On 8/02/12, the Administrator stated the staff had attempted using other methods to feed Resident #37 except "short of using a tall bar stool" for staff to sit on. The Administrator said there had been no occupational therapy evaluation to look at options other than staff standing to feed Resident #37.</p> <p><8/02/12 lunch observation in the large dining room></p> <p>Resident #30 was observed at 11:35 a.m. sitting at a table with her eyes closed. The resident had a bowl of a clear thickened substance in front of her that was covered with plastic wrap. At 11:52 a.m., she had not been assisted with her meal. By noon the resident remained sitting with the bowl in front of her with no assistance from staff.</p>	F 241			

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F 241	<p>Continued From page 20</p> <p>At 12:02 p.m., 3 bowls were placed in front of Resident #30. NAC #11 asked the resident, "Are you going to eat?" after the resident sat for 30 minutes with food in front of her and no offered assistance. NAC #2 then approached Resident #30 and began feeding the resident some yogurt.</p> <p>Resident #5 had been given one bowl of food that she ate immediately. The resident then sat for 20 minutes without any additional offers of food. During this time the resident picked at the penguin picture in front of her. After 20 minutes Resident #5 was offered more food which she then immediately ate.</p> <p>Resident #70 had a wheelchair alarm that went off three times as she leaned forward in her chair to eat from her plate. After three times of the alarm going off staff adjusted the string to stop alarming as the resident tried to eat her lunch.</p> <p>There was no observation of an assigned facility manager in the dining room during the meal for any length of time. There was no manager present to assist staff to cue and/or feed residents in a timely manner before their food became cold and unpalatable or keep them from eating off their tables and clothing protectors.</p>	F 241			
F 252 SS=B	<p>483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT</p> <p>The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.</p>	F 252			

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F 252	<p>Continued From page 21</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide a homelike environment during dining by delivering medications while residents were eating their meals. In addition, institutional signage was observed in 4 of 40 resident rooms. This failure placed the residents at risk for unmet needs regarding their autonomy, individual preferences, and provision of a homelike environment.</p> <p>Findings include:</p> <p><Small Dining Room></p> <p>On 7/24/12, during in the small dining room, 16 residents were seated for the noon meal. Medications were observed being passed to residents which interrupted the dining experience.</p> <p>Between 12:01 and 12:33 p.m. Licensed Nurses (LN) #3 and LN # 4 passed medications to Residents #2, #83, #62, #25, #50 and #39. Resident #39 was given an inhaler and then instructed by LN #3 to rinse her mouth and spit into a cup at the table with two other residents present.</p> <p>On 7/27/12, observation of breakfast dining showed medications were delivered to residents during meal service. LN #4 Student Nurse 1 passed medications to Resident #39 and #35.</p> <p>On 8/2/12 at 12:04 p.m., LN #3 said the typical routine with medications around meal times was,</p>	F 252	<p>F 252 CFR 483.15(h)(1) SAFE/CLEAN/COMFORTABLE HOMELIKE ENVIRONMENT SS=B</p> <p>AFFECTED & POTENTIALLY AFFECTED RESIDENT EVALUATION AND CORRECTION- <u>Residents # 2, 25, 39, 50, 62, 83 and others-</u> All current resident population will be interviewed (legal representatives will be contacted for non-interviewable residents) to determine their individual preferences regarding the medication administration process. Licensed Nurses will be trained on techniques of medication administration to ensure resident privacy and dignity needs are met. <u>Residents #16, 30, 42, 68 and potentially others-</u> All institutional signage will be removed unless the resident requests that it is left up, of which request(s) will be documented in their chart as a personal preference.</p> <p style="text-align: right;">Cont.</p>	
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F 252

Continued From page 22
"they (nurses) always pass medications in the dining rooms."

On 8/3/12 at 10:45 a.m., LN #4 was interviewed to learn how she knew which residents accepted medications in the dining room. She stated, "I just do." LN #4 verified the information was not documented anywhere to let nurses know of resident's preference for medications during their dining experience.

<Large Dining Room>

On 7/24/12 at approximately 12:15 p.m., during the lunch hour LN #3 administered a pill to one randomly observed resident. The resident was eating her lunch and stopped eating to ask what the pill was. LN #3 said, "That's your [redacted] medication) in a loud voice that could be heard across the dining room.

LN #4 was observed to give Resident #30 medication from a spoon with two spoonful's of water around 12:20 p.m. while the resident sat with her lunch in front of her. The resident was told to "swallow." The resident did not appear to know that she was receiving medications during her meal.

On 8/02/12 at 10:05 a.m., the Administrator said the facility residents had decided they wanted to have their medications administered during meal times. When asked what process had determined this decision, the Administrator said residents had discussed this in Resident Council or on a one to one basis.

Review of the facility Resident Council Minutes

F 252

SYSTEMIC CHANGES:
Policy and procedures regarding resident care and services will be revised to include assessing a resident's individual preference and choice for receiving medications. The resident's choice will be documented on the Medication Administration Record to inform all nurses of their decision. Licensed nurses will be trained on techniques of medication administration to ensure resident privacy and dignity needs are met.
Signage posting will only be allowed with Administrator approval.
Institutional signage in resident rooms will only be permitted by resident request.
QUALITY ASSURANCE MONITORING-
As part of the Quality Assurance Team's new monitoring program; a dining room service protocol review will be conducted quarterly. This process will also include resident/family interview sessions which will detect any concerns regarding "institutional-like" environment. Identified concerns will be addressed by the Quality Assurance Team as discovered.
Plan of Correction date: 9/16/12
Correction Assurance Manager: Candy Hayes, Administrator

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F 252	<p>Continued From page 23</p> <p>for the past year found no record of resident discussions regarding residents receiving their medications while they ate their meals.</p> <p>On 8/02/12, the Director of Nursing Services (DNS) stated there was no information listed on individual care plans regarding individual residents wanting to receive medications during their meals.</p> <p><Institutional Signage></p> <p>Regulation defines a "homelike environment" as one that de-emphasizes the institutional character of the setting.</p> <p>Observation on 7/26/12 during a tour of the facility noted institutional signage over resident beds:</p> <p>Resident #16, #30, #42: "Only use 1 draw sheet and 1 disposable pad on bed, wrinkle free."</p> <p>Resident #42: "No wipes"</p> <p>Resident #30, #68: "Comfort measures only. This resident has been put on comfort measures (line with handwritten name) please refer to comfort measure protocol for instructions."</p> <p>On 7/26/12, Resident #68 stated she did not know what the sign meant. "You should ask her (Dietary Supervisor)."</p> <p>On 7/31/12, the Resident Care Manager (RCM) stated that signs over resident beds directing care are posted for residents who have fragile skin which can be easily damaged. Information to</p>	F 252		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/10/2012
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OMB NO. 0938-0391

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F 252	Continued From page 24 staff that residents require comfort care is posted on a flyer over the resident's bed. The RCM stated that this is done because the facility wants staff to question before giving fluids or doing anything extraneous with residents receiving comfort care. Nurses are supposed to know the resuscitation status.	F 252		
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide housekeeping and maintenance necessary to maintain a sanitary, orderly and comfortable interior, clean and free from odor. This potentially diminished resident quality of life. Findings include: <Odor> During the course of survey 7/24 through 8/3/12, strong persistent odors were noted as follows: 7/24 12:28 and 4:15 p.m. Room 116 smelled of urine. 7/25 8:15 and 11:45 a.m. Room #116 smelled strongly of urine.	F 253	F 253 CFR 483.15(h)(1) HOUSEKEEPING AND MAINTENANCE SERVICES SS=B AFFECTED & POTENTIALLY AFFECTED RESIDENT EVALUATION AND CORRECTION- The facility was already in the process of rectifying concerns regarding identified odors in the environment of which included review of housekeeping practices, facility ventilation system, resident hygiene compliance, and resident care services. The identified problems center around resident medical and hygiene issues. The Quality Assurance team will continue to make revisions in care plan approaches until the problem is resolved. All noted non-resident ancillary rooms: Laundry, Medication, and Central Supply rooms have been repaired, painted, and refurbished. Housekeeping services are provided to these rooms on a regular scheduled cycle. An audit will be conducted to evaluate whether the thoroughness and frequency of all cleaning processes are substantial to meet standards necessary to maintain a sanitary, orderly, and comfortable interior.	

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F 253	<p>Continued From page 25</p> <p>7/26 9:00 a.m. strong odor urine in Room #116.</p> <p>7/26 10:12 and 2:00 p.m. strong urine odor outside room 121 in hallway; persistent unpleasant odor on entry to the facility.</p> <p>7/27 10:00 a.m. strong odor in hall and room #116.</p> <p>7/30 9:50 a.m. strong odor room #116.</p> <p>7/31 2:20 p.m. odor present room #116.</p> <p>8/1 12:00 p.m. odor in hall outside of room #116.</p> <p>8/2 10:04 a.m. and 2:16 p.m. strong odor hallway and lesser odor from room #116.</p> <p>Refer to F 241 and F 280</p> <p><Laundry Room></p> <p>On 7/30/12 at 11:15 a.m., observation noted the face of 3 dryers were grimy. The face of one washing machine had spilled white residue crusted on the front. There was soap residue on top of the washers. Paint was peeling on the floor in front of the dryers.</p> <p>There was one hand washing sink in the laundry area which was blocked by two ladders and piled up equipment and cleaning supplies. Housekeeping Aid #1 demonstrated how she washed hands by first removing the blocking items in order to get to the sink and then</p>	F 253	<p>SYSTEMIC CHANGES: Facility renovations will continue as currently scheduled. A review of projects and timelines for completion will be considered for re-prioritizing more critical concerns. On-going preventative and repair maintenance schedules will be established. Housekeeping schedules will also be reviewed by the Environmental Supervisor and Administrator to ensure all facility areas are cleaned on a regular basis.</p> <p>QUALITY ASSURANCE MONITORING- An auditing schedule will be developed for both plant and equipment maintenance and housekeeping services to ensure standards are met. Any identified concerns will be addressed by the Quality Assurance Committee for correction. <i>Plan of Correction date: 9/16/12</i> <i>Correction Assurance Manager: Candy Hayes, Administrator</i></p>	

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F 253	<p>Continued From page 26</p> <p>maneuvering around the items after hand washing.</p> <p>On 7/30/12, the Director of Environmental Services (DES) stated that staff was to wipe down laundry equipment every shift. The DES agreed the laundry room was not clean. According to the DES, the peeling floor paint compromised the cleanliness of the area.</p> <p>The DES stated there was a lot of refurbishing going on at the facility but it had not yet been done in the laundry room. The DES stated the ladders were used regularly by housekeeping and should be stored against the wall. According to the DES, the pile of other stuff blocking the hand washing sink was stacked up due to "laziness" of Maintenance staff who did not take the time to take things out to the storage shed.</p> <p><Medication and Central Supply Room></p> <p>On 7/27/12 at 10:54 a.m., observation of the medication room noted the floor was dirty, with nicks in the linoleum. There was old tape residue or black marks on cupboard doors, the back wall of the counter and on the counter top.</p> <p>The sink was dirty with hard water deposit residue and bubbles in the drain. There was built up water residue behind sink. The sink stopper on the back of the sink was dry with part of old alcohol wipe in it.</p> <p>The inside of the medication room door had spilled liquid with drips. Flashing was missing on the back wall.</p>	F 253			

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F 253	<p>Continued From page 27</p> <p>The Central supply (medication and medical supply storage) room adjacent to the nurses' station had dried, sticky, spilled liquid, black marks, one tile missing, and a patch on one wall that needed painting.</p> <p>On 7/27/12, Licensed Nurse (LN) #1 stated, "I see what you are seeing" while looking at the floor, counters and sink in the medication room. "It looks dirty... the sink is like hard water residue, is rough". Licensed Nurse #4 stated that nurses generally straighten up but Housekeeping does the cleaning.</p> <p>On 07/30/12, the DES stated, housekeeping staff had not scrubbed floors in the medication and central supply rooms anticipating that the floors would be replaced. The DES said, "This was not a good idea; we should have continued cleaning schedule." According to the DES, the back of the medication room door needed to be refurbished.</p> <p><Resident Equipment and Building></p> <p>On 7/27/12 at 9:44 a.m., observation noted a free standing air conditioner at the end of Horseshoe Hall that was vented to a small window leading to the outside. The screen was covered in a layer of dust. Two unsecured overlapping pieces of plastic material with old tape residue were nested in the open window space. The DES stated that the unsecured plastic pieces had been used for years to prevent hot air from re-entering the facility and were usually secured. The DES agreed that the window screen was dirty. "That screen did not make the list to be cleaned."</p> <p>On 7/27/12 at 9:55 a.m., observation noted the</p>	F 253			

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F 253	Continued From page 28 grab bar room 118 had grip material secured with layers of grimy bandage tape. The DES stated, "That's gross." He removed the soiled tape, saying, " that (bandage tape) is from nursing."	F 253	F 272 CFR 483.20(b)(1) COMPREHENSIVE ASSESSMENTS SS=D	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum	F 272	AFFECTED RESIDENTS- Resident #50- MDS and care plan are corrected to accurately reflect current dental issues. Facility is working with resident's legal representative for needed dental evaluation and services. Resident #55- Assessment has been completed. MDS and care plan have been corrected to accurately reflect seatbelt device. RESIDENT IDENTIFICATION PROCESS- Facility will review all residents with devices/restraints to ensure assessment, care plan and MDS reflect current medical condition and needs. Facility will assess each resident's dental issues and identify such on the MDS during quarterly/annual or change in condition RAI process. SYSTEMIC CHANGES- Nurse Consultant will provide in-servicing to Licensed Nurses and Director of Nursing Services on what constitutes a physical restraint versus a device. All residents will be assessed for devices/restraints during their quarterly/annual or change in condition MDS. Licensed nurses will be in-serviced regarding documentation of oral/dental status and concerns on the admit nursing assessment and reporting complaints of dental issues via the 24 hour reporting process for RCM follow-up.	

