

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

PRINTED: 04/24/2013
FORM APPROVED
OMB NO. 0938-0391

797

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 605455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/19/2013
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NAME OF PROVIDER OR SUPPLIER JUDSON PARK HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 23620 MARINE VIEW DRIVE SOUTH DES MOINES, WA 98198
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Judson Park Health Center on 04/11/13, 04/12/13, 04/15/13, 04/16/13, 04/17/13, 04/18/13 and 04/19/13. A sample of 23 residents was selected from a census of 69. The sample included 22 current residents, the records of one former and/or discharged residents, and two supplemental residents.</p> <p>Survey team members included: _____, MSW _____, RN, MN _____, RN, MN</p> <p>The survey team is from: Department of Social and Health Services Aging and Adult Services Administration Residential Care Facilities Region 2, Unit F 20426 72nd Avenue South, Suite 400 Kent, Washington 98032-2388</p> <p>Telephone: (253) 234-6000 Fax: (253) 395-5070</p> <p><i>Mite Ambrose</i> 04/24/13 Residential Care Services Date</p>	F 000	<p>The following Plan of Correction constitutes Judson Parks written Credible Allegation of Compliance for the deficiencies noted. Judson Park makes its best efforts to operate in substantial compliance with both Federal and State Laws. Nothing in this plan of correction is an admission otherwise. Judson Park has submitted this plan of correction in order to comply with its obligations and does not waive any objections to the merits or form of any allegations contained herein.</p> <p>POC: Plan of Correction (equals all items under number 3)</p> <p>PCC: Point Click Care (EMR)</p> <p>DNS: Director of Nursing</p> <p>ADON: Assistant Director of Nursing</p> <p>LN: Licensed Staff (RN & LPN)</p> <p>NAC: Nursing Assistant Certified</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Elizabeth L. Marsh</i>	TITLE Administrator	(X6) DATE 5-3-13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Received Time May. 3. 2013 3:31PM No. 8199

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F 242 SS=E	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents were afforded the ability to make choices identified as important to them. Based on observation, interview and record review, the facility failed to allow Resident #s 161, 6 and 47, three of three residents reviewed for choices and three supplemental residents (#s 159, 36 and 87) interviewed in Stage 1, the right to make choices regarding important daily routines. Failure to allow residents to choose between a shower and a tub bath or choose a bathing time or frequency of their preference placed residents at risk for a diminished quality of life, poor hygiene and to feel powerless and disregarded.</p> <p>Findings include:</p> <p>RESIDENT #161 According to the 03/19/13 admission Minimum Data Set (MDS), the resident was assessed to have no memory issues, was understood and able to understand and be understood in conversation. However, Section F indicated an interview should not be conducted regarding</p>	F 242	<p>F242 - Preferences</p> <ol style="list-style-type: none"> 1. Unable to correct past practices for resident # 6, 47, 87 & 159. Resident # 161 discharged. 2. All residents could be affected; new admits and each resident on roster interviewed, area corrected and POC completed. 3. ADON upon admission and per RAI schedule will interview resident to determine bathing preferences. Documentation of preferences will be noted in nursing progress notes, on care plan and care directive. 4. ADON will provide copy of progress note, care plan and care directive to DNS with new admits for 30 days post compliance date. DNS or designee will audit for 3 months or until compliance is maintained. Audit results will be reviewed at quarterly QA meeting. 5. DNS/designee is responsible for sustained compliance. 6. 6/5/13 	6/5/13	

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F 242	<p>Continued From page 2</p> <p>customary routine preferences as the resident was rarely/never understood and family was not available, however staff documented the resident preferred a shower.</p> <p>In an interview on 04/11/13 at 10:17 a.m. Resident #161 indicated she did not get to choose how many times a week she took a bath or shower stating, "No, it's twice a week. When I was at home it was four time a week. I haven't asked if I could (be bathed more frequently), I rather doubt they would let me they do that."</p> <p>Resident #161 elaborated she did not get to choose between a shower, tub or bed bath stating, "No, you take a shower, nobody offers a bath, I think I asked and I was told no". Resident #161 indicated she had pain in her feet and would like to soak her feet in a tub.</p> <p>In an interview on 04/18/13 at 11:30 a.m. Staff F (Activity Director) indicated she asked residents on admission and quarterly how important it was to choose between bathing options, but didn't ask residents which of the bathing options they preferred. Staff F stated, "I assume the people who actually provide the care, the CNAs (Certified Nursing Assistants) or nurses would ask what the resident wanted." When asked how staff determined which bathing preference was important to the residents, Staff F replied, "I suppose it would make sense if we asked the question, I don't know if someone else asks that... that's a good question, I don't know the answer to that."</p> <p>In an interview on 04/18/13 at 2:55 p.m., Staff O, a CNA who indicated she worked at the facility for</p>	F 242			

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F 242	<p>Continued From page 3</p> <p>over 30 years, stated, "our tub bath isn't working right now... it hasn't been working for a long time; oh my god no I can't tell you the last time I gave someone a tub bath it's been too long ago; I don't know what's wrong with the bathtub...". When asked how the tub worked Staff O stated, "No, I couldn't show you how it works."</p> <p>In an interview on 04/17/13 at 2:36 p.m. Staff K, a CNA who had worked at the facility for 15 years, indicated she bathed residents based on "a list in the assignment book". Staff K explained resident showers were based on the room the resident was in, stating, "if the resident changes rooms the day and shift of the shower changes."</p> <p>Staff K elaborated staff did not provide tub baths, "we don't use that (tub bath), they lost the chair... we would like to use it, especially for people who have wounds or pain, it would be perfect (but) they lost the chair, at one time they said they would order another, I've been here 15 years and haven't given a tub bath."</p> <p>In an interview on 04/17/13 at 2:27 p.m., Staff J (CNA), indicated she worked at the facility for four years, but had not provided a tub bath to any residents stating, "I don't know why we don't do tub baths."</p> <p>Similar interviews were conducted with Staff L, I and P, all CNAs who indicated they had never provided tub baths. Staff L stated on 04/17/13, "I haven't offered a tub bath. I don't know if we're allowed to use it...".</p> <p>In an interview on 04/18/13 at 1:06 p.m. Staff B (Director of Nursing Services) stated, "both tubs</p>	F 242		

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F 242	<p>Continued From page 4</p> <p>work" and the tubs were, "last used 20 years ago." Staff B confirmed current facility practice was to provide bathing based on resident room rather than preference. She confirmed the facility did not offer or utilize the bathtubs available.</p> <p>According to the February 28th, 2013 Town Hall meeting minutes residents questioned, "Can we get rid of bathtubs that aren't being used?" Rather than determine why the tubs weren't being used, the facility answered, "no, it's a requirement (to have tubs)."</p> <p>Similar findings were identified for Resident #6 who stated in an interview on 04/11/13 at 11:10 a.m., that she had not been offered a bath. She stated she did not know the facility had one available and that it would "be nice" if she could take one.</p> <p>Similar findings were identified for Resident #47 who stated on 04/11/13 at 1:25 p.m., he wasn't given a choice between shower or tub bath. Record review revealed no indication the resident received or refused bathing on 03/27, 03/30, 04/5 or 04/06/13.</p> <p>Similar findings were identified for Resident #159 who stated on 04/11/13 at 10:59 a.m., "I like to sit in a tub in the winter time, they don't have baths here, not that I've ever seen they always give me a shower, they don't ask." The resident indicated staff perform bathing at their own convenience stating, "It's when they want to do it, they tell me "tomorrow is the day you will have a shower." "I don't know where you would take a bath, they only have showers... at home my son put in more grab bars so I can take a bath."</p>	F 242		

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F 242	<p>Continued From page 5</p> <p>Similar findings were identified for Resident #36 who stated on 04/11/13 at 10:41 a.m., "No I don't get to choose (between a shower and a tub bath), yes I might want to take a bath." "They have a bath, they don't ask."</p> <p>RESIDENT #87 In an interview on 04/11/13 at 1.41 p.m., Resident #87 stated she did not feel staff listened to her. As an example she stated she preferred to receive one shower a week, however staff told her the facility was "required" to offer two showers a week. Resident #87 stated she was asked to take a second shower each week, sometimes more than once in the week. She stated she frequently told staff she only wanted one shower and to please stop asking about a second, but they "don't listen to me."</p> <p>Review of the resident's bathing record for the past three months revealed she consistently accepted one shower a week and refused the second.</p> <p>In an interview on 04/19/13 at 8:12 a.m., Staff D (Social Worker) stated if a resident refused care, staff would re-approach the resident several times in an attempt to get the resident to accept the care. She stated if the refusals were consistent, staff should ask questions to determine the cause of the refusals. Staff D explained if the facility needed to make a change to suit the resident that should be communicated and the care plan should be updated to reflect the change.</p> <p>Staff D stated she was unaware the resident preferred one shower a week but stated the</p>	F 242		

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F 242	Continued From page 6 facility "should accommodate that."	F 242	F250 Medically Related Social Services 1. a. Resident #122's 8/27/12 and 11/27/12 MOS were unable to be corrected. b. Resident #122's PASRR was updated to correctly reflect the resident's condition and appropriate referrals were made. c. IDT team reviewed resident #122's medications and identified specific behaviors, their triggers and appropriate diagnoses and the resident's care plan was updated with appropriate interventions. d. Social Services contacted resident #122's Guardian Ad Litem for medication consents (including Mental Health) and documentation follow up as appropriate. GAL informed Administrator that he cannot sign consents as his position is more of an investigator than a true guardian. It was his recommendation to have two staff members approach the resident and explain the medications and mental		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide medically related social services including mental health and coping interventions for Resident #122, one of ten residents reviewed for unnecessary medications. Failure to ensure this resident received services to assist her in attaining her highest practicable well-being placed her at risk for depression, anxiety and unmet needs. Findings include: RESIDENT #122 On 04/15/13 at 8:55 a.m., Resident #122 was observed to self propel her wheelchair to the nurse's station. She asked several people who passed her for information regarding a family member. She became louder and sounded more anxious each time she asked until a staff member assisted her with her request. This scenario was observed to recur on 04/17/13 and 04/18/13 after breakfast. At other times the resident was observed in her room watching television quietly	F 250			

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F 250	<p>Continued From page 7 or resting in bed.</p> <p>Resident #122 admitted to the facility in 04/12 with diagnoses that included depression, a paranoid state and communication difficulties.</p> <p>The 08/27/12 admission Minimum Data Set (MDS) assessed the resident with no mood indicators. She was noted to have refused care on four to six days of the assessment period, however according to the Care Area Assessment, the resistance to care was "a choice that she is making. She is able to make her needs known and she has a very independent nature. Will not proceed to CP (care plan) as this does not appear to be a behavior problem as much as self determination."</p> <p>The 11/27/12 MDS assessed the resident with no mood or behavior issues. The resident was not noted to have a diagnosis of dementia. The 02/26/13 MDS assessed the resident as feeling tired or having little energy. No behaviors were exhibited. This MDS identified the resident with diagnoses of dementia, ADL, continuity and depression.</p> <p>The Pre-Admission Screening and Resident Review (PASRR), dated 08/18/12, inaccurately indicated the resident had no mental illness and therefore did not require a Level II evaluation. A Level II is an evaluation which identifies specific interventions the facility could put in place to assist the resident, as well as recommending specialized services. The facility failed to revise the PASRR. The resident therefore did not receive a Level II evaluation.</p>	F 250	<p>health and document resident's acceptance or denial of medications/mental health until a permanent guardian is named.</p> <p>e. Resident 122's care plan will be updated and the resident will continue to be involved in her care planning as she is able until a permanent guardian is in place.</p> <p>f. Resident #122 will receive 1:1 Activities support when she refuses to participate in group activities. She also receives occasional visits from her daughter and granddaughter. Resident's activities care plan will be reviewed and updated as appropriate.</p> <p>2. All residents on psychotropic medications will be reviewed monthly or as necessary by the IDT team to ensure they are being provided with medically related social services to include, but not be limited to, mental health, coping interventions and unnecessary medications.</p> <p>3. Social Services/ADON will actively engage resident POA's regarding GDR to ensure GDR process per RAI process.</p>		

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F 250	<p>Continued From page 8</p> <p>Review of physician's orders revealed Resident #122 had numerous changes to her [REDACTED] medication since her admission. As of 04/17/13, she received [REDACTED] ([REDACTED]) for [REDACTED], [REDACTED] ([REDACTED]) three times a day for [REDACTED], [REDACTED] ([REDACTED]) daily for [REDACTED] with behavioral disturbances and [REDACTED] prn (as needed) for [REDACTED].</p> <p>Behavior monitors revealed behaviors associated with the [REDACTED] were "isolation, low motivation, resisting care". Behaviors associated with the [REDACTED] were "isolation and withdrawal". Additional behavior monitors identified "irritability, resists necessary care, unable to redirect and yelling".</p> <p>The April Behavior monitor revealed the resident exhibited irritability on six occasions, resists necessary care and yelling on two occasions, unable to redirect and low motivation once. There was no indication of how "irritability" presented itself or if it was a concern or problem for the resident.</p> <p>Record review revealed the [REDACTED] was initiated and the [REDACTED] was increased on 04/01/13. As of 04/19/13, neither consent was signed by the resident's representative nor was verbal consent noted. A 04/04/13 progress note identified a message was left for the resident's family regarding signing the consent forms and report was given to the night nurse to follow up. There was no further mention of the informed consents being pursued despite both medications being administered.</p>	F 250	<p>IDT team will review residents on psychotropic medications and identify specific behaviors, their triggers and appropriate diagnosis on admission and per RAI process.</p> <p>Nursing staff will be in-serviced on accurate documentation in PCC of resident specific behaviors.</p> <p>Social Services to review and update care plans with behaviors and diagnosis; Social Services will include non-pharmacological behavior modification plan as well as any appropriate medically related social services to include, but not be limited to, mental health, coping interventions and unnecessary medications.</p> <p>4. ADON will randomly audit behavior documentation in PCC weekly to ensure compliance x 30 days. DNS/designee will audit nursing systems for three months or until compliance is maintained. Audit results will be reviewed at quarterly QA meeting for recommendations and resolution of any issues/trends identified. Compliance of medically related social services being provided (i.e. mental health, unnecessary medications, and coping</p>		

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F 250	<p>Continued From page 9</p> <p>The March 2013 Antipsychotic Use in Assessment (Multidisciplinary Medication Management Committee) was signed by only the Social Worker and not dated. It identified medications in use were Tamoxifen 12.5 milligrams (mg) every day at 7am for antipsychotic; antipsychotic 25mg twice a day added 03/14/13; antipsychotic 0.5mg three times a day for antipsychotic; antipsychotic 500mg every day for antipsychotic with behavioral disturbances (started 12/17/12). A gradual dose reduction of the antipsychotic was recommended for the end of April at the same time it was noted to "add antipsychotic" and re-evaluate next time.</p> <p>A 02/01/13 Social Service (SS) progress note revealed a message was left for the resident's family member regarding Resident #122's "recent decline and decreased mood". It was noted the resident consented to counseling services but "may not understand to sign intake paperwork".</p> <p>The 03/01/13 Quarterly Social Service Assessment noted the resident exhibited mild short-memory loss and at times was easily distracted during conversation. The resident was noted to be "able to make her needs known". This note indicated the resident "would benefit from mental health (MH) services but has not been able to attend to task of signing consent and now has a (guardian) assigned, who will perhaps be able to assist with the initiation of MH services for this resident". This assessment noted a significant decrease from the 11/30/12 SS assessment in the level of participation and support the resident's family provided.</p> <p>Review of the resident's comprehensive care</p>	F 250	<p>Interventions) through the weekly psych meetings with mental health and IDT team. Any trends/issues will be reported to the Administrator to be taken to quarterly QA meeting for recommendations and resolution.</p> <p>5. Administrator/DNS/designee</p> <p>6. 6/5/13</p>	6/5/13	

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F 250	<p>Continued From page 10</p> <p>plans (CP) revealed no CP related to [REDACTED] or the [REDACTED]. The depression CP identified a goal that the resident would "show decreased episodes of s/sx of [REDACTED]" however did not identify how the resident's [REDACTED] manifested itself nor how this goal would be measured. In addition, there were no interventions related to behavior management or assisting the resident with coping skills. Listed interventions identified only medication management.</p> <p>The discharge care plan (CP) identified the goal that the resident would participate in her plan of care by making some choices to ensure that her quality of life is enhanced. Interventions included "Establish an individualized plan of care with the resident / GAL (guardian ad litem) and guardian to meet res(ident's) psychosocial and recreational needs."</p> <p>In an interview on 04/17/13 at 2:18 p.m., Staff D (Social Worker) stated the resident's family became less involved and more difficult to get ahold of over the course of the resident's stay. As the resident began to exhibit some cognitive loss the facility decided to pursue guardianship for the resident. Staff D stated she thought MH could be beneficial to the resident however it was "pending". She stated she spoke to the resident who agreed to the services, however she was deemed unable to sign the paperwork. Staff D further explained while the court assigned a Guardian ad litem, the facility was waiting for the appointment of an official guardian to ask about MH services. She was unable to explain why, if the facility thought it appropriate and a GAL was appointed, MH services had not been pursued more aggressively especially in light of the</p>	F 250		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 606455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/19/2013
NAME OF PROVIDER OR SUPPLIER JUDSON PARK HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 23620 MARINE VIEW DRIVE SOUTH DES MOINES, WA 98198		
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F 250	<p>Continued From page 11</p> <p>Instantlation of additional [REDACTED] medications.</p> <p>Staff D was further unable to explain why the resident received two [REDACTED] medications ([REDACTED] and [REDACTED]) or why the [REDACTED] was noted to be given for [REDACTED]. She stated the GAL should have been asked for consent to inflate the medications but had not been. She acknowledged while multiple behaviors were monitored for Resident #122, they were not specifically individualized to her particular concerns. She stated staff had been "talking about what we've seen for her behaviors" and were working to be more specific in what they monitored.</p> <p>In an interview on 04/18/13 at 10:35 a.m., Staff F (Activities) stated Resident #122 "does ok" for a time in activities but if "she gets anxious she will just leave when she wants." Staff F stated when the resident admitted to the facility she seemed to not be "adjusting well so she wouldn't really do anything". She stated the resident had improved and while she "still gets anxious, it's usually when (she's) alone". Staff F stated she tried to engage the resident in activities, however review of the March activity calendar revealed 13 days in which no formal activities were noted for this resident. Staff F stated the resident was not always interested in what was on the calendar and on those days nursing or other staff would be responsible for interacting with her.</p> <p>In an interview on 04/18/13 at 10:25 a.m., Staff B (Director of Nursing Services) stated nursing should be more involved in "looking at the medications and behavior monitoring". She stated</p>	F 250			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 508455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/19/2013
NAME OF PROVIDER OR SUPPLIER JUDSON PARK HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 23620 MARINE VIEW DRIVE SOUTH DES MOINES, WA 98198		
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F 250	Continued From page 12 nurses should be "in touch with the doctor when (medication) changes get made". She further acknowledged the GAL should have been asked to sign the MH consents so the resident did not go without a service identified as necessary.	F 250			
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	F272 – MDS Accuracy 1. Resident # 66, 13, 161, 89 60 & 23; area of concern corrected. Resident # 161 discharged. 2. All residents could be affected; new admits and each resident on roster reviewed and corrective action completed. 3. Oral cavity assessment video on CMS website to be viewed by dietician and LN completing MDS. Dietician to notify SS for dental referral as appropriate. Dietician to document in PCC when changed noted. Staff will document resident current cognitive/communication status in PCC when completing section F, B, & C at the time of the interview.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505485	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/19/2013
NAME OF PROVIDER OR SUPPLIER JUDSON PARK HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 23620 MARINE VIEW DRIVE SOUTH DES MOINES, WA 98198	
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F 272	<p>Continued From page 13 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 accurately assess three (#s 13, 66 & 23) of three residents reviewed for dental/nutritional status, two residents (#s 161 and 89) for preferences and one (#60) resident reviewed for falls. These failures placed residents at risk for unidentified and/or unmet needs.</p> <p>Findings include:</p> <p>RESIDENT #13 According to the 09/03/12 Minimum Data Set (MDS), Resident #13 had _____ and obvious or likely cavity or broken natural teeth. According to the 12/23/12 and 03/24/13 MDSs the resident no longer had any oral/dental problems.</p> <p>Observation on 04/11/13 at 1:28 p.m. revealed the resident appeared to have carious and missing lower teeth with white debris in the gumline. In an observation on 04/18/13 at 11:05 a.m. Staff C (Assistant Director of Nursing) confirmed the resident had what was described as "broken, carious teeth."</p> <p>According to Staff C, a dental referral was</p>	F 272	<p>4. ADON/MDS Coordinator to provide copy of progress note of section K & L or F, B & C when a discrepancy is noted for the first 30 days.</p> <p>DNS or designee will audit for 3 months or until compliance is maintained. Audit results will be reviewed at quarterly QA meeting.</p> <p>5. DNS/designee</p> <p>6. 6/5/13.</p>	6/5/13