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F 272	<p>Continued From page 29 Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to comprehensively assess 1 of 8 sampled residents (#50) of 39 residents reviewed for dental services and 1 of 9 residents (#55) of 39 residents reviewed for restraints. This failure placed the residents at risk for unmet needs.</p> <p>Findings include:</p> <p><Resident #50> Resident #50 was admitted to the facility on [REDACTED] from an adult family home. His medical diagnoses included [REDACTED]</p> <p>Resident #50's Minimum Data Set (MDS- an assessment tool) dated [REDACTED] noted his Brief Interview Mental Status (BIMS) had no cognitive deficits.</p> <p>On 7/30/12 the resident said he was missing teeth except his lower front teeth. He stated, "I need to go get some teeth." The resident said he had not seen a dentist and was unaware if the facility was working on an appointment.</p>	F 272	<p>QUALITY ASSURANCE MONITORING- As part of the Quality Assurance Team's new monitoring program; a device/restraint protocol review will be conducted quarterly. Any identified concerns will be addressed by the Quality Assurance Committee for correction. <i>Plan of Correction date: 9/16/12</i> <i>Correction Assurance Manager: Candy Hayes, Administrator</i></p>	

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F 272	<p>Continued From page 30</p> <p>Observation during the interview, confirmed the resident only had his front lower teeth which were in poor condition. His gums were red and inflamed.</p> <p>Review of his annual Minimum Data Set (MDS), an assessment tool, dated 4/20/12, did not address dental issues for the resident as the box "none of the above were present" was checked even though the resident had been identified by the hygienist as having decayed natural teeth.</p> <p>On 7/30/12, the resident's medical record documented the resident was followed by the facility hygienist routinely with notes that indicated he only had lower teeth with decay.</p> <p><Resident #55></p> <p>Resident #55 was re-admitted from the hospital on [REDACTED] after a fall in the facility on 3/23/12 resulting in [REDACTED]. The resident's medical diagnoses [REDACTED]</p> <p>Multiple observations of resident during the survey on 7/24, 7/25, 7/26, 7/27, 7/30, 7/31, 8/1, 8/2/12 found her to wear a seatbelt whenever she was in her wheelchair.</p> <p>Review of her admission and quarterly MDS dated 4/5/12 and 6/28/12 consecutively, found the use of an alarmed seatbelt in the resident's wheelchair was not assessed.</p> <p>On 7/30/12 at 9:34 a.m., the resident said, "They make me wear it because they think I'll fall but I</p>	F 272		
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F 272	Continued From page 31 won't. It makes noise if I unbuckle it so I can't do it." On 7/30/12 at 9:45 a.m., Nursing Assistant Certified (NAC) #1 confirmed the use of the seatbelt for resident safety. NAC #1 said it was used when the resident was in the wheelchair. She indicated the resident could unbuckle the belt but it alarmed to let staff know to reconnect the belt. On 7/30/12 at 11:56 a.m., Licensed Nurse (LN) #2 confirmed she completed the rehabilitation section of the MDS. LN #2 reviewed the MDS and verified the use of the seatbelt was not addressed on the MDS or the mobility quarterly progress note she completed each quarter to summarize the resident's needs.	F 272			
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	F 279	F 279 CFR 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS SS=D AFFECTED RESIDENTS- Resident #71- The Resident successfully discharged to a Memory Care Facility on [REDACTED] Resident #32- The resident's current care plan is maintaining the resident's highest practicable physical, mental, and psychosocial well-being. An active discharge plan will be added to the MDS and the care plan will continue to reflect that per resident and legal representative request, discharging will not be discussed with resident. Adjustment to living in long term care will be evaluated and documented by Social Services. Resident #58- The resident's current care plan is maintaining the resident's highest practicable physical, mental, and psychosocial well-being. An active discharge plan will be added to the MDS and the care plan will continue to reflect that per resident request, discharging will not be discussed with resident unless she chooses to want to discuss alternative plans. Adjustment to living in long term care will be evaluated and documented by Social Services.	<i>Const.</i>	

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F 279	<p>Continued From page 32</p> <p>§483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to develop comprehensive care plans for 1 of 1 former sampled resident (#71) reviewed for repeated incidents of exiting the facility and 2 of 3 current sampled residents (#32 & 58) reviewed for community discharge. These failures placed residents at risk for not receiving necessary care and services.</p> <p>Findings include:</p> <p><Resident #71 ></p> <p>The former resident was admitted [REDACTED] from the hospital with diagnoses to include [REDACTED] Former Resident #71 was discharged on [REDACTED] unavailable for interview and observations.</p> <p>The resident's Minimum Data Set, (MDS-an assessment tool) dated [REDACTED] identified the resident had daily wandering behavior without placing the resident at risk for exiting to the outside of the facility.</p> <p>The quarterly MDS dated [REDACTED] documented the resident exhibited wandering behaviors placing her at significant risk for getting to a</p>	F 279	<p>RESIDENT IDENTIFICATION PROCESS- In transitioning the responsibility for discharge planning from the Director of Nursing to Social Services, two residents were missed. Both residents had indicated they planned to reside in long term care. Medical records staff have audited all remaining resident records to ensure an active discharge plan is present.</p> <p>SYSTEMIC CHANGES: The Facility's Nurse Consultant will conduct training sessions with the Interdisciplinary Team to improve their ability to assess and develop Comprehensive Care Plans that address all a resident's needs. The Facility's revised 24 hour review process will improve opportunities to recognize when a care plan approach or goal needs revising or is missing a critical component.</p> <p>QUALITY ASSURANCE MONITORING- The facility is adopting a new Quality Assurance Monitoring process that will mimic the QIS process and will detect incomplete care plans and inadequate goals and approaches.</p> <p><i>Plan of Correction date: 9/16/12</i> <i>Correction Assurance Manager:</i> Candy Hayes, Administrator</p>

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F 279	<p>Continued From page 33 potentially dangerous place.</p> <p>The resident's "Alteration in Cognition" care plan with a printed date of 3/22/12 included the resident exhibited behaviors of exit seeking and wandering.</p> <p>The goals were for the resident to accept and acknowledge helpful reminders and direction through the next evaluation date. The care plan did not contain specific goals to address the resident's exit seeking behaviors or wandering.</p> <p>The care plan documented, "unable to exit or be alone outside." There were no specific interventions addressing the resident's wandering or exit seeking behaviors.</p> <p>A progress note dated 3/25/12 documented Resident #71 was found twice outside the facility on the same day, unsupervised by staff.</p> <p>Two days later, 3/27/12, the facility placed the resident on location checks every 15 minutes. The progress note documented, "CP (care plan) revised." A record review showed none of the resident's care plans contained documentation of the 15-minute check intervention or the 2 incidents of the resident exiting the facility on 3/25/12.</p> <p>The resident's record revealed the resident continued to exit the facility, unsupervised 5 more times, on 4/18, 4/28 (twice), 5/2 and 5/4. The resident read and entered the correct egress codes on the keypad at the exit doors. There was no documentation the facility reviewed and revised the resident's comprehensive plan of care</p>	F 279		
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F 279	<p>Continued From page 34</p> <p>to mitigate the repeated incidents of the resident's ability to exit the facility, unsupervised.</p> <p>The resident's "Alteration in Cognition" care plan with a printed date of 3/22/12 was updated 5/8/12 per Social Service Director, (SSD).</p> <p>The SSD lined through the intervention of "unable to exit or be alone outside." The SSD hand wrote "resident unsafe to be left alone outside" dated 5/8/12 and signed her name.</p> <p>The SSD hand wrote intervention #6 to take the resident out for walks daily 2 to 3 times weather permitting, must be supervised. The care plan was not revised with specific interventions and goals to address the resident's ability to wander and exit the facility unsupervised.</p> <p>According to the facility's documentation, the resident continued to have 8 additional incidents of exiting the building unsupervised to include "climbed out window...headed up town" on 6/14, and "made it all the way to stop sign at end of the road" on 7/8/12.</p> <p>Between 4/12 and 7/12 there was no documentation the facility reviewed and revised the resident's comprehensive plan of care to include specific interventions and goals to address the resident's ability to wander and exit the facility unsupervised 13 times.</p> <p>On 8/02/12 at 10:05 p.m., the Director of Nursing Service (DNS) said the facility did not have a specific elopement care plan. The DNS said the ongoing elopement issue was only addressed on the "Alteration in Cognition" care plan.</p>	F 279		
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F 279	Continued From page 35 The Administrator stated the facility had no clear plan except to discharge the resident as soon as the facility could find placement. Refer to F323. <Resident #32> Resident #32 was admitted to the facility on [REDACTED] from the hospital. Prior to hospitalization she lived in an assisted living facility. The resident's diagnoses included [REDACTED] The quarterly Minimum Data Set (MDS), an assessment tool, dated 6/25/12 indicated there was not an active discharge plan for the resident. A form in the chart identified as "MDS section Q review" dated 6/25/12, indicated the resident did not want to talk to someone about returning to the community and once is enough in regards to asking the MDS question. A progress note from the social services director (SSD) dated 4/4/12, regarding a discussion with the resident's daughter and power of attorney, noted, "Please don't ask her that, it will only upset her, we all know she is not able to leave here." On 8/1/12 at 2:05 p.m. the resident stated, " This is home now; I have nowhere else to go in my old age." <Resident #58> Resident #58 was admitted to the facility on [REDACTED] from the hospital. Prior to admission she	F 279			

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F 279	<p>Continued From page 36</p> <p>lived in an assisted living facility. The resident's diagnoses included [REDACTED]</p> <p>The admission MDS dated [REDACTED] indicated the resident expected to discharge to the community, no active discharge plan in place for discharge to the community, and referral made to local contact agency as determined by resident and care planning team.</p> <p>The quarterly MDS dated [REDACTED] indicated there was not an active discharge plan for the resident. A form in the chart identified as "MDS section Q" dated 6/18/12, indicated the resident did not want to talk to someone about the possibility of returning to the community.</p> <p>On 8/1/12 at 4:16 p.m., the resident stated, "This is where I'm going to live" She said she required more help at times than the assisted living could offer.</p> <p>Review of Resident #32 and Resident #58 records did not find a discharge care plan to address the discharge needs/plans for the residents and adjustment to living in long term care.</p> <p>On 8/1/12 at 2:45 p.m., the SSD said all residents got a discharge care plan no matter their status. The SSD added, "I just took it over, the Director of Nursing (DNS) used to do the discharge planning." The SSD verified no care plan addressing discharge was in the residents' charts.</p> <p>At 2:35 p.m. the DNS confirmed all residents,</p>	F 279		
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F 279	Continued From page 37 even long term care residents, got a discharge care plan listed under discharge summary which is the last page of the care plan section. The DNS reviewed the charts and thinned records. The DNS verified no discharge care plans for 2 named residents existed at the time of survey.	F 279	F 280 CFR 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CARE PLAN SS=D AFFECTED RESIDENTS- <u>Resident #45-</u> The Resident's care plan has been revised to include: contracture interventions, fluid restrictions, and care services for ██████ patient, including, ongoing assessments and monitoring. All supportive documents will be updated to insure all staff has information needed for providing services so the resident's entire needs will be met. <u>Resident #42-</u> The Resident's care plan has been revised to include: fluid needs, route, and required documentation, and hygiene services, including, ongoing assessments and monitoring. All supportive documents will be updated to insure all staff has information needed for providing services so all the residents' needs will be met.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to revise a care plan for 1 of 2 sampled residents (#45) of 2 residents	F 280	RESIDENT IDENTIFICATION PROCESS- Facility will review all residents who have contractures to ensure there is a specific plan identified to address contractures and potential for skin breakdown specifically to meet the needs of each individual resident. Facility will implement instructions for the care of each resident with a vascular access. SYSTEMIC CHANGES- All residents who have a vascular access will be assessed for appropriate care plan measures by 9/16/12 and reviewed again during their quarterly/annual or change in condition MDS and care planning process. All residents will be assessed upon admission and on a quarterly basis for contractures and skin breakdown. Care plans will be individualized to identify potential and actual problems specific to each resident.	Cont.