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NAME OF PROVIDER OR SUPPLIER JUDSON PARK HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 23620 MARINE VIEW DRIVE SOUTH DES MOINES, WA 98198		
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F 272	<p>Continued From page 14</p> <p>triggered if the MDS indicated the resident had oral/dental issues. The Social Worker (SW) reviewed the MDS and made referrals based on the data. However, review of quarterly notes revealed the SW continued to document, "no dental issues". Staff C stated, "they would have gotten this information from the MDS, because the MDS was incorrect the referral to a dentist was never made." In an interview on 04/19/13 at 8:05 a.m., Staff D (Social Worker) confirmed the resident had not been seen by a dentist.</p> <p>RESIDENT #66 According to the 09/17/12 MDS, Resident #66 was determined to have no natural teeth and a height of [REDACTED]. The 12/18/12 MDS indicated the resident was 60 inches tall and had teeth. The 03/22/13 MDS reflected the resident was 57 inches tall and had teeth.</p> <p>Observation 04/11/13 at 12:54 p.m. revealed the resident had no teeth and was wearing no dentures. On 04/18/13 at 11:18 a.m., Staff C confirmed the resident was edentulous (without teeth). Facility staff were unable to explain why or how the MDS assessed the resident with five inches of variability in height or why staff did not code the resident as edentulous. Failure to ensure oral status and height were accurately assessed prevented staff from establishing correct nutritional requirements and developing care plans which reflected the resident's needs.</p> <p>Similar findings were identified for Resident #23 whose 09/05/12 MDS assessed the resident with "obvious or likely cavity or broken natural teeth" but for whom the 12/06/12 and 03/07/13 MDS assessments did not identify the resident with</p>	F 272			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 272	<p>Continued From page 15</p> <p>broken teeth. Observation on 04/12/13 at 10:25 a.m. revealed the resident with numerous chipped front teeth. The resident's care plan indicated the resident had "several broken and chipped teeth".</p> <p>RESIDENT #161 According to the 03/19/13 admission Minimum Data Set (MDS) the resident was determined to have no memory issues, and was understood and able to understand and be understood in conversation. However section F indicated an interview should not be conducted regarding customary routine preferences as the resident was rarely/never understood and family was not available.</p> <p>In an interview on 04/16/13 at 1:00 p.m., Staff Q stated, "She (Resident #161) was very alert and oriented... she could be interviewed" Staff Q later reported, "the resident was interviewable but was with therapy so wasn't interviewed." Staff Q was unable to explain how staff determined resident preferences without speaking with the resident and stated, "It (resident interview) should have been done." Failure to interview residents capable of conveying preferences placed residents at risk for unmet needs and dissatisfaction with care.</p> <p>Similar findings were identified for Resident #89 whom staff assessed with clear speech and usually understood and usually able to understand others on the 03/09/13 quarterly MDS. However, staff indicated on the BIMS, mood and daily & activity preferences sections the resident was rarely / never understood and so none of those interviews were conducted.</p>	F 272			

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

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F 272	Continued From page 16 RESIDENT #60 In an interview on 04/12/13 at 10:43 a.m., Staff M said Resident #60 sustained a fall approximately a week before. He had gotten out of bed early in the morning, sat on the wheelchair and when Staff M asked him Resident #60 said, "I slid out of the chair." Review of the resident's record revealed the fall occurred on 04/02/13. According to the progress note upon assessment the resident was noted with three skin tears to his left elbow and arm. The 04/05/13 Fall Risk Assessment also indicated the resident received three skin tears to the left elbow as a result of the 04/02/13 fall. The 04/07/13 Care Plan indicated the Resident had an actual fall with minor injury. The goal listed was "Resident's left forearm will resolve without complication." According to the 04/08/13 MDS the resident had one non-injury fall since admission or prior MDS. In an interview on 04/17/13 at 2:00 p.m. Staff E reviewed the resident's record and agreed the MDS should have been coded to reflect the fall with minor injury.	F 272			
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after	F 285	F285 – PASRR Requirements 1. Residents #122 and #91 have had their PASRRs updated and appropriate referrals made. Resident #164 discharged from facility.		

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F 285	<p>Continued From page 17</p> <p>January 1, 1989, any new residents with:</p> <p>(i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission;</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>For purposes of this section:</p> <p>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).</p> <p>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 285	<p>2. Social Services will audit all residents for PASRR accuracy. Any inaccuracies will be corrected.</p> <p>3. New admissions will have the PASRR audited within 72 hours of admission for accuracy. Any inaccuracies will be corrected and appropriate referrals made. Long term residents will have PASRRs reviewed at their Quarterly care conferences or as appropriate with change of condition.</p> <p>4. Social Service to use weekly resident roster to audit new admission PASRRs. Weekly roster with audit results will be given to the administrator. Any issues or trends will be taken to quarterly QA meeting for recommendations and resolution.</p> <p>5. Administrator/designee</p> <p>6. 6/5/13</p>	6/5/13	

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F 285	<p>Continued From page 18</p> <p>Based on interview and record review the facility failed to accurately complete a Pre Admission Screening and Resident Review (PASRR) for two (#122 & 91) residents who required, but did not receive, a Level II evaluation. Additionally, the facility failed to ensure PASRRs were updated to reflect the current status of one (# 164) supplemental resident. These failures left the facility unable to identify residents who required Level II evaluations and placed residents at risk for unmet mental health needs.</p> <p>Findings Include:</p> <p>Refer to: CFR 483.15(g)(1), F250, Medically Related Social Services</p> <p>During the entrance conference, the facility was asked to provide the names of all residents who required a Level II evaluation. On 04/11/13, the Administrator provided a form that indicated no residents currently at the facility required a Level II evaluation through the PASRR process.</p> <p>RESIDENT #122 Review of Resident #122's record revealed she was admitted to the facility on 08/18/12 with a diagnosis of [REDACTED]. She received an [REDACTED] medication upon admission. Hospital records contained in the resident's record noted she also presented with [REDACTED] and [REDACTED]. The PASRR, completed by the hospital and dated 08/18/12, inaccurately indicated the resident had no mental illness present.</p> <p>While in the facility, Resident #122 was subsequently started on a variety of [REDACTED]</p>	F 285		

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

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F 285	Continued From page 19 medications. As of 04/19/13, she received two medications , an antipsychotic , and a medication . Records indicated she continued to exhibit behaviors consistent with anxiety and depression . In an interview on 04/17/13 at 2:18 p.m., Staff D, Social Services, stated she was unaware the PASRR had not been revised when the resident admitted to the facility. She stated she regularly reviewed PASRRs from the hospital and made changes when appropriate. She acknowledged she should have requested a Level II evaluation based on Resident #122's diagnosis. Staff D stated it "must have been missed." Similar findings were identified for Resident #91 who admitted to the facility with a PASRR that inaccurately identified the resident with no mental health indicators. Record review revealed the resident received medications for a diagnosis of depression and an antipsychotic medication for a diagnosis of anxiety . In an interview on 04/19/13 at 9:27 a.m. Staff N, Social Services, reviewed Resident #91's PASRR and said "This is wrong, he has depression ." Staff N acknowledged the resident required a Level II evaluation but had not received one. Similar findings were identified for Resident #164 whose PASRR did not accurately reflect the resident's status to indicate a mood disorder.	F 285			
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309	F309 – Necessary Care & Services 1. Resident # 13, 114, 17, 57, 47, 100, 27, 66, 17 & 89; areas of concern corrected. Resident # 161 discharged.		