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F 280	<p>Continued From page 38</p> <p>reviewed for pressure ulcers, and 1 of 1 sampled residents (# 45) for dialysis and 1 of 2 (#42) for urinary incontinence. This failure placed residents at risk for unmet needs.</p> <p>Findings include:</p> <p><Resident #45></p> <p>A) Record review found that Resident #45 was admitted to the facility [REDACTED] with medically disabling conditions including [REDACTED]. Resident #45's Admission Minimum Data Set (MDS - a standardized assessment) dated [REDACTED] identified that Resident #45 required extensive assist of 2 persons for activities of daily living. Resident #45's Admission MDS dated [REDACTED] identified [REDACTED].</p> <p>A therapy note documented that Resident #45 was discharged from physical and occupational therapy on [REDACTED] as the resident refused to allow therapists to work with him. Therapy recommendations were to attempt a restorative aid range of motion program as tolerated.</p> <p>A Restorative Therapy evaluation done 6/14/12 by Licensed Nurse (LN) #2 documented that the resident had left hand deficits without stating if the deficits were minimum, moderate or severe. The LN documented, "Refuses palm guard or cloth."</p> <p>Resident #45's care plan dated 7/9/12 identified that staff was to report skin problems after a skin</p>	F 280	<p>QUALITY ASSURANCE MONITORING-</p> <p>The facility is adopting a new Quality Assurance Monitoring process that will mimic the QIS process and will detect incomplete care plans and inadequate goals and approaches.</p> <p><i>Plan of Correction date: 9/16/12</i></p> <p><i>Correction Assurance Manager:</i> Candy Hayes, Administrator</p>	

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F 280	<p>Continued From page 39</p> <p>check with each bath or shower and staff was to clean and check nails. The care plan identified that a restorative aid would provide range of motion exercises to upper and lower extremities. There was no mention of contractures or the use of splints or supports for contractures. There was a general plan to address care refusal and pressure ulcer prevention, but no specific plan related to the resident's left hand deficit and risk of pressure injury in the hand.</p> <p>On 8/2/12 at 11:00 a.m. it was observed that Resident #45 kept his left arm and hand close to his body, with the left hand in a closed position. Resident #45 had been observed with his arm and hand in the same position over previous days of survey from 7/24 to 8/2/12.</p> <p>Resident #45 reported that he had an itch in his left hand. Student Nurse #1 and LN #4 assessed the hand and found two hand wounds measuring 0.25 centimeter (cm) by 0.25 cm and 0.5 cm by 5 cm resulting from the resident's fingernails digging into the flesh of his hand. LN #4 reported and documented that there was redness and yeast-like odor between the fingers of the left hand. Staff documented obtaining an order for _____</p> <p>On interview 8/2/12 LN #2 stated that the nursing staff was responsible to prevent skin issues and none of the staff identified the resident's hand as a potential problem. LN #2 stated that she could not answer why the issue was not care planned.</p> <p>B) Resident #45</p>	F 280			

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F 280	<p>Continued From page 40</p> <p>According to "Fundamentals of Nursing" Lippincott, Williams & Wilkins, 7th Edition, 2011, page 1255 to 1289, Dialysis care for the patient's vascular access includes measures that instruct staff in the following: "The affected arm should not be used for any other procedure such as obtaining blood pressure, which could lead to clotting of the graft or fistula. Venapuncture or IV access could lead to an infection of the affected arm and could cause the loss of the fistula." "Fluid restriction orders indicate the amount of fluid a patient can have in a 24 hour period and must be followed to prevent fluid and electrolyte imbalances in the patient."</p> <p>Resident #45's [REDACTED] care plan dated 7/9/12 directed staff to monitor the resident's right chest [REDACTED]. The care plan did not indicate that the resident had any restrictions on blood pressure monitoring related to current or former surgically placed [REDACTED]. The care plan identified that the resident was on a fluid restriction. Nursing was allowed to give 240 cubic centimeters (cc) fluid daily. The nutritional care plan listed Hi Cal Med Pass (a prescription nutritional supplement). A hand written entry dated 6/18/12, directed staff to provide 240 cc LNP (a different nutritional supplement) Monday, Wednesday and Friday on [REDACTED].</p> <p>Medication Administration Records for June 2012 showed that Resident #45 was given Med Pass 120 cc twice daily. LN #1 reported that the resident was also given 320 cc of LNP Mighty shake in addition to the Med Pass. This exceeded the fluid restriction amount allotted per the [REDACTED] care plan.</p>	F 280		

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F 280	<p>Continued From page 41</p> <p>On interview 7/25/12 LN #1 stated that the Med Pass prescription was not transcribed onto the Medication Administration Record (MAR) in July 2012 but was given by nursing staff, including nursing staff who sent Resident #45 to [REDACTED] early in the morning. According to LN #1, on [REDACTED] Resident #45 was given Med Pass to take to [REDACTED] with him, but there was no system to account for how much Med Pass the resident ingested. On 7/27/12, LN #7 (regular night nurse) stated that she never sent nutritional supplements to [REDACTED] with Resident #45.</p> <p>See findings under F 309.</p> <p>On interview 7/30/12 NAC #4 and #9 both stated that they took vital signs on residents but had no knowledge of any special directions or concerns about taking blood pressure for residents on [REDACTED] or for Resident #45 in particular. Neither staff had knowledge of Resident #45's fluid restriction.</p> <p>On 7/31/12 the care plan and care plan face sheet (posted in the room for caregivers) was updated with the information that the resident had an old healed fistula in the right upper arm and staff should not take blood pressures in the right arm. The face sheet had no reference to a fluid restriction.</p> <p>On 8/2/12, LN#1 stated that the resident's fluid restriction information was communicated to Nursing Assistant Certified (NAC) staff on the care plan summary and face sheets which were posted in resident rooms.</p>	F 280		
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F 280	<p>Continued From page 42 <Resident #42></p> <p>Record review found that Resident #42 was admitted to the facility [REDACTED] with [REDACTED]. Resident #42's MDS dated 5/2/12, identified that the resident was always incontinent of bowel and bladder. The MDS identified that Resident #42 had coughing or choking during meals and received 500 cc or less daily by intravenous or tube feeding.</p> <p>Resident #42's care area assessment (CAA) dated 5/2/12 and care plan dated 6/22/12, identified staff would provide specific incontinence care in the a.m., p.m., between meals, night time and as needed. The care plan identified staff was to offer fluids frequently, leave unconsumed glass at bedside and offer 180 cc nectar juice at snack time due to inadequate water acceptance. The care plan included routine bathing assistance with skin checks 1-2 times per week.</p> <p>Facility records documented that Resident #42 ate foods but received additional fluids and medications through a gastrostomy tube (a tube into the stomach). Records show that since 5/26/11 the resident was given a water bolus of 250 cc 4 times per day (1 liter) in addition to fluids provided during medication flushes to treat chronic dehydration.</p> <p>Multiple observations on different dates and times noted a strong urine odor in the resident's room or in the hallway outside of the room:</p> <p>7/24/12 12:28 p.m. room smells of urine</p>	F 280		
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F 280	<p>Continued From page 43</p> <p>7/25/12 8:15 a.m. strong urine odor emanating into hall from resident's room.</p> <p>7/26/12 9:00 a.m. strong odor urine in room</p> <p>7/27/12 10:00 a.m. strong odor</p> <p>7/30/12 9:50 a.m. strong urine odor in room</p> <p>7/31/12 2:20 p.m. odor present</p> <p>8/1/12 12:00 p.m. odor in hall outside of room</p> <p>On interview 7/30/12 at 4:25 p.m. NAC #10 stated that she started working at the facility in April 2012. She identified Resident #42 as having a persistent odor that was more under control than before.</p> <p>7/31/12 5:45 p.m. The Social Services Director (SSD), administrator, and Resident Care Manager (RCM) all confirmed a strong unpleasant odor outside of Resident #42 's room. The administrator stated that there was a four room vicinity where the facility was trying to sort out the source of the odor.</p> <p>On interview 8/1/12 at 11:15 a.m., the Director of Nursing Services (DNS) acknowledged that Resident #42 had an odor problem which could be due to Resident #42's concentrated urine. "(Resident #42) does not drink well at all ...Urine is concentrated and smells. (Resident #42) has body odor even after a shower (and) has a little vaginal discharge which is an odor issue."</p> <p>According to the DNS, the amount of fluid given</p>	F 280		
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F 280	<p>Continued From page 44</p> <p>to Resident #42 is not adequate to dilute the odor or concentrated urine. The DNS stated that the facility hoped that Resident #42 could drink more fluids but the resident won't drink thickened liquids which are required for her swallowing condition. The DNS stated the facility hadn't really thought of providing more fluids through the gastrostomy tube.</p> <p>According to the DNS, Resident #42's odor problem had gone on quite a while but had worsened since Resident #42 preferred to stay in bed and watch T.V. The DNS stated the urine odor was not as bad when Resident #42 spent more time up in the wheelchair. The DNS stated she believed the source of the odor to be Resident #42's mattress, which had been chemically treated in the past.</p> <p>On interview, LN #1 stated that Resident #42 received 30 cc medication flushes in addition to the 4 times daily water bolus, but the total amount of medication flushes were not specifically documented.</p> <p>The care plan was not revised to address how Resident #42 was to receive enough fluid to make urine less concentrated in order to address the persistent odor problem. The care plan was not revised to include additional measures related to hygiene or physical environment to control odor.</p>	F 280			
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309			

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F 309	<p>Continued From page 45</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide services to prevent development of a hand wound and infection for one resident (#45) and failed to follow professional recommendations for 3 of 3 (#45, 58, 50) of 39 residents reviewed. This failure placed residents at risk for unmet needs and potential harm.</p> <p>Findings include: <Resident #45></p> <p>A) Record review found that Resident #45 was admitted to the facility [REDACTED] with [REDACTED]</p> <p>[REDACTED]</p> <p>Resident #45's Admission Minimum Data Set (MDS - a standardized assessment) dated 6/12/12 identified that Resident #45 required extensive assist of 2 persons for activities of daily living including nail care and hygiene assistance. Resident #45 was identified as "at risk" for pressure ulcer or skin breakdown and was admitted with one or more pressure sores.</p>	F 309	<p>F 309 CFR 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL-BEING SS=E</p> <p>AFFECTED RESIDENTS- <u>Resident #45-</u> (Refer to F280) All related physician orders/recommendations (contracture assessment and appropriate treatment and nutritional supplement orders) have been processed accurately. Supportive documents have been updated to insure all staff have information needed for providing services so the resident's entire needs will be met. <u>Resident #58-</u> The Registered Dietician's medication referral has been submitted to the resident's physician for processing. Supportive documents have been updated to insure all staff have information needed for providing services so the resident's entire needs will be met.</p> <p>RESIDENT IDENTIFICATION PROCESS- See POC for F-280</p> <p>SYSTEMIC CHANGES: The Facility's revised 24 hour review process will improve accuracy and completeness in processing physician and referral recommendations. Contracture Management Program will be reviewed and revised where necessary to insure assessments and treatment are timely and suitable to maintain the resident's highest practicable physical well-being. See POC for F-280</p>	

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F 309	<p>Continued From page 46</p> <p>Resident #45's mobility quarterly progress notes dated 6/12/12, identified that Resident #45 had contractures of the upper and lower extremities. Staff was to provide extensive assistance with repositioning. The facility was to provide therapy to establish a range of motion program. Therapy evaluation done 6/14/12 by Licensed Nurse (LN) #2, documented that the resident had left hand deficits without stating if the deficits were minimum, moderate or severe. Therapy notes documented, "Refuses palm guard or cloth."</p> <p>Resident #45's care plan dated 6/5/12, identified that staff was to report skin problems after skin checks with each bath or shower and staff was to clean and check nails. There was no use of splints or supports for contractures.</p> <p>Review of progress notes found no reported skin problems related to the resident's contractures.</p> <p>Multiple observations during days of survey 7/25 to 8/2/12 noted that Resident #45's left arm and hand were kept close to his body, with the left hand in a closed position.</p> <p>On 8/2/12 at 11:00 a.m., after an observed heel ulcer dressing change, Resident #45 told LN #4 that he had an itch in his left hand. Student Nurse (SN) #1 who was assisting with the dressing change opened the resident's left hand. SN #1 stated it looked like a layer of skin was removed by the resident's fingernail.</p> <p>Observation noted that Resident #45's fingernails on the left were longer than the tips of his fingers.</p>	F 309	<p>QUALITY ASSURANCE MONITORING- Systemic changes in policies and procedures will identify issues. All system failures will be reviewed by the Quality Assurance Committee for analysis and plan of correction. <i>Plan of Correction date: 9/16/12</i> <i>Correction Assurance Manager: Candy Hayes, Administrator</i></p>	