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F 309	<p>Continued From page 20 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 ensure a system was in place to provide: bowel management care to four (#s 114, 13, 17 & 57) of ten residents reviewed for unnecessary medications, proper positioning for two (#s 86 & 100) of three residents reviewed for positioning and one (#27) of three resident reviewed for pressure ulcers; monitoring of skin conditions for two (#s 161 & 47) of three residents reviewed for non-pressure skin issues; pain management for one (#89) of three residents reviewed for pain and fluid monitoring for one (#17) resident. These failures placed residents at risk for constipation, skin breakdown, worsening or untreated skin issues, pain and dehydration.</p> <p>Findings include: The facility's bowel management protocol was requested. On the afternoon of 04/16/13, Staff B provided a copy of the Medical Director's "Standards", which included "Bowel Protocol a. Senna and prune juice routine. MOM (Milk of Magnesia) if no BM (bowel movement) for 48 hours. If ineffective contact MD."</p> <p>BOWEL MANAGEMENT RESIDENT #114 According to the 02/18/13 Minimum Data Set</p>	F 309	<p>2. All residents could be affected; new admits and each resident on roster reviewed and corrective action completed.</p> <p>3. LN will be In-serviced on Bowel Protocol.</p> <p>Nursing staff will be In-serviced on notifying ADON when assistive devices are changed/removed.</p> <p>Nursing staff will be In-serviced on documenting adverse skin conditions when observed.</p> <p>LN will be In-serviced on assessing pain in residents with dementia with behaviors.</p> <p>LN will be In-serviced on completing a pain assessment on resident with dementia who have behaviors before giving a PRN psychotropic medication or before calling the MD.</p> <p>4. ADON will randomly audit BM record weekly to ensure compliance x 30 days.</p> <p>ADON will audit new assistive devices weekly to ensure they are present and appropriate to ensure compliance x 30 days.</p>		

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NAME OF PROVIDER OR SUPPLIER JUDSON PARK HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 23620 MARINE VIEW DRIVE SOUTH DES MOINES, WA 98198		
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F 309	<p>Continued From page 21</p> <p>(MDS), Resident #114 admitted to the facility with diagnoses that included a hip fracture, stroke and osteoporosis. Physician's orders (POs) for Resident #114 included directions to staff regarding "BM monitor". Directions indicated the resident was to receive prune juice on day shift if no BM in 48 hours. If no results, MOM was to be given on the evening shift. If no results by the next morning, staff were to notify the physician. Orders for an enema and a suppository were also present as needed, with no direction as to when they should be administered or in what order. In an interview on 04/16/13 at 2:45 p.m., Staff B stated when the physician was contacted, staff would be directed on administration of the enema or the suppository.</p> <p>Review of bowel monitors revealed the resident had a bowel movement on the afternoon of 03/22/13. The next noted BM was on the late morning of 03/27/13, over one hundred and ten hours later.</p> <p>Review of the resident's record, including progress notes and Medication Administration Records (MAR), revealed no indication prune juice was administered during this span, which clearly exceeded the 48 hour parameter. Staff noted MOM was given on the night shift on 03/26/13, four days after the last recorded BM.</p> <p>Further review revealed staff noted the resident had two BMs on the afternoon of 03/27/13. The resident's next BM was recorded on the late night of 04/01/13, over 120 hours later. A progress note revealed prune juice was given to the resident on 03/31/13 at 2:00 p.m., four days after his last BM. Twenty-four hours later, on 04/01/13 at 2:00 p.m.,</p>	F 309	<p>ADON will randomly audit skin documentation weekly of LN and NAC to ensure congruence of skin status for compliance x 30 day.</p> <p>ADON will randomly audit PRN psychotropic medication use weekly to ensure a pain assessment was completed to ensure compliance x 30 day.</p> <p>DNS or designee will audit for 3 months or until compliance is maintained. Audit results will be reviewed at quarterly QA meeting.</p> <p>5. DNS/designee is responsible for sustained compliance.</p> <p>6. 6/5/13</p>	6/5/13	

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

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NAME OF PROVIDER OR SUPPLIER JUDSON PARK HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 23620 MARINE VIEW DRIVE SOUTH DES MOINES, WA 98108		
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F 309	<p>Continued From page 22</p> <p>staff recorded the administration of MOM. On 04/01/13 at 9:00 p.m., staff noted "Suppository placed. No BM after MOM...". A progress note dated 04/01/13 at 10:08 p.m., revealed the resident "finally had a BM" at 10:00 p.m. There was no indication the physician was notified during this time.</p> <p>In an interview on 04/18/13 at 10:00 a.m., Staff B stated staff did not note on the MAR if prune juice was administered. She explained prune juice was documented on a form that was kept in a binder and that staff discarded the forms at the end of each month. She stated there was no way to monitor the administration of the prune juice or its effectiveness.</p> <p>Similar findings were identified for Resident #s 13, 17 and 57 for whom staff failed to assess bowel monitors and administer medications as directed by the physician.</p> <p>POSITIONING RESIDENT #66 Observation on 04/11/13 at 12:58 p.m. revealed Resident #66 sitting in a wheelchair in her room. The head rest was tilted forward, rendering it ineffective as a head support. Similar observations were made on 04/15/13, 04/16/13, 04/17/13 and 04/18/13.</p> <p>On 04/18/13 at 11:10 a.m., Staff C (Assistant Director of Nursing) confirmed the resident's headrest was loose and not positioned in a manner that would provide the resident head support. She further indicated she expected staff to report if equipment was not working properly.</p>	F 309			

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

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F 309	<p>Continued From page 23</p> <p>Similar findings were identified for Resident #100 who was assessed to require a tilt-in-space wheelchair but for whom one was not provided. This contributed to the resident being improperly positioned throughout the survey.</p> <p>Similar findings were identified for Resident #27 for whom staff failed to implement a foot cradle when the resident was in bed as care planned.</p> <p>NON PRESSURE SKIN ISSUES RESIDENT #161</p> <p>Record review revealed Resident #161 was originally admitted to the facility on 02/12/13. According to the nursing admission assessment there were no issues noted with either foot. An ultrasound was conducted on 03/19/13 and revealed the resident had _____ which were moderate on the _____ and significant on the _____. The resident was discharged on 03/22/13.</p> <p>The resident was readmitted to the facility on ____/13. Hospital discharge records indicated the resident had a "_____" of the left foot and the _____ was _____ on the right foot. Discharge records indicated the resident, "was noted to have dusky discoloration especially of the left foot".</p> <p>Observations on 04/11/13 at 10:31 a.m. revealed the distal two thirds of the resident's _____ toe was _____ and the _____ on the _____ was swollen, red and inflamed.</p> <p>According to the functional (admission) assessment, dated 03/30/13, the resident had a left third toe which staff documented was "dark</p>	F 309		

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

PRINTED: 04/24/2013
FORM APPROVED
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F 309	<p>Continued From page 24</p> <p>██████ (necrosis?)" and a right foot that was purple which was described as a "6"; which, according to this assessment tool, was a bruise.</p> <p>Record review revealed no Care Plan (CP) which addressed the resident's questionable necrotic toe nor direction to staff to monitor the feet, both of which were identified as having problems.</p> <p>In an interview on 04/16/13 at 10:41 a.m., Staff C indicated that staff performed weekly skin checks for residents and, "if there is an issue there is a progress note (describing the issue)". In an interview on 04/16/13 Staff Q stated the resident had, "Just a discoloration of the toe... Yes, we would monitor that, she is at risk...". Staff Q reviewed physician's orders and confirmed there were no directions to staff to monitor the resident's toe.</p> <p>In an interview on 04/16/13 at 2:30 p.m. Staff C stated, "There should be a care plan for skin (at risk)." Failure to provide consistent monitoring with objective measurable assessments of identified skin issues prevented staff from identifying a decline in condition.</p> <p>Similar findings were identified for Resident #47 who was observed on 04/11/13 at 12:28 p.m. with multiple bruises to both arms and discoloration to the top of his head. Staff noted performing weekly skin checks, however there was no indication staff noted or monitored the resident's skin issues. In an interview on 04/18/13 at 2:00 p.m., Staff C stated staff should document bruises when noted.</p>	F 309			

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

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F 309	<p>Continued From page 26</p> <p>RESIDENT #89 Resident #89 was observed on 04/12/13 at 10:37 a.m. shifting his weight and fidgeting in his wheelchair. He intermittently called out over the next twenty minutes. On 04/16/13 at 1:05 p.m. the resident was observed seated in a wheelchair in the dining room. He moved his legs back and forth but was unable to respond to questions regarding his comfort level.</p> <p>Review of the resident's diagnosis list revealed he experienced a hernia, generalized pain, arthritis and the effects of a stroke. The 03/09/13 quarterly MDS identified the resident received as needed pain medications but no routine pain medications.</p> <p>Review of the April 2013 MAR revealed the resident received as needed medication on only one occasion (04/05/13) for leg pain. He received only three doses in March. He also received three doses of as needed medication an anti-anxiety medication, in April for "agitation" and on two occasions in March.</p> <p>The Pain CP identified the resident was at risk for pain/discomfort related to degenerative joint disease in both hips. Staff noted the resident was "not able to alert staff when having pain" related to discomfort. Interventions included report to nurse verbal and non-verbal complaints of pain or requests for pain treatment and observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM, withdrawal or resistance to care.</p> <p>In an interview on 04/18/13 at 11:40 a.m., Staff C was unable to explain why the resident did not</p>	F 309		

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

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FORM APPROVED
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F 309	<p>Continued From page 26</p> <p>receive routine pain medication, given his diagnoses and inability to verbalize pain. On 04/19/13 at 9:20 a.m., Staff C reiterated the resident should have been on routine pain medication as it was possible some of his agitation and restlessness was due to untreated pain.</p> <p>INTAKE AND OUTPUT RESIDENT #17</p> <p>According to Resident #17's April 2013 POs, staff were directed to "make sure resident drinks enough water (every shift)." Staff were also directed to monitor the resident's Intake and Output (I & O) and document the total 24 hour intake at the end of each day.</p> <p>According to 03/13 TARS (Treatment Administration Records) staff documented intake ranging from 270 to 1500 ccs (cubic centimeters) a day. According to 04/13 TARs, staff documented the resident's 24 hour intake as ranging from 580 to 1460 ccs a day.</p> <p>In an interview on 04/18/13 at 10:22 a.m. Staff C stated, "The LN (Licensed Nurse) documents at night the total intake for the day, including what the Aides document at meals, between meals, and includes med(ication) pass fluids." Staff C indicated she expected the nurse to refer to the Registered Dietician assessment and see if the total was a sufficient amount of fluid for the resident. She stated staff should see if the resident's needs were being met. Staff C later confirmed staff did not identify and intervene when the I & Os reflected the resident was not meeting the dietitian's recommended daily fluid intake.</p>	F 309			