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F 309	<p>Continued From page 47</p> <p>Two small open areas were observed on the palm of Resident #45's hand where his fingers had rested.</p> <p>Staff documented that Resident #45's hand wounds measured 0.25 centimeter (cm) by 0.25 cm and 0.5 cm by 5 cm. Staff documented that the resident had dry flaky areas on his left hand fingers. The left hand was red in between the fingers with a slight yeast smell and itching. Staff documented they obtained an order [REDACTED] on the resident's hand.</p> <p>On interview 8/2/12, LN #2 stated that the resident was evaluated by speech and occupational therapy but there was no indication that there was a need for a hand splint. The LN stated that the nursing staff was responsible to prevent skin issues and none of the staff identified the resident's hand as a potential problem. "We did not see issues until today, (it is) possible nails got a little long and need trimming."</p> <p>B) Record review found that Resident #45's admission MDS dated [REDACTED] identified the resident had [REDACTED]</p> <p>Resident #45's care plan dated 7/9/12, identified staff was to offer snacks before and after [REDACTED] appointments. The resident was on a 1500 cubic centimeters (cc) fluid restriction, with 240 cc liquid allowed for nursing. The care plan listed Hi Cal Med Pass (a prescribed nutritional supplement). A hand written note dated 6/18/12, directed</p>	F 309		
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F 309	<p>Continued From page 48</p> <p>"provide 240 cc carton LNP (a different nutritional supplement) Monday, Wednesday, Friday on [REDACTED]</p> <p>Review of medication records found that nurses documented giving Med Pass 120 cc twice daily through June 30th, but no documentation that Med Pass was given in July 2012.</p> <p>On interview 7/25/12, Licensed Nurse (LN) #1 stated that in preparing for the survey interview, it was discovered that the order for Med Pass was not transcribed onto the July Medication Administration Record (MAR). The LN stated that nursing staff was giving Med Pass nutritional supplement even though it was not listed on the MAR. LN #1 acknowledged that there was no way to know for sure if the Med Pass was given as it was not documented.</p> <p>According to LN #1, Resident #45 took a 320 cc carton of Med Pass with him on [REDACTED] days as the resident refused breakfast on those days. LN #1 stated that there was no record of how much Med Pass Resident #45 took. The [REDACTED] staff did not report if the resident took any Med Pass. LN #1 stated that Resident #45 was not reliable to tell how much Med Pass he drank.</p> <p>LN #1 continued to explain that the LNP Mighty Shake is in addition to Med Pass nutritional supplement. "We don't sign on the MAR for that, but it is on the care plan for kitchen to send." The LN did not know if there was an order for the LNP.</p> <p>On interview 7/27/12, LN #7 stated that she worked 3 to 4 night shifts per week providing</p>	F 309			

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F 309	<p>Continued From page 49</p> <p>medication services to residents. The LN stated she did not any nutritional supplement with Resident #45 to [REDACTED] that morning or any other day.</p> <p><Resident #58> Resident #58 was admitted on [REDACTED] from the hospital. Her diagnoses included [REDACTED]</p> <p>Resident #58 was evaluated by the registered dietitian (RD) on 7/12/12 for a "nutrition referral on low weights with goal of gain." The resident's last weight was 89 pounds which reflected a 6.32% loss over 3 months from April to July 2012.</p> <p>The RD developed a plan to address the resident's low weight which included recommendations to be reviewed by the resident's doctor. The plan was to review the current use of [REDACTED] and [REDACTED] which have a potential side effect of loss of appetite; and to consider adding [REDACTED] for weight gain.</p> <p>On 8/1/12 at 4:37 pm, an interview with Licensed Nurse (LN) 1 found she did follow-ups on the RD recommendations to the doctor. LN #1 stated she did the follow-up to the doctor in regards to medications. The usual routine as described by LN #1 was the RD completed her visit, she gives a log of who was seen and it is reviewed at an exit meeting. Recommendations were reviewed</p>	F 309		
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F 309	<p>Continued From page 50</p> <p>when the doctor visited the 1st and 3rd Wednesdays of the month, unless urgent.</p> <p>LN #1 reviewed the recommendation for Resident #58 and verified the 7/18/12 information was not forwarded to the doctor. Resident #58 was not seen today because "she (nurse practitioner) was busy with urgent only." LN #1 stated "We are working on a system to make sure the doctor is notified on July 1st and haven't worked all out yet."</p> <p><Resident #50></p> <p>Resident #50 was admitted on [REDACTED] with [REDACTED]</p> <p>Initial observation during the resident interview on 7/24/12 at 3:27 pm, showed the resident was missing all his natural teeth except for the front lower teeth. The gum line surrounding the remaining teeth was red and inflamed with a whitish substance along the tooth/gum line. The resident reported during the interview the need for teeth and that he had not seen a dentist nor was he aware if the facility had arranged a dental appointment.</p> <p>Review of Resident #50's medical record found he was seen routinely by the facility hygienist with the last visit 5/22/12. The screening form completed by the hygienist for that date contained a recommendation for fluoride rinse. No documentation was seen in the chart to show that the recommendations were forwarded to the doctor.</p> <p>On 8/1/12 at 9:36 am interview conducted with</p>	F 309		
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F 309	Continued From page 51 LN#1 to determine the routine for follow-up with the hygienist recommendations. She stated the hygienist visited monthly, made recommendations, and contacted the doctor and family. LN #1 said the recommendations were to be reviewed by herself, the director of nursing, or the social services director. LN #1 reviewed Resident #58's record and verified the recommendation for the fluoride rinse was not given to the doctor for follow-up. LN #1 was unsure of how it was missed. LN #1 stated they were getting used to a new system for follow-up which started in July. The administrator (ADM) and director of nursing were interviewed on 8/2/12 at 10:05 a.m. to discuss the system for recommendation follow-ups. The ADM stated the process is the same, but a new tool was started in July to follow-up on recommendations. The information is put in the book, talked about in the morning daily meeting until the issue is signed off or highlighted as done. The ADM stated if something, "falls through the cracks" it becomes a Quality Assessment and Assurance (QAA) committee issue to address.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312	F 312 CFR 483.25(a) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS SS=D AFFECTED RESIDENTS- Resident #30- Due to the resident's anticipated decline in overall condition, hospice services were initiated in May, 2012. As per the resident's legal representative and physician's request, the resident was placed on the facility's comfort care plan protocol which alerts staff not to be assertive in attempting to provide ADL care services. The resident's care plan has been revised to provide the resident extensive assistance for eating. Per facility dining room protocol, staff will offer alternatives if resident eats less than 50% of her meal or is not satisfied with what has been offered. The LN will be notified if she eats less than 25% of her meal and substitute offerings. As the resident's condition causes continued decline; ADL's and services provided will be revised.	

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F 312	<p>Continued From page 52</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to ensure necessary services were provided to maintain nutrition for 1 of 2 dependent residents (#30) reviewed for activities of daily living (ADL). This may have contributed to weight loss and diminished quality of life.</p> <p>Findings include:</p> <p>Record review found that Resident #30 was admitted to the facility [REDACTED] with [REDACTED].</p> <p>[REDACTED] The resident's annual Minimum Data Set (MDS - an assessment tool) dated 6/4/12 identified that the resident required full assistance with ADLs including total dependence for eating.</p> <p>The Care Area Assessment (CAA) dated 6/4/12, identified the resident was at risk of poor nutrition, significant weight loss, high risk for aspiration (getting food or fluid into the lungs), and delayed swallow. The resident was to receive a pudding thick liquid diet. The CAA referenced a plan of care for safe swallow management. Staff should honor food preference of family as the resident was unable to speak for herself. The resident was on Hospice services for failure to thrive and end stage disease progress. Facility records document that Hospice services started 5/17/12.</p> <p>Weight records identified that from January to May 2012 before going on Hospice the resident lost 11 pounds. From 5/17/12 through August 1st she lost 15 pounds as follows: 5/28 100 lbs; 6/26 92 lbs; 7/22 89 lbs; 8/1 86 lbs.</p>	F 312	<p>RESIDENT IDENTIFICATION PROCESS- All residents receiving comfort care services or who have triggered for significant weight loss will be reviewed by the interdisciplinary team to insure their care plan for ADL assistance is clear, matches what the staff are doing for the resident, and are designed to achieve the maximum well-being for the resident.</p> <p>SYSTEMIC CHANGES: See POC F-241</p> <p>QUALITY ASSURANCE MONITORING- As part of the Quality Assurance Team's new monitoring program; a dining room service protocol review will be conducted quarterly. This process will also include resident/family interview sessions which will detect any concerns regarding dignity and respect. Identified concerns will be addressed by the Quality Assurance Team as discovered.</p> <p><i>Plan of Correction date: 9/16/12</i> <i>Correction Assurance Manager:</i> Candy Hayes, Administrator</p>	

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F 312	<p>Continued From page 53</p> <p>Resident #30's care plan dated 6/27/12 identified that staff would set up and supervise eating, cue the resident to eat as needed and provide extensive assist to complete the meal. Staff was to offer replacement or alternatives for refusals or consuming less than 50% of meal.</p> <p>Observation noted the following:</p> <p><7/30/12 dinner observation ></p> <p>At 5:00 p.m., Resident #30 was seated in dining room staring into space covered dishes of pureed food in front of resident. No staff was observed feeding or interacting with the resident. At 5:45 p.m., Resident #30 remained seated at her table with all of her food covered in plastic wrap. A nursing assistant approached her and removed the food without offering any assistance. The resident was removed from the dining room without eating.</p> <p><8/02/12 lunch observation></p> <p>Resident #30 was observed at 11:35 a.m. sitting at a table with her eyes closed. The resident had a bowl of a clear thickened substance in front of her that was covered with plastic. At 11:52 a.m. she had not been assisted with her meal. By noon the resident remained sitting with the bowl in front of her with no assistance from staff. At 12:02 p.m. 3 bowls were placed in front of Resident #30. NAC #11 asked the resident, "Are you going to eat?" but offered no assistance. Nursing Assistant Certified (NAC) #2 approached Resident #30 and began feeding the resident some yogurt after approximately 35 minutes of</p>	F 312		

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F 312	<p>Continued From page 54 having food placed in front of her.</p> <p>Interview found differing practice by different nursing staff related to feeding:</p> <p>7/31/12 at 11:30 a.m. the Resident Care Manager (RCM) stated that staff fed the resident.</p> <p>On 8/1/12 at 11:15 a.m. the Director of Nursing Services (DNS) stated that for residents receiving comfort care or Hospice, "We are going to give food and fluids as able but are not going to super work at person to give nourishment if they can't."</p> <p>On 8/1/12 licensed nurse (LN) #4 stated that occasionally Resident #30 feeds herself but had declined and is on Hospice.</p> <p>On 8/1/12 at 1:51 p.m. NAC #4 stated that she fed residents in the dining room, including Resident #30. According to NAC #4, sometimes Resident #30 could feed herself, occasionally using a spoon or her hands. Sometimes staff needed to feed her. "When (Resident #30) spits out food she is done, you can ask her." NAC #4 stated that depending on how hungry she was, it takes 10 to 15 minutes for Resident #30 to eat. According to NAC #4 staff was assigned to the dining room, not to specific residents. If a resident needed assistance staff were pulled away from feeding to help with care.</p>	F 312		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	<p>Continued From page 55</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain a safe and accident free environment for 3 of 7 current sampled residents (#83, #30, #85) of 7 residents reviewed, to provide adequate supervision for 1 of 1 former resident (#71) with repeated elopements reviewed for accidents and supervision. The facility failed to keep hazardous chemicals locked. Failure to provide adequate supervision and implement safe interventions for residents placed them at risk for safety hazards and the potential for serious injury, harm, or impairment. These failures caused actual harm to Resident #83.</p> <p>Findings include: <Resident #83></p> <p>Resident #83 was admitted to the facility on [REDACTED] with [REDACTED]</p> <p>The resident was on multiple medications making him prone to fragile skin conditions and bleeding.</p> <p>A care plan dated 6/28/12, documented the resident's skin was at risk. Care plan approaches</p>	F 323	<p>F 323 CFR 483.25(b) FREE OF ACCIDENT HAZARDS AND RESIDENT RECEIVES SUPERVISION AND ASSISTIVE DEVICES TO PREVENT ACCIDENTS SS=G</p> <p>AFFECTED RESIDENTS- Resident #83- Staff was trying to provide assistance to resident during when incident on 7/24/12 happened. Although there have never been any reported incidents due to the location of this resident vending machine, management recognizes that it does make it more difficult for residents to get through the east doorway of the small dining room. The resident vending machine will be relocated to an area that is safer and easier for residents to access. Resident #30- There was a breakdown in communication between all staff and resident contracted services with this resident's wheelchair. The wheelchair has been replaced with a fully functional, good-repair, tilt wheel chair. Resident #85- As soon as we recognized the resident's unsafe action with his [REDACTED] we ordered a different style (smaller) [REDACTED] Resident had been ambulating with staff assist so there wasn't an opportunity for the resident to present poor judgment in safety while ambulating with his [REDACTED]</p>	