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

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F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure two of three dependent residents reviewed for Activities of Daily Living received necessary care. Failure to ensure oral hygiene services were provided placed Resident #13 at risk for further tooth decay, pain related to gum disease, poor hygiene and dissatisfaction with care. Failure to ensure bathing care was provided placed Resident #23 at risk for poor hygiene and skin breakdown.</p> <p>Findings Include:</p> <p>RESIDENT#13 Resident #13 was admitted to the facility in 12/12 with care needs related to _____ and _____ _____ and _____. According to the 03/24/13 quarterly Minimum Data Set (MDS) the resident was dependant on staff for Activities of Daily Living, including personal hygiene.</p> <p>Observation on 04/11/13 at 1:28 p.m. revealed the resident appeared to have no upper teeth but had carious and missing teeth with white debris in the lower gumline. Similar observation of white debris noted in the gumline and along the lower teeth were noted during hourly observations from</p>	F 312	<p>F312 – ADL Care: Dependent Residents</p> <ol style="list-style-type: none"> 1. Unable to correct past practices for resident # 13 & 23 corrected. 2. All dependent residents could be affected; new admits and each dependent resident on roster reviewed and corrective action completed. 3. Nursing staff will be in-serviced on proper oral care. Nursing staff will be in-serviced on proper bathing care. 4. ADON will randomly audit oral care of residents weekly for compliance x 30 days. ADON will randomly audit bathing care of residents weekly for compliance x 30 days. DNS or designee will audit for 3 months or until compliance is maintained. Audit results will be reviewed at quarterly QA meeting. 5. DNS/designee is responsible for sustained compliance. 6. 6/5/13 	6/5/13	

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F 312	<p>Continued From page 28</p> <p>8:00 a.m. to 1:30 p.m. on 04/15/13, 04/16/13 and 04/17/13. Observations throughout the survey revealed a denture cup near the sink containing one denture plate covered with water but with no lid.</p> <p>In an interview on 04/16/13 at 12:40 p.m. the resident's daughter identified the dentures belonged to Resident #13, but indicated she was not sure how they were cleaning her lower teeth.</p> <p>On 04/15/13 at 11:10 a.m., observation of the resident's personal care equipment revealed a bag containing a dry toothbrush in a plastic holder and a tube of toothpaste which had no lid and toothpaste which appeared to be dried out. Similar observations were made on 04/16, 04/17 and 04/18/13.</p> <p>In an interview on 04/17/13 at 2:25 p.m., Staff K, (evening shift CNA caring for the resident) indicated she did not use a toothbrush for the resident's oral care stating, "she no wanna open her mouth you really have to use the sponge... we do (oral care) with sponge".</p> <p>Staff J (day shift CNA caring for the resident) stated on 04/17/13. at 2:32 p.m., "she is total assist, she allows care, she doesn't use her upper dentures... we use toothettes every morning... I use the toothbrush on the front (teeth)... in the morning every day."</p> <p>In an interview on 04/18/13 at 11:00 a.m. Staff C stated it was the facility expectation that residents with teeth would have them brushed.</p> <p>Observation on 04/18/13 at 11:05 a.m. revealed</p>	F 312			

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

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F 312	<p>Continued From page 29</p> <p>the resident had what Staff C described as "black and broken" teeth stating, "yes they are broken, carious teeth". Observation of the resident's personal care items at that revealed a dry toothbrush and a tube of toothpaste without a lid, the contents of which were so dry Staff C was unable to expel any toothpaste. Staff C confirmed it did not appear the residents teeth were brushed.</p> <p>RESIDENT #23 On 04/12/13 at 10:25 a.m., Resident #23 was observed with multiple coarse facial hairs, between 1/8th and 1/4 of an inch long. She was also noted with white debris in her teeth along the gumline.</p> <p>The ADL CP identified the resident required assistance with ADLs related to advanced dementia. Interventions included bathing twice a week, remove facial hair weekly and prn on bath day, and Oral care: Total assist after every meal.</p> <p>Review of the Bathing record for the past 30 days revealed the resident received a shower on 03/18, 22, 04/01, 04/12 and 04/15. Staff marked "not applicable" on 03/25, 28, 04/05 and 04/08. There was no indication the resident refused care or was provided with bathing at a different time.</p> <p>Resident #23 was observed on 04/16/13 at 1:35 p.m. Staff V, CNA, removed the resident from the dining room after lunch, provided peri-care, washed her face and placed her in bed. Staff V stated she had not brushed the resident's teeth as she appeared tired.</p> <p>In an interview on 04/18/13 at 11:25 a.m., Staff C</p>	F 312			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 312	Continued From page 30 stated Resident #23 sometimes refused showers on night shift when she was scheduled and staff on another shift would sometimes bathe her. She stated staff were unable to document this due to the way the computer system had been set up. She was unable to explain why staff consistently recorded "not applicable" when they had the option to state the resident refused. Staff C was unable to explain, nor was she able to verify the resident received a shower in the 11 days prior to the observation on 04/12/13.	F 312		
F 328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure two of two residents (#91 & 13) reviewed for oxygen services received proper treatment and care as ordered by the resident's physician. These failures put the residents at risk for respiratory complications related to running out of, or having too much, oxygen.</p>	F 328	<p>F328 – Oxygen Services</p> <ol style="list-style-type: none"> 1. Unable to correct past practice for resident # 13 & 91. 2. All residents receiving O2 could be affected; new admits and each resident on O2 reviewed and corrective action completed. 3. LN will be in-serviced on appropriate O2 order entry to include input of actual liters per minute in PCC when documenting O2 saturation. <p>LN will be in-serviced to monitor liters per minute at the time they take O2 saturation and compare to order; notify MD to adjust order as necessary to resident's needs.</p>	

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F 328	<p>Continued From page 31</p> <p>Findings include:</p> <p>RESIDENT #13 According to the 03/24/13 quarterly Minimum Data Set (MDS), Resident #13 was dependant on staff for care and required treatment for heart and lung disease. Review of April 2013 Physician's Orders (PO) revealed the resident should receive, "oxygen via NC (Nasal Canula) at 2/LPM (Liters per minute) to keep sats (saturation rates) > (greater than) 90%... check sats every shift."</p> <p>Observation on 04/11/13 at 1:30 p.m. revealed the resident lying in bed receiving oxygen (O2) via NC at 3.5 LPM. Similar observations were made on 04/15/13, 04/16/13 and 04/17/13.</p> <p>Per request, Staff M (Licensed Nurse) checked the resident's O2 saturation level and O2 flow on 04/17/13 at 10:01 a.m. According to Staff M, the resident's O2 saturation rate was 91% while receiving oxygen at 3.5 LPM. Staff M reset the O2 to 2.5 LPM stating, "It should be two to three liters."</p> <p>In an interview on 04/18/13 at 10:21 a.m., Staff C indicated staff should administer oxygen according to POs and they were, "working on the oxygen system." Failure to ensure staff administered appropriate levels of oxygen placed the resident at risk for complications related to carbon dioxide retention.</p> <p>RESIDENT #91 According to the 03/04/13 MDS, this alert and oriented resident had diagnoses including perforated colon, pulmonary embolism and received</p>	F 328	<p>Nursing Staff/Other non-nursing staff will be in-serviced on monitoring O2 tank gauge status and how to exchange tank when empty.</p> <p>4. ADON will randomly audit O2 order entry weekly to ensure compliance x 3 days.</p> <p>ADON will randomly audit O2 liter flow and saturation documentation in PCC weekly to ensure compliance x 30 days.</p> <p>DNS or designee will audit for 3 months or until compliance is maintained. Audit results will be reviewed at quarterly QA meeting.</p> <p>5. DNS/designee is responsible for sustained compliance.</p> <p>6. 6/5/13</p>	6/5/13

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 328	<p>Continued From page 32</p> <p>oxygen. The resident was assessed with shortness of breath (SOB), trouble breathing when sitting at rest and when lying flat.</p> <p>Review of the April POs revealed a 01/07/13 order for "Oxygen via NC at 3 LPM to keep sats greater than 90% for Resident #91 - continuous O2" and an 01/18/13 order for "Ambulatory oxygen at 6 LPM via NC with activity for SOB." The 01/22/13 Oxygen therapy CP listed the intervention "O2 via nasal prongs at 3 L continuously." Review of the resident's record revealed no plan to monitor the resident's oxygen tank to ensure the tank had oxygen to administer.</p> <p>On 04/11/13 at 8:30 a.m. Resident #91 approached the medication cart in an electric wheelchair looking for a nurse. Resident #91 said "I'm out of oxygen." The oxygen tank on the back of his wheelchair was set at 3 LPM via nasal canula but the reading on the tank was in the red indicating the tank was out of oxygen. Staff R (Licensed Nurse) arrived and got Resident #91 a full tank. After the oxygen was on, the resident measured his O2 saturation level which was 67% and rising.</p> <p>In an interview on 04/11/13 at 11:25 a.m. Resident #91 said "some of the tanks leak." Resident #91 said he had gone downstairs to do his therapy "and wondered why my oxygen (saturation) level kept dropping. My therapist looked and said it was empty. That panics me, I've experienced it a couple times and it went down to 64%, and that scares me."</p> <p>In an interview on 04/17/13 Staff S (Rehab Manager) said that while in therapy the resident</p>	F 328			

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

PRINTED: 04/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/19/2013
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F 328	<p>Continued From page 33</p> <p>would experience SOB and, even with the 02 flow rate increased, the resident's saturations dropped below 80% with activity.</p> <p>On 04/11/13 at 11:25 a.m. when asked who monitored the oxygen level of the tank, Resident #91 replied, "I do. When I go back to my room I have a nurse or helper come shut down the tank or flow meter. I will periodically stop by the nurse's station and check how it's doing." Resident # 91 said staff did not monitor his 02 tank on a routine basis.</p> <p>On 04/12/13 at 8:43 a.m. Resident #91 was observed in his wheelchair in the hallway. The 02 gauge was inside the white zone inside the red zone. When informed, Resident #91 said "That means I need a new oxygen tank." Resident #91 waited by the medication cart for the nurse on duty. Staff M arrived and replaced the 02 tank as he requested.</p> <p>Further review of the resident's record revealed there was no documented monitoring of when the 02 tanks were changed, no documented assessment of the resident on 04/11/13 when he ran out of oxygen, nor was there a plan developed to ensure it did not happen again.</p> <p>In an interview on 04/18/13 at 1:34 p.m. when asked about a plan to ensure Resident #91 had a full tank, Staff C said "Because he is intact he is able to direct others." When noted that the resident is unable to read the 02 gauge on the tank behind his wheelchair, Staff C said "The CNA and the nurse both know how to check how full it is" and noted "If it is getting low then you would change it." Failure of the facility to develop</p>	F 328			