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F 323	<p>Continued From page 56</p> <p>included the resident was to wear geri-gloves at all times except when he was bathing.</p> <p>The resident's Minimum Data Set (MDS), an assessment tool, dated 7/07/12, documented the resident had poor safety awareness and was at risk for falls and injury. He required extensive assistance from staff to ambulate, transfer and perform activities of daily living. Staff was to check the resident frequently and anticipate his care needs.</p> <p>On 7/30/12 at 11:25 a.m., Resident #83 said he was trying to get through a doorway a few days before when he hit his hand causing a cut. The resident's left hand was extensively bruised along the outer and top part of the hand. The resident had steri-strips (bandages) covering a skin tear.</p> <p>An incident report dated 7/24/12, documented, "Resident reported to staff he was in the small dining room trying to get to the vending machine and grabbed a table with left hand and received a skin tear, 1x1x1 cm (centimeter)."</p> <p>On 7/24/12 at 12:45 p.m. Resident #83 was observed using his hands to self propel towards the doorway of the small dining room. An activity assistant started to assist the resident out of the room when his left hand scraped the vending machine that partially obstructed the doorway by one foot. Resident #83 was observed trying to maneuver between another resident in a wheelchair (blocking another 6 inches of the doorway) and the vending machine in an attempt to get through the doorway when the accident occurred.</p>	F 323	<p>Resident #71- The facility worked as quickly as possible in securing the resident an appropriate new community that would accept her payer resource and meet her specific care and cognitive needs. The facility was not given any support or assistance from her family members in locating the resident to a new location. The resident successfully discharged to a Memory Care Facility on [REDACTED]</p> <p>RESIDENT IDENTIFICATION PROCESS-</p> <p>All residents can potentially be at risk if hazards exist and resident supervision or assistive devices are unavailable, therefore, immediate training will be conducted with staff so that all employees have the knowledge to detect and report concerns and obligation to take prompt action.</p> <p>SYSTEMIC CHANGES:</p> <p>The facility will implement systems in cooperation with the safety committee and the quality assurance process to audit the physical plant, systems, and environment to evaluate or detect any present or potential hazards. Staff will be trained on how to detect and report concerns as they arise daily, i.e. plant, equipment repairs, and resident access to chemicals. All reports of a safety nature will be copied and presented at the monthly Quality Assurance meetings. Quarterly audits will be performed by the safety committee and the Quality Assurance process will detect concerns during resident review (QIS process).</p> <p>Additionally, the maintenance department will supervise and ensure that all resident equipment is repaired promptly upon a report being made. They will design identification and tracking system for all wheelchair equipment for the purposes of recording dates and type of repair that has been performed.</p>	cont.

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F 323	<p>Continued From page 57</p> <p>The activity assistant along with a nursing assistant immediately took the resident to a nurse.</p> <p>On 8/02/12 the doorway was measured at approximately 4.5 feet. The vending machine was noted to partially block the doorway reducing the doorway exit to 3.5 feet. The width of the resident's wheelchair was approximately 2.5 feet. There appeared to be very little space for the resident to maneuver between the other wheelchair and the vending machine that partially blocked the doorway.</p> <p>On 7/3/12 at 3:40 p.m., the Director of Nursing Service (DNS) stated the vending machine blocked the dining room doorway "somewhat" and thought it should be moved.</p> <p>On 8/02/12 the DNS reported she interviewed the resident the same afternoon as the incident. Resident #83 told the DNS he was trying to get through the partially blocked doorway when he sustained the skin tear. The DNS acknowledged the resident tore his skin on the vending machine.</p> <p><Resident #71 ></p> <p>The former resident was admitted [REDACTED] from the hospital with diagnoses to include [REDACTED]</p> <p>The former Resident was discharged on [REDACTED] unavailable for interview and observations.</p> <p>The resident's MDS dated [REDACTED] identified the</p>	F 323	<p>QUALITY ASSURANCE MONITORING-</p> <p>Systemic changes in policies and procedures will identify issues. All system failures will be reviewed by the Quality Assurance Committee for analysis and plan of correction.</p> <p><i>Plan of Correction date: 9/16/12</i></p> <p><i>Correction Assurance Manager:</i> Candy Hayes, Administrator</p>	

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F 323	<p>Continued From page 58</p> <p>resident was severely impaired for daily decision making skills with disorganized thinking and inattention behaviors. The MDS documented the resident had daily wandering behavior without placing the resident at risk for exiting to the outside of the facility.</p> <p>The quarterly MDS dated [REDACTED] documented the resident exhibited wandering behaviors placing her at significant risk for getting to a potentially dangerous place.</p> <p>The resident's "Alteration in Cognition" care plan with a printed date of 3/22/12 included the resident exhibited behaviors of exit seeking and wandering.</p> <p>The goals were for the resident to accept and acknowledge helpful reminders and direction through the next evaluation date. The care plan did not contain specific goals to address the resident's exit seeking behaviors or wandering.</p> <p>The care plan interventions listed #1 as ability to exit building. Documented below this was "unable to exit or be alone outside." There were no specific interventions addressing the resident's wandering or exit seeking behaviors.</p> <p>A progress note dated 3/25/12 documented Resident #71 exited the facility and was found outside during the day shift and again at 4:00 p.m.</p> <p>A Social Service Director's (SSD) note dated 3/26/12 documented a new intervention of the family agreeing to move the resident's room closer to the nurse station.</p>	F 323		
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F 323	Continued From page 59 On 3/27/12, the facility placed the resident on location checks every 15 minutes. The progress note documented, "CP (care plan) revised." A record review showed none of the resident's care plans contained documentation of the 15-minute check intervention or the 2 incidents fo the resident exiting the facility on 3/25/12. Progress notes within a 17-day period, dated 4/18/12 at 8:12 p.m., 4/28/12 at 10:45 p.m. and 5/2/12 at 12:30 p.m., 5/4/12 at 12:30 p.m., documented the resident read and entered the correct egress codes on the keypad for all doors. The resident exited the facility and was found outside 5 times, unsupervised. No specific outside location was documented. After each incident of the resident's ability to exit the building, unsupervised, there were no new documented prevention measures on any of the care plans to mitigate the occurrence of additional incidents of the resident exiting the building, unsupervised. The facility provided documents titled Resident Location starting with 4/21/12. The facility was not able to locate the Resident Location documents for 3/25/12 to 4/20/12. The documentation for the continuous 15-minute location check contained blank spaces during the time the resident was able to exit the building unsupervised on 4/28/12, 5/2/12 and 5/4/12. Record review revealed after the resident eloped a total of 7 times, on 5/17/12, the SSD documented for the first time a discussion with the family regarding the best setting for the	F 323			

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F 323	<p>Continued From page 60 resident including placement in another facility.</p> <p>Twenty-eight days after the SSD's documentation of potentially placing the resident at another facility, the facility's investigative report dated 6/14/12 documented the resident climbed out of the window and went uptown. The documentation for the 15-minute location check contained blank spaces during the time the resident exited the facility from her room window, unsupervised.</p> <p>There were no new interventions documented in the resident's record to prevent the resident from climbing out of her room window or addressing her ability to enter the correct egress codes on the keypad for all doors and exit the facility, unsupervised.</p> <p>Physician notes dated 5/16/12 and 6/20/12 documented review for safety/elopement and behavior with interventions in place. The physician did not document new orders or recommendations to alleviate additional incidents of the resident exiting the facility, unsupervised.</p> <p>Between 6/17/12 and 7/8/12, record review revealed the resident continued to enter the correct egress codes on the keypad for all doors and exit the facility, unsupervised 7 more times.</p> <p>A progress note dated, 6/17/12 at 2:30 p.m., documented Resident #71 was found in the front parking lot at the beginning of the next block away from the facility. The documentation for the continuous 15-minute location check contained blank spaces during the time the resident was able to exit the building unsupervised.</p>	F 323		
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F 323	<p>Continued From page 61</p> <p>The resident was found in the front parking lot on 6/27, 6/28, on the patio on 6/30.</p> <p>The Resident Location document for 7/8/12 indicated the resident "made it all the way to the stop sign at the end of the road." The resident walked off of the facility's property reaching the main business road.</p> <p>The resident's record did not reflect prevention interventions to mitigate 15 documented incidences between 3/25/12 to 7/27/12 of the resident exiting the facility to the outside through a window or her ability to enter the correct egress codes on the keypad for all doors and exit the facility, unsupervised</p> <p>The physician's note dated 7/18/12 reviewed the resident's blood pressure, weight, and pain control. There was no documentation addressing the resident's additional 7 incidents of exiting the facility totaling 15 within 4 months.</p> <p>On 8/02/12 at 10:05 p.m., the DNS said the facility did not have a specific elopement care plan for former Resident #71. The DNS said the ongoing elopement issue was only addressed under the "Alteration in Cognition" care plan problem section. There was no other care plan section with specific guidance to staff to address multiple elopements over a 4 month period.</p> <p>Regarding supervision of residents, the Administrator said the facility was not equipped to manage residents who had "elopement behaviors." The Administrator said the facility was unaware of the resident's prior elopement history upon admssion.</p>	F 323	

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F 323	<p>Continued From page 62</p> <p>The Administrator acknowledged the facility retained the resident in the facility for 7 months when the resident had multiple incidents of leaving the facility unattended. The Administrator stated the facility had no clear plan except to discharge the resident as soon as the facility could find placement.</p> <p><Resident #30></p> <p>Record review found Resident #30 was admitted to the facility admit [REDACTED] with [REDACTED]</p> <p>[REDACTED] Resident #30's Care Area Assessment (CAA) dated 6/4/12 and care plan dated 6/27/12 identified that the resident had limited mobility and uses a tilt wheelchair with footrests for mobility and safety.</p> <p>Observation on 8/1/12 at 10:50 a.m. noted Resident #30 seated in her tilt wheelchair in her room accompanied by a family member. The resident was awake and conversant but confused. Resident #30's family member stated that the tilt wheelchair had many issues, demonstrating these for the surveyor: The left foot rest was difficult to latch and maneuver; both calf rests had gouges in upper outer or inner corners, exposing padding; the left side tire was completely worn down; the right brake did not align with the wheel unless it was manually moved over; the metal plate footrests were worn at the edges.</p> <p>On interview Resident #30 ' s family member stated that the Director of Environmental Services</p>	F 323		
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F 323	<p>Continued From page 63</p> <p>(DES) knew about it and told him "that's a mess" but did nothing. According to the family member, Resident #30 has had the chair for 5 years and the lack of service and repair was a great concern "It is not just matter of comfort issue, it is safety."</p> <p>On interview 8/1/12, the Director of Nursing (DON) and Licensed Nurse (LN) #2 (who is also the rehabilitation coordinator) stated that the chair's condition was not acceptable. The LN stated that she had no idea how it happened that no one noticed that the chair was not in good repair. "No one mentioned it (family, Hospice, nursing assistants, maintenance staff or restorative aides). We replace worn equipment all the time."</p> <p><Resident #85></p> <p>Record review found that Resident #85 was admitted to the facility with [REDACTED]</p> <p>[REDACTED] Resident #85's care plan dated 7/9/12 stated "resident [REDACTED] report concerns to nurse [REDACTED]"</p> <p>[REDACTED]</p> <p>Facility policy [REDACTED] states that the nursing department will determine appropriate [REDACTED] to provide the resident with maximum independence and safety.</p> <p>Observation on 7/31/12 at 4:39 p.m. noted Resident #85 seated in his room [REDACTED]</p>	F 323			

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F 323	<p>Continued From page 64</p> <p>██████████ A observed lying unsecured across the handlebars of the resident's seated walker.</p> <p>On interview, Licensed Nurse (LN) #8 stated that facility staff had tried to talk Resident #85 into other means to carry ██████████ but the resident was set in his ways. The LN addressed Resident #85 " You are set in your ways aren't you." The resident agreed that he was set in his ways. Resident #85 then rose from his chair, changed his ██████████ and walked down the hallway with ██████████ balanced on the handlebars of his seated walker.</p> <p>Observation on 8/1/12 at 3:50 p.m. noted Resident #85 in his room with the ██████████ again resting unsecured on the handle bars of seated walker. Nursing Assistant Certified (NAC) #8 stated " That is not safe, it would be better to have this tied down." Resident #85 said "That would be good, then I could sit on my walker, I can't sit there now".</p> <p>Licensed Nurse #2 came to Resident #85's room and identified that it was not safe to keep the unsecured ██████████ balanced on the handlebars of the seated walker because the ██████████ could fall and cause injury to residents.</p> <p><Unlocked Chemicals></p> <p>Observation noted the following:</p> <p>7/27/12 10:17 a.m. Horseshoe Hall tub room: One gallon heavy duty carpet prespray cleaning</p>	F 323		
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F 323	<p>Continued From page 65</p> <p>solution (label reads caution causes eye and skin irritation) unsecured on the floor next to tub and a 24 oz container of shampoo on back of tub (2 oz remaining). This was brought to Licensed Nurse #1 's attention, who promptly locked the shampoo and carpet cleaning solution. On interview 7/30/12, the ESD stated that the carpet prespray cleaning solution was left there from scrubbing floors 1-2 days before and should have been locked up. According to the ESD the shampoo should also have been locked up.</p> <p>7/30/12 11:00 a.m. Flagship Hall large shower room: 1 gallon body wash pump was located in the in unlocked common shower room. The label included the warning: "Caution for external use only. "Avoid contact with eyes. In case of eye contact, flush eyes and call physician. There was a locked padlock on a storage cabinet but the padlock was not looped through both doors. The unsecured storage locker contained a full 15 oz Suave shampoo; 14 oz shaving cream, a partially full 23.7 oz dry scalp shampoo; ¼ full 16 oz hibicleans pump soap, 2 gallons (almost empty) of the body wash.</p> <p>7/12/12 11:44 a.m. Horseshoe Hall shower room: One gallon body wash open and accessible, multiple containers of shampoo noted in unlocked cupboard. Bath Aide (BA) #1 stated that the shampoo not locked this a.m. when she showered a resident. According to BA #1 the rule is that the cupboard is supposed to be locked" as we have residents who like to wander. It needs to be locked so residents don't harm themselves." Bath Aide #1 then took a padlock key from a cup stored on the linen supply shelf, accessible to all.</p>	F 323		

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F 323	Continued From page 66 7/30/12 12:05 p.m. Mid Flagship Hall shower room: Two unlocked cupboards contained common shampoo, razor and shaving cream. A gallon container of tearless body wash with pump was open and accessible. BA #2 asked, "Should this be locked up?" and then stated that the container would not fit in the storage cupboard (although the body wash was secured in an identical cupboard in the Horseshoe shower room). Bath Aide #2 showed the key to the soap cupboard was kept on a hook on the back of the door. According to BA #2, no one knew about the key for the large Flagship shower room as it was the shower room used by Occupational Therapy. "They tried the keys this morning and none worked." During the 8 days of survey 7/24, 7/25, 7/26, 7/27, 7/30, 7/31, 8/1, 8/2/12 Resident #56 (who had obvious [REDACTED] was observed actively mobile throughout the facility. Facility staff identified two other mobile residents (Resident #21 and Resident #55) with [REDACTED] Unsecured chemicals placed those residents at risk for accidental ingestion or burning from toxic substances. In addition to unsecured chemicals and hygiene supplies, topical medications were observed in the Horseshoe Hall Tub room treatment cart on 7/27/12. Refer to F-431	F 323	F 412 CFR 483.55(b) ROUTINE AND EMERGENCY DENTAL SERVICES IN NFS SS=D AFFECTED RESIDENTS- Resident #50- Social Service Designee is working with resident's legal representative for needed dental evaluation and services. RESIDENT IDENTIFICATION PROCESS- An audit will be conducted by nursing to review the last 6 months of RD reports to ensure no other recommendations have been missed. SYSTEMIC CHANGES- The facility has struggled to find Dental Service coverage for residents on state medical assistance in Clark and Cowlitz County. Transportation to dental appointments is a non-covered benefit. The Social Service Designee will continue to search for free or low cost services for residents with no dental coverage. Administration will review with nursing possibly expanding monthly hygienist services and more frequent nursing training and education for both oral assessment and ADL assistance with oral needs to prevent decay. QUALITY ASSURANCE MONITORING- The Quality Assurance Committee will monitor referral service follow-up, including hygienist recommendations. Identified areas of concern regarding follow-up or service needs will be reviewed and corrective action will be taken. Plan of Correction date: 9/16/12 Correction Assurance Manager: Candy Hayes, Administrator	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS	F 412		

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F 412	<p>Continued From page 67</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide dental services for 1 of 3 sampled residents (#50) reviewed for dental status and services. This failure placed the resident at risk for unmet dental needs, mouth pain, inadequate nutritional intake and weight loss.</p> <p>Findings include:</p> <p>Resident #50 was admitted on [REDACTED] from an adult family home. Medical diagnoses included [REDACTED]</p> <p>Initial observation during the resident interview on 7/24/12 at 3:27pm, showed the resident was missing all his natural teeth except for the front lower teeth. The gum line surrounding the remaining teeth was red and inflamed with a whitish substance along the tooth/gum line.</p> <p>The resident reported he needed teeth. The resident had not seen a dentist nor was he aware if the facility had arranged an appointment.</p>	F 412	<p>F 412 CFR 483.55(b) ROUTINE AND EMERGENCY DENTAL SERVICES IN NFS SS=D AFFECTED RESIDENTS- Resident #50- Social Service Designee is working with resident's legal representative for needed dental evaluation and services. RESIDENT IDENTIFICATION PROCESS- An audit will be conducted by nursing to review the last 6 months of RD reports to ensure no other recommendations have been missed. SYSTEMIC CHANGES- The facility has struggled to find Dental Service coverage for residents on state medical assistance in Clark and Cowlitz County. Transportation to dental appointments is a non-covered benefit. The Social Service Designee will continue to search for free or low cost services for residents with no dental coverage. Administration will review with nursing possibly expanding monthly hygienist services and more frequent nursing training and education for both oral assessment and ADL assistance with oral needs to prevent decay. QUALITY ASSURANCE MONITORING- The Quality Assurance Committee will monitor referral service follow-up, including hygienist recommendations. Identified areas of concern regarding follow-up or service needs will be reviewed and corrective action will be taken. <i>Plan of Correction date: 9/16/12</i> <i>Correction Assurance Manager:</i> Candy Hayes, Administrator</p>	

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F 412	<p>Continued From page 68</p> <p>Review of Resident #50's medical record found he was seen routinely by the facility hygienist with the last visit 5/22/12. The screening form completed by the hygienist for that date addressed the condition of natural teeth as decay and recommended fluoride rinse; the condition of gum tissues was listed as severe inflammation; oral hygiene was inadequate. The resident was to be seen for dental care.</p> <p>The screening forms dated 3/5/12, 11/17/11, and 9/26/11 all had the box checked to refer for care.</p> <p>A note was made on the 9/26/11 form documented "Resident denied outpatient care at this time and will re-evaluate with next hygienist visit."</p> <p>No documentation was found in the chart to show that attempts were made to obtain follow-up dental care.</p> <p>On 8/1/12 at 9:36 a.m., Licensed Nurse (LN) #1 was interviewed to determine how residents were referred to a dentist after the recommendation was made by the hygienist. She stated she remembered it was discussed with Resident #50's guardian who was unable to get funding for dental care and the plan was to monitor for infection or pain. LN #1 verified the information was not documented in the resident record. LN #1 was unaware the resident wanted dentures and was not sure of the facility's responsibility to get dentures.</p> <p>Interview with the Administrator on 8/1/12 at 9:49 a.m., found she was not aware of Resident #50's</p>	F 412		

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F 412	Continued From page 69 lack of dental follow-up and stated need for dentures. She said the facility, "will do the best to arrange an appointment, but no Medicaid coverage for dental. I believe they can still get first time dentures." The administrator (ADM) and director of nursing were interviewed on 8/2/12 at 10:05 a.m. and stated a new tool was started in July to track follow-up recommendations. The information in the 24 Hour Book. According to the Administrator the follow-up issues were discussed in the daily morning manager meetings until the issue is signed off or highlighted as done. She stated if something "falls through the cracks" it becomes a QAA issue to address.	F 412	F 431 CFR 483.60(d),(e) DRUG RECORDS, LABEL, STORAGE OF DRUGS AND BIOLOGICALS SS=E AFFECTED & POTENTIALLY AFFECTED RESIDENTS- No residents were affected by deficiencies. The licensed nurses who were assigned to the treatment carts on the noted dates when they were left unsecured will be issued disciplinary action for their negligence in responsibility. All of nursing are trained to the importance and the facility policy regarding the security of the treatment and medication carts and the medication room. The DNS will audit the carts and treatment products (supplies) will be either dated or exposed of and properly resident specific labeled, as appropriate.		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431	SYSTEMIC CHANGES- Licensed nurses will be in-serviced by the contracted pharmacy regarding destroying outdated supplies and locking/securing medication and treatment carts when more than an arm's length away. QUALITY ASSURANCE MONITORING- Quality Assurance Program will include an audit of the medication and treatment carts on a monthly basis. Responsibility for auditing will be rotated between assigned facility nursing staff and the contracted pharmacy nursing staff. Plan of Correction date: 9/16/12 Correction Assurance Manager: Candy Hayes, Administrator		

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F 431	<p>Continued From page 70</p> <p>facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to consistently date and secure medication and biologicals for 1 of 2 treatment carts. This failure placed the residents at risk for accidental ingestion of medications.</p> <p>Findings include:</p> <p>Multiple observations on 7/26/12 throughout the day noted that the treatment cart stored in the Horseshoe Hall tub room was unlocked, accessible to all as the door stood open.</p> <p>On 7/27/12 at 8:05 a.m., 8:35 a.m., & 9:41 a.m. observation noted that the treatment cart stored in the Horseshoe Hall tub room was unlocked and accessible through the door which remained standing open.</p>	F 431			

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F 431	<p>Continued From page 71</p> <p>Observation of treatment cart contents at 9:41 a.m. noted the following: TOP OF CART: One jar silvadene cream dated 5/27/12; Open jar of Normal Saline on top dated 7/25 with lid not secure.</p> <p>FIRST DRAWER: Three tubes topical paste with calcium and phosphate (2 strawberry, 1 mint for stella Irvin); Twelve 0.9 gm packets triple antibiotic ointement.</p> <p>SECOND DRAWER: Resident #21-2 tubes Clotrimazole- Betameth cream 1.59 oz (one full, tube dated 7/3/12); Resident #68-.5 oz Silvasorb Gel topical cream dated 4/6/12, Asper-Flex cream 3 oz for Unnamed Resident-no date; baggie with 1 % hydrocortisone cream almost empty, no date, no name; baggie with almost empty Xanaderm cream 60 gm Resident #21, no date; Resident #36- 30 cc tube lidocaine HCL 2 % jelly dated 10/2/11; one undated athletes foot cream 1 oz. name Scott.</p> <p>THIRD DRAWER additional prescription creams for residents. Example: Resident #55-premarin vaginal cream 1 ½ oz 3/19/12 disp, no date opened; Resident #25- Nstop 100,000 units topical 60 gm 11/3/11 dispensed no date opened.</p> <p>FOURTH DRAWER additional prescription creams for residents. Example: Resident #25-Hydrocortisone 2.5% cream 1.1 oz, 11/13/11 disp, no date opened; Resident #68 - Nystatin 100,000 u/gm cream 1.1 oz dispensed 7/12/12 no date opened.</p> <p>On 7/27/12 LN #1 acknowledged the treatment cart containing topical medications should have</p>	F 431		
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F 431	Continued From page 72 been locked.	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (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. (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. (c) Linens Personnel must handle, store, process and	F 441	F 441 CFR 483.65 INFECTION CONTROL, SPREAD OF INFECTION PREVENTION, HANDLING OF LINENS SS=D AFFECTED & POTENTIALLY AFFECTED RESIDENTS- Resident 45 and 47- No indications of exposure to infection have been noted. Immediate training and surveillance of Licensed Nurse practice will be conducted to correct Hand Hygiene procedures and to prevent cross contamination during treatments, medication administration, and personal care. SYSTEMIC CHANGES- The facility's current policies and procedures and training format will be reviewed for compliance to most current, acceptable standards of practice, including: *Non-sterile dressing changes *Sterile dressing changes *Hand Hygiene Protocol Revisions will be made where needed and training will be conducted with staff for changes in procedure. QUALITY ASSURANCE MONITORING- The Quality Assurance Committee will conduct monthly audits of: treatments, personal care giving, medication administration, and other assigned areas of potential cross contamination to evaluate improvement in infection control practices. Individual and group training will be conducted for any staff that are still not in compliance of acceptable Hand Hygiene Process. <i>Plan of Correction date: 9/16/12</i> <i>Correction Assurance Manager:</i> Candy Hayes, Administrator		

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F 441	<p>Continued From page 73</p> <p>transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to follow standard infection control procedures for 5 care observations related to hand washing and a dressing change. This failure placed residents at risk for cross contamination and infection.</p> <p>Findings include:</p> <p>Facility policy on hand hygiene stated that staff must use either soap and water or alcohol based hand rub before and after direct resident contact. Soap and water wash includes wetting hands with clean running warm water, applying product to hands, rubbing hands together vigorously for at least 15 seconds covering all surfaces of the hands and fingers, then rinsing and drying.</p> <p>Facility policy on dressing changes and procedures did not direct staff to wear double sets of gloves. Facility policy states that staff will wash hands when changing gloves.</p> <p>According to "Fundamentals of Nursing" Lippincott, Williams & Wilkins, 7th Edition, 2011, page 673, Standard nursing practice states that once an item is contaminated by a dirty dressing, it should not be used for a clean procedure unless properly cleaned. "Handle used patient care equipment that is soiled to prevent transfer of microorganisms. Clean and reprocess items</p>	F 441			