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

PRINTED: 04/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/19/2013
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F 328	Continued From page 34 a plan to monitor the resident's oxygen tank contributed to the resident running out of oxygen and increased anxiety. On 04/16/13 at 1:34 p.m. the resident was observed using O2 from an oxygen concentrator which was set at 3.5 LPM rather than at 3 LPM as ordered. Review of the April Treatment Administration Record revealed staff documented monitoring of O2 saturation levels above 90% on every shift, but did not note at what O2 rate the saturations were measured. Review of progress notes in March revealed staff documented administering O2 to the resident at a higher or lower rate than ordered, without physician notification. For example, on 03/10/13 at 2:09 p.m. staff noted an "O2 sat 97% on 3-4 L per NC". In March staff documented the flow at 2.5 LPM, less than the ordered rate, on 03/06/13, 03/07/13, and 03/08/13. In February, staff documented the flow at more than the ordered rate, 4 LPM, on 02/24/13, 02/26/12, 02/27/13 and 02/28/13. Failure to ensure the O2 was delivered at the rate as ordered placed the resident at risk of complications related to carbon dioxide retention.	F 328			
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose	F 329	F329 – Unnecessary Medications 1. Unable to correct past practice for resident # 34 & 91 regarding cardiac medications. Residents 13, 3, 57, 122, 89 & 91; areas of concern corrected. Resident # 161 discharged.		

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

PRINTED: 04/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/19/2013
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F 329	<p>Continued From page 35 should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure: adequate monitoring, gradual dose reductions and that medications were administered within Physician Ordered parameters for seven (#s 91, 3, 122, 57, 13, 89, 161) of 10 residents reviewed for unnecessary medications and one (#34) supplemental resident. These failures placed residents at risk for adverse side effects and/or to receive unnecessary medications.</p> <p>Findings include: Refer to: CFR 483.15(g)(1), F-250, Social Services CFR 483.25, F-309, Care and Services</p> <p>CARDIAC MEDICATIONS</p>	F 329	<p>2. All residents could be affected; new admits and each resident on roster reviewed and corrective action completed.</p> <p>3. LN will be In-serviced on the importance of following cardiac medications directions.</p> <p>Social Services/ADON will actively engage resident POA's regarding GDR to ensure GDR process per RAI process.</p> <p>IDT team will review residents on psychotropic medications and identify specific behaviors, their triggers and appropriate diagnosis on admission and per RAI process.</p> <p>Nursing staff will be In-serviced on accurate documentation in PCC of resident specific behaviors.</p> <p>Social Services to review and update care plans with behaviors and diagnosis; Social Services will include non-pharmacological behavior modification plan.</p> <p>4. ADON to review residents on admit who are on anticoagulant & proton pump inhibitors to ensure appropriate dx.</p>		

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

PRINTED: 04/24/2013
FORM APPROVED
OMB NO. 0938-0391

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F 329	<p>Continued From page 36</p> <p>RESIDENT #34 Review of Resident #34's record revealed a Physician's Order (POs) for metoprolol twice a day. Staff were directed to hold the medication and contact the physician if the resident's systolic blood pressure (SBP) was less than 110 or greater than 150. Review of the April 2013 Medication Administration Record (MAR) revealed on four occasions, for each dose on 04/06 and 04/13, staff noted the resident's SBP was 160. Staff noted the medication was given on each of those occasions. There was no indication the physician was notified of any of the SBP readings being above the stated parameters.</p> <p>In addition, staff administered metoprolol metoprolol on 04/06/13 and 04/13/13 outside physician ordered parameters. There was no indication the physician was notified.</p> <p>RESIDENT #91 Physician's orders revealed Resident #91 received metoprolol twice a day for hypertension. Administration instructions included "hold if SBP" less than 110. Review of the MAR revealed on 03/04/13 at 8:00 p.m. staff measured an SBP of 102 and administered the medication. In an interview on 04/16/13 at 12:41 p.m. Staff C said the medication should have been held.</p> <p>Similar findings were identified for Resident #161 who received the cardiac medication Metoprolol on 04/01/13 and 04/02/13 outside physician ordered parameters.</p> <p>MONITORING RESIDENT #91 According to the 03/04/13 Minimum Data Set</p>	F 329	<p>ADON will randomly review resident cardiac documentation weekly to ensure compliance x 30 days.</p> <p>ADON will randomly audit behavior documentation in PCC weekly to ensure compliance x 30 days.</p> <p>Administrator or designee to review social services behavioral care plans to ensure compliance x 30 days.</p> <p>Administrator or designee to audit social services behavior care plans for 3 months or until compliance maintained. Audit results will be reviewed at quarterly QA meeting.</p> <p>DNS or designee will audit nursing systems for 3 months or until compliance is maintained. Audit results will be reviewed at quarterly QA meeting.</p> <p>5. DNS/designee is responsible for sustained compliance by nursing staff.</p> <p>Administrator/designee is responsible for sustained compliance by social services staff.</p> <p>6. 6/5/13</p>	6/5/13

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

PRINTED: 04/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/19/2013
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F 329	<p>Continued From page 37</p> <p>(MDS), the resident was alert and oriented with diagnoses including anxiety disorder and depression, received antidepressant and antipsychotic medications daily and had no scheduled pain meds.</p> <p>Review of the POs revealed the resident received the antidepressant Buspar twice daily, Ativan and Buspar daily for depression, and the antipsychotic medication Ativan at bedtime for anxiety.</p> <p>In an interview on 04/16/13 at 1:34 p.m. Resident #91 said Ativan was the primary antidepressant and the Buspar was ordered as an adjunct therapy to "increase the effectiveness of the Ativan." Resident #91 said the Buspar was ordered not for depression, but to treat peripheral pain and "it's helped". Resident #92 confirmed the Ativan was for anxiety and commented "If I don't take Ativan at night I can't go to sleep."</p> <p>Review of the resident's record revealed the 01/22/13 Depressive behaviors Care Plan (CP) indicated he was on antidepressant and antipsychotic for depression. Interventions included "Monitor/document for effectiveness". The Depressive behaviors CP did not identify the resident's use of Buspar. Review of the 01/22/13 Chronic Pain CP did not address the use of Doxepin for peripheral pain. There was no CP for anxiety, sleeplessness or any CP addressing the use of Ativan.</p> <p>Identified target behaviors monitored to evaluate the effectiveness of the Ativan included "anxiety", "refusing care", and "agitation." There was no sleep monitoring.</p>	F 329			

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

PRINTED: 04/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/19/2013
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F 329	<p>Continued From page 38</p> <p>In an interview on 04/19/13 at 9:30 a.m., when asked how she determined the indications for each medication and what behaviors each medication was being used for Staff N, Social Services, said "we look through the chart, talk to resident and family." Staff N was unable to show she spoke to the resident or his family regarding the use of his medication, despite the resident being alert and oriented. Staff N said nursing staff completed the psychoactive medication care plans and identified the target behaviors to be monitored.</p> <p>Failure to accurately identify the purpose behind psychoactive medications prevented staff from monitoring behaviors/conditions that were being treated. This left staff unable to determine the effectiveness of these medications.</p> <p>Similar findings were identified for Resident #161 for whom staff identified target behaviors of "low motivation" "resisting care" and "anxiety" for the medication [REDACTED] which was prescribed for [REDACTED]. In an interview on 04/19/13, Staff C confirmed staff were not monitoring the effectiveness of the medication for its intended purpose.</p> <p>Similar findings were identified for Resident #122 who received two [REDACTED] an [REDACTED] and a mood stabilizer but for whom staff failed to identify accurate diagnoses and monitor individualized target behaviors.</p> <p>ADEQUATE INDICATIONS RESIDENT #13 According to the 03/24/13 quarterly MDS.</p>	F 329			

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

PRINTED: 04/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/19/2013
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F 329	<p>Continued From page 39</p> <p>Resident #13 had multiple medically complex diagnosis as well as delirium and depression diagnoses.</p> <p>According to a fax dated 12/19/12, the physician was notified the "resident (is) on medication medication 1.5 mg every 72 hours. She always holds a full mouth (of) saliva and refuses to spl out. Head of bed elevated but still risk for aspiration. Please advise". The physician responded, "suction if possible".</p> <p>An additional fax sent to the physician on 12/19/12 indicated, "Res(ident) is yelling when in bed. Saying something not making sense. Denied pain. On Ciprodine (antipsychotic)... (each day) Ciprodine (antipsychotic) 10 mg each day, please advise." To which the physician replied, "Increase Ciprodine to 20 mg each day."</p> <p>Review of target behavior monitoring revealed the resident demonstrated no behaviors for the month of December. However, yelling was not a behavior for which the resident was originally receiving the medication.</p> <p>Review of progress notes for December 2012 revealed a note on 12/20/12 when staff documented, "no yelling this shift." No other documentation regarding the resident yelling was noted.</p> <p>A fax to the physician, dated 12/20/12, indicated, "Resident with congestion, O2 (oxygen) sats (saturation) 78% on 2 (Liters) at 3:00 a.m., suctioned x1 and medicated with (as needed) Albuterol x1 via (nebulizer) with good results... resident was apprehensive to suction but</p>	F 329			

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

PRINTED: 04/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/19/2013	
NAME OF PROVIDER OR SUPPLIER JUDSON PARK HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 23620 MARINE VIEW DRIVE SOUTH DES MOINES, WA 98198		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	<p>Continued From page 40 tolerated well after several attempts."</p> <p>There was no evidence staff considered on 12/19 or 20/12 the resident was yelling out because her secretions were negatively impacting her ability to breath, despite obtaining an order for suctioning related to increased secretions and O2 sats of 78.</p> <p>In an interview on 04/19/13 at 9:13 a.m., Staff N (Social Worker), was asked if one shift of yelling out was sufficient cause to double a resident's medication. Staff N stated "no". Staff N was asked to provide evidence staff identified the resident's antidepressant dose was doubled based on one night of yelling out or considered a plan to reduce the medication after the resident's respiratory problems resolved. No information was provided.</p> <p>Similar findings were identified for Resident #89 for whom staff administered as needed medication without first ruling out pain as a cause of his agitation. In addition, progress notes revealed on 03/28/13 the resident was "very agitated". Staff first attempted to give a dose of medication but were unable to administer it to the resident. The physician ordered staff to administer medication however staff "could not give him anything". Staff then received an order to increase the medication following this incident, without first attempting a routine pain medication or ruling out pain as a possible trigger.</p> <p>RESIDENT #161 According to the April 2013 MAR, Resident #161 received medication (antidepressant medication) every evening at bedtime for "medication". In an</p>	F 329		

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

PRINTED: 04/24/2013
FORM APPROVED
OMB NO. 0938-0391

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F 329	<p>Continued From page 42 reason for use.</p> <p>GRADUAL DOSE REDUCTIONS RESIDENT #3 According to the 02/01/13 MDS, Resident #3 had diagnoses of anxiety and depression and received antidepressant medication daily. According to the 03/26/13 CP, the resident used psychotropic medications for anxiety disorders and appetite stimulation. Interventions listed included, "Consult with pharmacy, MD to consider dosage reduction when clinically appropriate."</p> <p>Review of POs revealed the resident had received the same dose of Propranolol ER for months with behavioral disturbances since 10/31/11 and Propranolol for months since 03/04/12.</p> <p>A letter to the facility from the resident's representatives, dated 01/11/12, stated, "I am specifically prohibiting any changes to (Resident #3's) medication, medication, or psycho-pharmaceutical medications...".</p> <p>A 12/10/12 counseling progress note indicated Social Service staff told the counselor Resident #3 had "no problem with mood or behavior. Chart review confirms the same." Resident #3 "describes her mood as "Very Cheerful" she states her sleep and appetite are good and she denied anxiety or fear. Her affect is calm & bright." The counselor analysis was that the resident's mood and behavior symptoms were in remission.</p> <p>A Mood, Behavior and Medication Review, dated</p>	F 329			

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

PRINTED: 04/24/2013
FORM APPROVED
OMB NO: 0938-0391

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F 329	Continued From page 43 01/02/13, indicated a plan to "look at decrease of Depakote in January". In addition, it was noted a "GDR due in December for Depakote per pharmacy. Family has asked medications not be changed. Will ask pharmacy and MD about this issue. Possible benefit and risk form needs to be signed." According to the 02/07/13 Social Services Quarterly Review, "The Remeron has been requested by Pharmacy to be reduced... as (Resident #3) has not had any weight or intake changes in quite some time. The Psych Medication Team will be looking at Depakote decrease further down the line also." "...She no longer is experiencing the behaviors she used to have." Review of the resident's record revealed no documentation indicating the resident had GDRs in the past which were unsuccessful. In addition there were no notes indicating the physician had been consulted regarding the pharmacist's recommendation, the family consulted since the January 2012 letter, or a GDR attempted in December 2012 or January 2013 as planned. In an interview on 04/19/13 at 9:34 a.m. Staff N acknowledged "nothing happened" but was unable to explain why.	F 329			
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit	F 425	F425 – Pharmacy 1. Unable to correct past practice for resident # 6, 70 & 4. Residents 100, 91, 114, 89, 57, 17, 3, 34, & 68; area of concern corrected. 2. All residents could be affected; new admits and each resident on roster reviewed and corrective action completed.		

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

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F 425	<p>Continued From page 44 unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure medications were available and/or administered as ordered for two residents (#s 6, 70) and failed to transcribe, clarify and/or follow Physician's Orders for seven (#s 100, 91, 114, 89, 57, 17 and 3) of 10 residents reviewed for unnecessary medications and four supplemental residents (#34, 68, 91 and 4). These failures placed residents at risk for untreated medical conditions, medication errors and pain.</p> <p>Findings Include: Refer to CFR 483.25(l)(1)(2)(ii), F-329, Unnecessary Drugs</p>	F 425	<p>3. LN will be In-serviced on accurate order entry of treatment related orders to include affected areas and parameters for monitoring of BP & P.</p> <p>LN will be In-serviced on cardiac medications and the process of how to and when to place/remove a medication on hold according to MD order.</p> <p>LN will be In-serviced on writing, transcribing and administering medication per complete and accurate orders.</p> <p>Licensed Staff to be In-serviced on requesting refill medications with 7 days (not doses) remaining</p> <p>Neighborhood Coordinator In-serviced on printing the Rx Order Status report from Omniview for both neighborhoods every morning</p> <p>LN will be In-serviced on calling Omniview after review of Rx Order Status report and noting that ordered medication has not been processed.</p> <p>LN will be In-serviced on notify administrative nurse (ADON/DNS) if Omniview is unable to process</p>	

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

PRINTED: 04/24/2013
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 506455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/19/2013
NAME OF PROVIDER OR SUPPLIER JUDSON PARK HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 23620 MARINE VIEW DRIVE SOUTH DES MOINES, WA 98198		
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F 425	<p>Continued From page 45</p> <p>FAILURE TO ORDER/HAVE MEDICATIONS AVAILABLE</p> <p>RESIDENT #6</p> <p>According to the 01/29/13 Minimum Data Set (MDS) assessment, Resident #6 had diagnoses that included multiple sclerosis and epilepsy. This MDS revealed the resident received routine pain medications as well as non-medication interventions to treat her pain. The resident had a physician's order (PO) for [REDACTED] a [REDACTED] patch, to be changed every three days. According to the Medication Administration Record (MAR), the patch was to be placed at 8:00 a.m.</p> <p>The MAR revealed the patch was placed on 03/17/13. Staff noted it was not available on 03/20/13 and was next placed on 03/24/13.</p> <p>A progress note, dated 03/20/13 at 8:40 p.m., revealed "[REDACTED] out; called pharmacy; said will contact MD to request an active prescription order and will deliver tonight; unable to get authorization number either."</p> <p>In an interview on 04/17/13 at 9:37 a.m., Staff B stated the [REDACTED] patch was available in the facility's emergency kit. She stated it appeared from the progress note staff requested authorization to access the supply however it was not granted as the physician had to be contacted first. She stated staff should have ordered the patch when they realized the supply was almost out so there was not a lapse in administration. She further stated staff should have followed up with the pharmacy and physician to ensure the proper authorization was obtained to prevent the resident being without the medication.</p>	F 425	<p>medication once follow up phone call was made checking on status.</p> <p>Licensed Staff to be in-serviced on the procedure for "checking in" medication when they are delivered by pharmacy</p> <p>ADON to review controlled substance cards weekly for frequency of use; if frequent use, follow up as appropriate.</p> <p>4. ADON to randomly audit weekly residents with eye drops and skin care to ensure compliance x 30 days.</p> <p>ADON to randomly audit weekly order entry regarding affected site of skin treatment, cardiac medication monitoring, order writing and transcribing to ensure compliance x 30 days.</p> <p>DNS or designee will audit for 3 months or until compliance is maintained. Audit results will be reviewed at quarterly QA meeting.</p> <p>5. DNS is responsible for sustained compliance.</p> <p>6. 6/5/13</p>	6/5/13	

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

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FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER JUDSON PARK HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 23620 MARINE VIEW DRIVE SOUTH DES MOINES, WA 98198		
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F 425	<p>Continued From page 46</p> <p>In an interview on 04/18/13 at 9:35 a.m., Staff B stated she spoke to the pharmacy and determined the authorization was obtained to administer the patch on 03/22/13. She was unable to determine why there was no indication the patch was placed until two days later on 03/24/13.</p> <p>RESIDENT #70 Record review revealed Morphine, a muscle pain reliever, and Ativan, an anti-anxiety medication, were ordered prn (as needed) on 04/04/13 by the resident's physician. The orders were faxed to the pharmacy. A second request was faxed on the night of 04/04/13, as neither medication had been received from the pharmacy. While the Ativan was delivered on the night shift on 04/04/13, the facility did not receive the Morphine.</p> <p>A progress note, dated 04/08/13, noted the resident "denies pain and denies SOB (shortness of breath) despite resp(iration) rate of 52. Please continue to offer Morphine for management of SOB."</p> <p>Progress notes dated 04/11/13 revealed at 11:01 a.m. the Hospice nurse observed the resident "in bed moaning. Denies pain. Asked if she would like medicine to help her breathing feel easier...". The note further revealed the resident and her family agreed to the Morphine "to ease her suffering. Facility (nurse) to give a dose of Morphine as soon as possible." A note at 11:14 a.m. revealed the "Morphine has not been delivered to the facility as original order did not include MD DEA number." The facility called the pharmacy who was to request authorization from the physician. At 2:58 p.m., the facility noted they</p>	F 425			