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F 441	<p>Continued From page 74 used for another patient."</p> <p>On 7/26/12 at 4:06 p.m., Licensed Nurse (LN) #8 was observed giving medication to resident #70. After delivering medication, LN #8 went into the resident bathroom and rinsed her hands for less than 10 seconds, no wash or lather was seen. The nurse then returned to the medication cart to assist the next resident.</p> <p>On 7/27/12 at 11:16 a.m., LN #3 brought Resident #13 to her room in preparation of checking glucose and giving insulin. With gloved hands, LN #3 used the automatic lancet to obtain the first drop of blood. Without removing gloves, LN #3 opened the glucose strip container and put the glucose monitoring strip into the glucometer stating, "I usually do that first you must be must be making me nervous."</p> <p>After administering insulin, LN #3 took the glucose supplies to the medication cart and removed her left hand glove revealing another glove underneath the first glove. The LN then proceeded to clean the glucose monitor. LN #3 stated that she wears double gloves so that when she takes the top glove off, there is a clean glove underneath which she uses to clean the glucometer. The LN used hand sanitizer after removing the underglove.</p> <p>On 7/30/12 at 3:55 p.m., during observation of incontinence care of Resident #45 Nurse Assistant Certified (NAC) #7 wiped bowel movement from the resident's skin with wipes and then touched clean linen and the resident before prompted by NAC #9 to change gloves. NAC #7 removed and disposed of her</p>	F 441		
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F 441	<p>Continued From page 75</p> <p>contaminated gloves and donned new gloves retrieved from her pocket. NAC #7 did not wash between glove changes.</p> <p>On 7/30/12 5:25 p.m. medication pass, LN #6 was observed spooning medication into a resident's mouth. After completing the medication pass LN #6 did not wash or use hand sanitizer. LN #6 then moved the medication cart to the hall outside the dining room where she prepared medications for Resident #37.</p> <p>The LN donned gloves to open a capsule and then removed gloves to crush medications and mix with applesauce without using hand sanitizer. LN #6 went to the dining room and spooned medications into Resident #37's mouth. The LN used sanitizer after finished giving medications to the resident.</p> <p>On 8/2/12 at 10:45 a.m. during a dressing change for a heel pressure ulcer, LN #4 laid out supplies including scissors on a clean field on the overbed table. After starting to remove the protective boot and old dressing, LN reached into her pocket for scissors then retrieved the clean scissors from the clean field and cut through the old dressing. After cutting through the soiled dressing LN #4 returned the now contaminated scissors to the clean field. LN #4 changed gloves 3 times, using hand sanitizer with the first glove change but not the second or third glove change. The LN applied the new dressing, using the contaminated scissors to cut the gauze.</p> <p>On interview, LN #4 stated that she did not know that she was to use hand sanitizer or wash between glove changes (as outlined in facility</p>	F 441		
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F 441	Continued From page 76 policy). The LN stated that her usual practice was to clean scissors between dirty and clean procedures.	F 441		
F 464 SS=E	<p>483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS</p> <p>The facility must provide one or more rooms designated for resident dining and activities.</p> <p>These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide sufficient dining space in 1 of 2 dining rooms. This failure placed the residents at risk for unmet needs.</p> <p>Findings include: <Dining Room> Observation of lunch dining on 7/24/12 noted a large and small dining room. A T.V. room was adjacent to the small dining room. Observation of lunch in the small dining room began at 11:33 a.m.</p> <p>A sign on the wall indicated the room capacity was 22. There were 16 residents in the small dining room for lunch with all but 2 residents in wheelchairs to include 2 large electric wheelchairs.</p>	F 464	<p>F 464 CFR 483.70(g) REQUIREMENTS FOR DINING AND ACTIVITY ROOMS SS=E</p> <p>AFFECTED & POTENTIALLY AFFECTED RESIDENTS- Resident #27 and 35- The resident's nutritional status will be reviewed to ensure there are no weight loss concerns related to the dining room disruptions. Both residents will be interviewed by the Dietary Supervisor to solicit concerns and frustrations they have with seating and space problems. Additionally, group discussion will be held to solicit feedback from the residents that use the small dining room for meals. This will allow an opportunity to share with them our ideas for immediate and future expansion of the dining room.</p> <p>SYSTEMIC CHANGES- Until we can make some major renovations to the current design of the small dining room, dining services will be expanded to the adjacent room. Consideration of two meal settings was turned down by most of the residents that use this dining room. Additional changes to reduce congestion and improve space will include: *Walk to Dine Program (leaving wheelchairs out of dining room) * New seating chart * Re-routing outdoor access during meals</p>	

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F 464	Continued From page 77 Resident #27 was in an electric wheelchair, she was sitting at a center table. Resident #27 had to move from the table and go to the T.V. room three times, once to allow two smokers to reenter the building and the 2 other times to allow other residents access to tables near the window. On 7/27/12, Resident #27 she said, "I never get to stay in one place." The resident stated it bothered her to have to move during her meal. At 12:00pm Activity Aide (AA) 1 stated she had to pour hot drinks in the hall because the small dining room was too crowded. At 12:12 p.m. Resident #27 was in the T.V. room after being asked to move three times from the small dining room. The tray cart arrived and was observed to block the doorway. As Resident #27 was returning to the dining for the third time the dietary supervisor said to Resident #27, "You are going to have stay in (the dining room) now because the door will be blocked by the cart." At 12:14pm AA 1 asked Resident #27 if she planned on keeping her wheelchair parked sideways at the table to eat and she responded, "Why not? I will have to move again anyway." On 7/27/12 at 7:32a.m. during observation of breakfast dining Resident #35 was observed to be sitting angled at the table. The activities supervisor (AS) was observed serving hot drinks to Resident #35 between 7:41 a.m. and 8:17 a.m. AS did not assist Resident #35 to position her wheelchair up to the table for the meal. Resident #35 stated she could not get her chair	F 464	QUALITY ASSURANCE MONITORING- As part of the Quality Assurance Team's new monitoring program; a dining room service protocol review will be conducted quarterly. This process will also include resident/family interview sessions which will detect any concerns regarding dignity, respect, and a comfortable dining environment. Identified concerns will be addressed by the Quality Assurance Team as discovered. Plan of Correction date: 9/16/12 Correction Assurance Manager: Candy Hayes, Administrator	

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F 464	Continued From page 78 into the tight space. On 7/30/12 observation of the dinner meal at 5:07 p.m. in the samll dining room found Residents #32, #52, and #83 all seated at a center table. AA1 had to move the entire table and all three residents to accommodate a larger wheelchair in order to serve trays. On 8/2/12 at 12:10 p.m. the AS said there was a lack of dining space when the dining room was nearly full. She said "the regulars get their spots; some don't come down frequently so we can use those spots." She indicated the electric wheelchairs are placed so they can move in and out easier. AS said she did not know what they would do if all residents came for a meal; "We would have to figure something out." On 8/2/12 at 12:46 p.m. Resident #25 was asked to move her electric wheelchair to allow Resident #83 to be assisted from his table so he could leave the dining room.	F 464		
F 514 SS=E	483.75(I)(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	F 514	F 514 CFR 483.75(I) (1) RESIDENT RECORDS- COMPLETE, ACCURATE, AND READILY ACCESSIBLE SS=E AFFECTED & POTENTIALLY AFFECTED RESIDENTS- Resident #71- Discharged out of the facility ██████████ Administrator and DNS did not state that an investigative report should have been completed every time the resident tried to go outside of the building. This practice would not parallel our incident reporting policy.	

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F 514	<p>Continued From page 79</p> <p>services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to accurately and completely document the resident's status, the care and services provided in accordance with current professional standards and practices or complete investigations for 5 of 39 residents (#71, #52, #34, #45, #83) reviewed for record completion. This failure placed the residents at risk for unmet needs.</p> <p>Findings include:</p> <p>According to "Fundamentals of Nursing" Lippincott, Williams and Wilson, 7th Edition, 2011, page 125: "Nurses should write a comprehensive nursing note for each patient problem addressed during the time of duty. The note should include the current nature of the problem, intervention, the patient's response, and future priorities for care. Nursing documentation should demonstrate continuity of care until the problem is resolved. Documentation must be factual, complete, accurate, and entered in a timely fashion."</p> <p><Former Resident #71></p> <p>Former Resident #71 was admitted on [REDACTED] from the hospital with diagnoses to include [REDACTED]. The former Resident was discharged on [REDACTED] unavailable</p>	F 514	<p>Resident #83- The resident incident report will be reviewed and completed along with witness statements to rule out abuse or neglect.</p> <p>Resident #34- The first report of the missing lower dentures was made to Social Services on 7/24/12. The resident stated he was not sure how long they had been missing. Resident is always tucking away his personal items and then stating they are missing. Typically the staff locate the missing item by the end of the day or the next day. The Social Service Designee has made all appropriate entries along with nursing's assessment.</p> <p>Resident #45- Correction has been made to resident record and related documents.</p> <p>Resident #52- Social Services has made all appropriate entries into the resident's chart including psychosocial follow-up to resident incident of 7/24/12.</p> <p>SYSTEMIC CHANGES- The facility's new 24 hour follow-up procedure will monitor that all incident reports are completed in full, including witness reports and all phases of the investigative process. The nursing department will receive training on data gathering as part of the investigative process. The Facility Nurse Consultant will conduct training with the Social Service Designee on documenting resident grievances and missing items. The Administrator will review policy and procedure on timely charting for grievances and missing items.</p> <p>QUALITY ASSURANCE MONITORING- The newly revised Quality Assessment and Assurance Program will track incomplete or missing documentation for purposes of identifying training needs.</p> <p>Plan of Correction date: 9/16/12 Correction Assurance Manager: Candy Hayes, Administrator</p>		

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F 514	<p>Continued From page 80 for interview and observations.</p> <p>A progress note dated 3/25/12, documented Resident #71 left the facility unsupervised twice in the same day. The facility implemented new interventions to include location checks every 15 minutes.</p> <p>According to the facility's documentation, the resident continued to have 13 additional incidents of leaving the facility between 4/12 and 7/12. After each incident, the facility failed to document new elopement prevention measures on any of the care plans to mitigate the occurrence of additional exiting incidents.</p> <p>The facility provided one documented investigation report after the total of 15 exiting seeking and/or elopements from the building.</p> <p>On 8/02/12, the Administrator and Director of Nursing Services said the staff should have completed investigation reports regarding the resident leaving the building.</p> <p>Record review of "Resident Location" sheets dated 7/17/12, used to document the 15 minute checks, were found to have blank areas from 12:00 a.m. to 10:30 p.m. (22 hours). There was no documentation until 10:30 p.m. when the resident was noted to be watching TV.</p> <p>Review of the facility 15 minute checks dated 7/18/12, were found to be left blank for 16 hours from 6:15 a.m. to 10:15 p.m.</p> <p>On 8/02/12 the Director of Nursing Services</p>	F 514			

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F 514	<p>Continued From page 81</p> <p>(DNS) said the blanks meant the resident was in the same area. This information did not explain how or why the resident could be in the same place for 16 to 22 hours (such as sitting in the T.V. room).</p> <p>A record review showed none of the resident's care plans contained documentation of the 15 minute check intervention or the 2 elopements from 3/25/12.</p> <p>Refer to F-279, F323</p> <p><Resident #83></p> <p>On 7/24/12 Resident #83 sustained a skin tear to his hand when he attempted to go through a partially blocked doorway and did not have sufficient room to avoid the accident.</p> <p>Two staff were present when the resident sustained the injury.</p> <p>The DNS interviewed the resident the same day as the incident and determined the cause of the injury incident.</p> <p>Record review of the Incident Investigation Report dated 7/24/12, found incorrect information as to how and why the incident occurred. There were no witness statements included in the investigation report.</p> <p>On 8/02/12 the Administrator and DNS said all witnessed incident reports were to include witness statements. The Administrator and DNS acknowledged the information regarding the</p>	F 514		

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F 514	<p>Continued From page 82</p> <p>incident was incorrect and missing the required witness statements. The Administrator said the two staff should have given witness statements to rule out abuse or neglect.</p> <p>Refer to F-323</p> <p><Resident #34></p> <p>Progress note review found that on 7/21/12 Resident #34 requested [REDACTED] and began to cough and turn red in the face. The resident coughed up what staff described as an "old navy bean" that the resident reported he had inhaled.</p> <p>Facility incident report for the 7/21/12 incident and progress note review found that staff documented monitoring the resident for further choking but did not identify if or how the resident's lack of lower dentures contributed to inhaling and coughing up a whole bean. Facility incident investigation and care documentation did not identify that the resident's lower denture was missing.</p> <p>Record review found that Resident #34 reported to the Social Services Director (SSD) on 7/24/12 that his lower dentures had been missing for a couple of weeks. There was no documentation in the progress notes that nursing staff had knowledge of Resident #34's missing lower dentures until 8/1/12 when the SSD documented about the missing teeth.</p> <p>Facility progress notes did not include the missing teeth or cause of choking, future priorities for care or continuity of care until the problem was</p>	F 514		

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F 514	<p>Continued From page 83 resolved.</p> <p>See F 226</p> <p><Resident #45> Record review found that Resident #45 's care plan indicated that on 6/18/12 staff was to provide a 240 cc carton of LNP (another nutritional supplement) Monday, Wednesday, and Friday on [REDACTED] days. There were no directions regarding giving Med Pass on [REDACTED] days.</p> <p>Review of July 2012 medication and nursing records found no documentation that Resident #45 received Med Pass nutritional supplement or LNP.</p> <p>On interview 7/25/12 Licensed Nurse (LN) #1 stated that there was no documentation of Med Pass delivery for July 2012 because of a transcription error. According to LN #1, Resident #45 was being given the Med Pass even though it was not listed on the medication record. The LN stated that nursing staff gave the Med Pass nutritional supplement for Resident #45 to take with him to [REDACTED] as he did not like to eat breakfast.</p> <p>Documentation did not meet minimum standards.</p> <p><Resident #52> Record review found that Resident #52 had as assessment and plan of care to address chronic foul odor and chronic urine leakage. The resident's care plan dated 6/28/12 identified measures to manage odor, incontinence and skin care.</p>	F 514		
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F 514	Continued From page 84 Record review found a progress notes dated 7/19/12 recording an incident where Resident #52 became upset when the resident care manager (RCM) was sniffing in the resident's room and told him that there was a bad odor. Record review on 7/31/12 found that there was no other documentation in the progress notes or on the grievance log about the incident. On interview 7/25/12, Resident #52 stated that a staff person told him he smelled "Yesterday they said I stunk." The resident stated that this made him upset, made him feel like leaving the facility if he had anywhere else to go. On interview 7/31/12 the RCM (a licensed nurse) stated that she told the social services director (SSD) and charge nurse (LN #1) about the incident. On interview 7/31/12 both LN #1 and the SSD stated that they were aware of the incident. LN #1 deferred to the SSD. The SSD stated that she asked Resident #52 how things were going but did not ask or document specifically about the alleged incident." I should have wrote that I talked to him." According to the SSD, she did not know all of the facilities policies on how to address or document such issues.	F 514			
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility;	F 518	F 518 CFR 483.75(m) (2) TRAIN ALL STAFF-EMERGENCY PROCEDURES AND DRILLS SS=E AFFECTED & POTENTIALLY AFFECTED RESIDENTS- All residents potentially can be affected when staff do not fully understand proper steps to take in an emergency situation; therefore all staff training was conducted immediately. Additional training will be hosted by the local fire department which will a live demonstration extinguishing the fire, at the beginning of September. All staff will either have to be present at the live simulation or pass a written knowledge test by September 12 th , 2012.		

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F 518	<p>Continued From page 85</p> <p>periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that emergency training was effective for staff by teaching incorrect information on how to properly extinguish a fire. This failure placed residents at risk inappropriate response to fire emergency.</p> <p>Findings include:</p> <p>Facility Emergency training and policy states that at the time of employment all employees will be thoroughly instructed in the concepts and procedures related to fire response. Facility policy identified that if a fire is small, staff are to extinguish the fire using proper extinguishing methods taught in the inservice training session.</p> <p>Review of facility inservice training session documentation for 11/22/11 identified that in order to extinguish a fire, staff are to aim the fire extinguisher at the base of the fire, not the flames. "This is important - in order to put out the fire, you must extinguish the fuel."</p> <p>During Emergency preparation interviews on 7/30/12, 3 staff (Bath Aide #1, Activity Supervisor, Housekeeping Aid #1) stated that they would extinguish the fire from the top down (not at the base of the fire).</p> <p>On interview 7/27/12 the Director of</p>	F 518	<p>SYSTEMIC CHANGES- The Environmental Services Director will review all current policies, procedures and training materials to ensure the facility has the most up-to-date and accurate information and recommendations. Training on Fire Response and Safety will be conducted at least quarterly, covering all steps to take in responding to a fire and the proper method to extinguish a fire.</p> <p>QUALITY ASSURANCE MONITORING- As part of the Quality Assurance Team's new monitoring program; staff knowledge interviews will be conducted quarterly. Questions on Abuse, Fire, Disaster Action, and other critical topics will be asked of all different staff levels and departments. The responses will detect any concerns regarding employees training needs. Identified concerns will be addressed by the Quality Assurance Team as discovered.</p> <p>Plan of Correction date: 9/16/12 Correction Assurance Manager: Candy Hayes, Administrator</p>		

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F 518	Continued From page 86 Environmental Services (DES) stated that he supervises 10-15 employees and provides the fire safety training to all staff for the facility. The DES stated that to extinguish the fire he isolates the heat source and uses a sweeping motion starting away from fire and from top to bottom so not spread it (the fire). On 8/2/12 the DES acknowledged that he had provided incorrect training to staff. "It was my fault, I trained them incorrectly."	F 518		
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify	F 520	F 520 CFR 483.75 (o)(1) QUALITY ASSESSMENT & ASSURANCE COMMITTEE MEMBERS, PROGRAM & PLAN SS=E AFFECTED & POTENTIALLY AFFECTED RESIDENTS- Resident #71- The facility had multiple conversations with resident's family regarding discharge plans to a location that could offer the resident an opportunity to enjoy the outdoors without constant one on one monitoring, but the family would not take any initiative to start the search. The facility worked as quickly as possible in securing the resident an appropriate new community that would accept her payer resource and meet her specific care and cognitive needs. The facility recognized that the resident's primary desire was to be outdoors as often as possible. This was where she spent a good deal of time prior to becoming memory impaired. The facility tried to honor this life pattern as safely as possible by offering her frequent staff accompanied walks and independent walks with staff monitoring visually from a close distance. The resident successfully discharged to a Memory Care Facility on	Cont.

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NAME OF PROVIDER OR SUPPLIER WOODLAND CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 FOURTH STREET WOODLAND, WA 98674		
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F 520	<p>Continued From page 87 and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations of resident care, review of facility records and staff interviews, the facility failed to ensure their Quality Assessment and Assurance (QA & A) committee identified and effectively addressed relevant care issues which affected the quality of life for facility residents. Areas of identifying/ reporting and responding to allegations of abuse and neglect, as well as ensuring all residents were provided care and services in a manner which promoted their dignity were identified as areas of deficient practice during this survey.</p> <p>Findings include:</p> <p>Refer in this report to problems cited under F226, regarding Resident Behavior and Facility Practice, and the facility's failure to identify and implement policies to protect residents from abuse, neglect and mistreatment.</p> <p>Refer in this report to problems cited under F241 and F252, regarding Quality of Life, and F464 -Physical Environment, and the facility's failure to ensure residents had dining experiences that ensured the residents' dignity and respect while eating their meals in 2 of 2 common dining areas.</p> <p>Refer in this report to problems cited under F253, regarding Quality of Life, and the facility's failure to ensure the facility maintained an environment free from persistent odors that impacted</p>	F 520	<p>SYSTEMIC CHANGES- The facility will be implementing a new QAA program which parallels the federal/state Quality Indicator Survey process. This program provides more opportunity to detect compliance to regulation and insure Quality of Life and Care in delivery of services.</p> <p>QUALITY ASSURANCE MONITORING- Evaluation or success of QAA program revisions will be assessed through:</p> <ul style="list-style-type: none"> * Improved State/Federal Surveys * Five Star Rating System * Positive Resident Outcomes * Positive Feedback on Resident and Family Satisfaction Surveys * Decrease in Resident Incident (and other measurable outcomes) <p>Plan of Correction date: 9/16/12 Correction Assurance Manager: Candy Hayes, Administrator</p>		

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F 520	<p>Continued From page 88 residents' quality of life.</p> <p>Refer in this report to problems cited under F323, regarding Quality of Care, and the facility's failure to ensure the facility maintained an environment free from accidents and provision of adequate supervision of residents.</p> <p>On 8/02/12 at 10:05 a.m., the Administrator and Director of Nursing Services (DNS) were interviewed regarding the facility's QA & A process.</p> <p>Regarding supervision of residents, the Administrator said the facility was not equipped to manage residents who had "elopement behaviors." The facility prescreened all potential admissions and would not admit residents who might elope. The Administrator said they had not received complete information regarding former Resident #71 and her prior elopement history until about [REDACTED] after she was admitted to the facility.</p> <p>The Administrator acknowledged the facility retained the resident for 7 months after she had multiple incidents of leaving the facility unattended with no clear plan except to discharge the resident as soon as the facility could find placement. The Administrator said the particular issue of former Resident #71 could have been a QA & A management case to review.</p> <p>Regarding the process of conducting thorough investigations to rule out abuse or neglect the</p>	F 520		
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F 520	<p>Continued From page 89</p> <p>Administrator said any unwitnessed event would have a two phase investigation. If witnesses were involved the staff was to document their statements. The DNS added, "We have not normally done an incident report every time someone leaves the building but we will look at that differently from now on."</p> <p>Both the Administrator and DNS acknowledged several investigation reports were missing witness statements or had not ruled out abuse or neglect.</p> <p>Regarding the dining room observations, the Administrator referred to facility policy to ensure residents were treated with dignity and respect. It was not acceptable to stand and feed residents (except for one resident who did not have the area of concern care planned), call them nick names, or disrupt their seating by moving them multiple times to accommodate other residents entering or leaving the dining room.</p> <p>Regarding medication delivery at the mealtime, the Administrator and DNS said the residents had chosen to have their medications administered at mealtimes through the Resident Council process or in one to one conversations. However, no documentation could be found to address the topic that medications administered at meal times was acceptable to the residents.</p> <p>The DNS stated the medication delivery information was not documented on individual</p>	F 520		
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F 520	<p>Continued From page 90 resident care plans.</p> <p>When asked specifically about persistent odors associated with care issues for Resident #42 and #52, the Administrator acknowledged the issue needed to be addressed as a quality process. The Administrator acknowledged Resident #42 had an ongoing care issue that was only finally addressed during survey. The Administrator acknowledged the way in which the issue with Resident #52 was mishandled as a "miscommunication" that caused hurt feelings on the part of the resident.</p>	F 520		
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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 505232	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 8/3/2012
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 247	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE</p> <p>A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide notification before a room or roommate change for 1 of 2 sampled residents (Resident #34) of 15 residents reviewed for notification. This failure placed the resident at risk for unmet needs.</p> <p>Findings include:</p> <p>On 7/24/12 at 3:12 p.m., Resident #34 stated he "was not told ahead of time" when asked if he was given notice before a roommate change.</p> <p>Review of Resident #34 record did not show documentation of the roommate change, either in the progress notes or social services section. The progress notes were dated 4/22/12 and 5/8/12 with no entries in between. According to the new roommate's record, the move took place on 4/25/12.</p> <p>On 8/1/12 at 3:07, p.m., Licensed Nurse (LN) 1 said the staff would let a resident know of a new roommate and monitor for adjustment. On a follow-up interview with LN #1 on 8/2/12 at 10:35 a.m., she stated Resident #34 was informed prior to the move. LN #1 reviewed the resident's record and verified there was no documentation in either the progress notes or social services section to address the roommate change. LN #1 stated the social services director (SSD) "puts them on alert charting and it doesn't look like in this chart it happened."</p> <p>On 8/2/12 at 10:40 a.m., the SSD said room changes were discussed with the team, the new roommate and their family. The information was to be documented in the social services section or in the progress notes. The SSD indicated the resident would be monitored for adjustment by "alert charting" for 3 days. She also stated a room change request form would be filled out for maintenance to check that everyone was notified.</p> <p>The SSD indicated the forms were kept in a file drawer in her desk. She stated, "I keep this form for 3 months" and added, "I know he (Resident #34) was notified because he is very fussy, and he was agreeable once he knew who it was."</p> <p>The SSD reviewed the record for Resident #34 and acknowledged the documentation of the roommate change was not in either the progress notes or the social services section to indicate he was informed prior to receiving a new roommate.</p> <p>Review of the "Room to Room Transfer" policy provided by the facility, indicated the resident(s) should be consulted about the room transfer and if agrees the room change request form should be utilized, and the resident should be placed on alert charting. The retention guidelines stated to store the form with the</p>
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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

The above isolated deficiencies pose no actual harm to the residents

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F 247	<p>Continued From Page 1 resident's personal medical chart for 7 years from discharge.</p> <p>F 247 CFR 483.15 (e)(2) RIGHT TO NOTICE BEFORE ROOMMATE CHANGE AFFECTED & POTENTIALLY AFFECTED RESIDENTS- Resident #34- The facility had multiple conversations with resident prior to the roommate change, including introducing the resident to his new roommate. He was in agreement to the change. There is no negative outcome related to this room change.</p> <p>SYSTEMIC CHANGES- The facility will insure that all documents and processes currently established will be followed..</p> <p>QUALITY ASSURANCE MONITORING- The facility will be implementing a new QAA program which parallels the federal/state Quality Indicator Survey process. This program provides more opportunity to detect compliance to regulation and insure Quality of Life and Care in delivery of services.</p> <p><i>Plan of Correction date: 9/16/12</i> <i>Correction Assurance Manager:</i> Candy Hayes, Administrator</p>		