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

PRINTED: 04/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 605455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/19/2013
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F 425	<p>Continued From page 47</p> <p>were still waiting on authorization to administer the Morphine from the e-kit.</p> <p>In an interview on 04/18/13 at 9:50 a.m., Staff B stated the pharmacy provided authorization for a dose of Morphine to be administered on the evening of 04/11/13, however staff did not administer the first dose until 04/15/13. At that time it was noted the facility had still not received the Morphine from the pharmacy. The medication was delivered on 04/17/13, two weeks after it was first requested.</p> <p>The delay between receiving authorization from the physician, in addition to the pharmacy failure to ensure prompt delivery once authorization was obtained placed this resident at risk for untreated pain and/or shortness of breath.</p> <p>In addition, a PO for Spectrazole cream was dated 03/29/13. Progress notes revealed the cream was not available until 04/01/13, despite several calls to the pharmacy. In an interview on 04/18/13 at 9:57 a.m., Staff B stated she contacted the pharmacy to inquire about the delay in delivery. She stated the pharmacy claimed they never received an order for Spectrazole cream, however she provided evidence two medications, including the cream, were ordered on 03/29/13 on the same form. The second medication was delivered, however the cream was not. The pharmacy has since delivered two tubes of the cream, despite their denial they received an order.</p> <p>Similar findings were identified for Resident #34 for whom review of the MAR revealed on 04/10/13 the resident's Resident was not</p>	F 425		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 425	<p>Continued From page 48</p> <p>administered as it was "not available". Staff noted it would be "given when received". In an interview on 04/17/13 at 10:15 a.m., Staff B stated the order should have been discontinued as it did not appear to be appropriate for this resident. In addition, she stated there was an issue with the computerized MAR as when the vaccine was not administered on the scheduled day, the computer would not notify staff it had not been given. Therefore, according to Staff B, staff would not know the vaccine was not given and would need to be administered in the future. Staff B stated the error was both in that the vaccine was ordered and that the computer system did not allow for a change to the schedule.</p> <p>ORDERS NOT CLARIFIED / TRANSCRIBED RESIDENT #8</p> <p>A Pharmacy recommendation, dated 12/26/12, and accepted by the physician on 01/29/13, directed staff to discontinue the hold parameters for [REDACTED] and change blood pressure (BP) monitoring to once a week. Staff failed to transcribe this order. Monthly Consolidated orders contained hold parameters and daily blood pressure monitoring. In an interview on 04/17/13 at 9:37 a.m., Staff B acknowledged the pharmacy recommendation for the parameters should have been transcribed and the error should have been caught on monthly recaps.</p> <p>Similar findings were noted for Resident #100 for whom the prior BP and pulse (P) parameters were not discontinued and staff failed to implement them as written.</p> <p>Similar findings were noted for Resident #91 for whom the parameters associated with the [REDACTED]</p>	F 425			

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

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F 425	<p>Continued From page 49</p> <p>medication Carvedilol instructed staff to hold if pulse was greater than (>) 60. In an interview on 04/16/13 at 12:41 p.m. Staff C said "It should be less than 60, the arrow is the wrong direction."</p> <p>Similar findings were identified for Resident #34 for whom a PO read "No ER as long as keeping fluids encouraged and WNL." According to Staff B on 04/17/13 at 9:22 a.m., the order should have been discontinued as it was no longer applicable to the resident's situation. In addition, she stated the order was confusing as written and should have been clarified.</p> <p>RESIDENT #114</p> <p>Review of POs revealed a Menthol and menthol cream was to be administered "to affected area daily". A PO for Vitamin E cream directed staff to "apply sparingly to affected area topically twice a day". There was no indication in either order of what or where the affected areas were. As both creams were ordered to be applied at 9:00 a.m., there was no direction as to whether the areas were different or if both creams were to be applied to the same area.</p> <p>A PO directed staff to administer "Glipizide before breakfast everyday. (If resident is not eating breakfast do not give.)" A PO for Lasix directed staff to "Hold if resident is not eating..."</p> <p>In an interview on 04/17/13 at 9:31 a.m., Staff B stated the orders for the creams should be clarified as they did "not tell staff what to do". She also stated the Glipizide order "needs clarified" as it was unclear how staff would know if the resident would eat breakfast or not. She stated she believed the Lasix order meant if the resident</p>	F 425		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 425	<p>Continued From page 50</p> <p>had not eaten or drank his "normal amount in the past 24 hours" staff should hold the medication. She acknowledged that was not clear and that all nursing staff might not interpret the order the same. Staff B stated the facility had a template for what physician's orders should include, "but obviously staff aren't following them".</p> <p>RESIDENT #89 A progress note, dated 04/09/13 at 1434 revealed the physician was informed of Resident #89's "combative behavior when doing his blood sugar check." A new order was received to decrease the blood sugar check to once weekly.</p> <p>Review of the April TAR revealed staff continued to perform daily blood sugar checks through 04/18/13. In an interview on 04/18/13 at 11:10 a.m., Staff C stated the new order had not been transcribed into the computer system. She stated the nurse who took the verbal order should have placed it in the computer. Staff C stated "someone should have caught that the blood sugars are not to be done daily."</p> <p>RESIDENT #57 Record review revealed a 02/11/12 PO for [REDACTED] one tablet daily (at 8:00 a.m.) "if P <60 or >90, BP <110 or >150 contact MD. Hold medication if not eating or drinking and contact MD." In an interview on 04/16/13 at 1:05 p.m. Staff C said the instructions to 'hold the medication if not eating or drinking and contact MD' are supposed to go with diuretics irregardless of the vitals signs, not with the antihypertensive medication. Staff C added, "those instruction don't go there they go on a diuretic."</p>	F 425			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 425	<p>Continued From page 51</p> <p>In addition the resident had a PO for [redacted] everyday at 8:00 a.m. with instructions to hold if patient is not eating/drinking and BP <110. Review of the March and April MAR revealed there was no monitoring of the resident's BP prior to administering the [redacted] or [redacted] medications at 8:00 a.m. In an interview on 04/16/13 at 1:05 p.m. Staff C said she "would expect 8:00 a.m. BP" monitoring as ordered.</p> <p>Review of POs revealed a 01/30/13 order to check BP and Pulse every week. Notify physician if SBP is less than 110 or greater than 150. Review of the April MAR revealed on 04/03/13 the resident's SBP was 109. Review of the progress notes revealed no entry indicating the physician was notified as ordered. In an interview on 04/16/13 at 1:05 p.m. Staff C said "I would expect them (the nurse) to send a fax to notify her (the physician) and I didn't see one."</p> <p>Similar findings were identified for Resident #17 who was identified with BPs outside physician ordered parameters on 04/01/13 and 04/19/13 without physician notification. Additionally, facility staff documented the resident refused 8:00 p.m. medications on 04/15/13. Staff documented the resident received the 9:00 p.m. medications but provided no explanation why the 8:00 p.m. medications weren't attempted nor was there evidence the physician was notified the 8:00 p.m. medications were not administered.</p> <p>RESIDENT #3 Review of POs revealed an order for [redacted] every day, "hold if patient is not eating/drinking and SBP <110 and notify MD." Review of the March MAR revealed no BP was assessed on 03/05, 03/06.</p>	F 425			

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

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F 425	<p>Continued From page 52</p> <p>03/11, 03/15, 03/18, 03/20 and 03/22/13. Further review revealed the SBP and BP entries were not always the same. For example on 03/01 staff noted the SBP was 120 and the BP was 132/66. Similar findings were noted on 03/02, 03/03, 03/04, 03/07, 03/09, 03/10, 03/12, 03/16, 03/26 and 03/29/13 and on the April MAR.</p> <p>On 04/16/13 at 1:14 p.m. Staff C asked Staff T to explain why the blood pressures were different. Staff T said she often pushed a button, a "bypass", indicating she "didn't check the BP", and used the prior BP reading. Staff T said to Staff C, "Last time we changed a lot of the people to one time a week and her BP is stable so..."</p> <p>Review of Resident #3's record revealed no pharmacy recommendation or physician's order to decrease the BP monitoring to a weekly basis. Staff C indicated she expected nursing staff to obtain the BP prior to administering the medication as ordered.</p> <p>Similar findings were noted for Resident #68 when during medication administration observation on 04/17/13 at 7:16 a.m. Staff U did not monitor the resident's BP prior to administering medication. According to the PO, the medication had attached instructions "If SBP <110 or >150 Contact MD."</p> <p>RESIDENT #91 Review of the POs revealed a 04/12/13 order for a medication give 1 bottle PR one time only, which was scheduled to be administered on 04/18 and 04/25. In addition was a 04/12/13 order for medication 10 ounces to be given one time only, which was scheduled for 04/18/13.</p>	F 425			

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

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F 425	<p>Continued From page 53</p> <p>In an interview on 04/18/13 at 8:20 a.m. Staff C said the resident returned from a doctors appointment on 04/09/13 with the orders. Staff sent the doctor a fax to clarify the orders on 04/09/13, the doctor responded on 04/12/13 indicating it was a one time only order. The nursing staff did not administer the medications at that time because he "didn't need" them as he was having bowel movements.</p> <p>Review of Resident #91's record revealed a 04/18/13 10:42 a.m. progress note indicating the resident was offered and refused [REDACTED] A 04/18/13 11:15 a.m. progress note indicated the resident was offered and refused a fleet enema.</p> <p>In an interview on 04/19/13 at 8:44 a.m. Staff C said the fleets enema and [REDACTED] orders should have been discontinued and not offered to the resident.</p> <p>RESIDENT #4 Observation of medication pass on 04/17/13 at 9:44 a.m. revealed Staff M prepare and administer [REDACTED] eye drops to Resident #4. According to POs, staff were directed to apply lacrimal pressure for one minute after administration of the eye drops. Upon administering the drops to the left eye, Staff M provided Resident #4 with a tissue and directed her to "press here for a minute." Staff M walked away to change gloves and wash hands as Resident #4 was noted to only dab at her eye, applying no pressure. Staff M returned and administered drops to the right eye, and applied pressure for only 35 seconds. Staff M was noted</p>	F 425			

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

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F 425	Continued From page 54 to be without a watch and stated, "I couldn't really see the clock, it was too far away." Failure to ensure POs were followed placed the resident at risk for receiving less than the intended effects of the prescribed medication.	F 425			
F 441 SS=E	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.	F 441	F441 – Infection Control 1. Unable to correct past practice. 2. All residents during the month who have facility acquired infections will be reviewed and corrective action completed. 3. ADON will analyze microorganisms, identify trends and implement corrective action regarding facility acquired infections on a monthly basis. 4. DNS or designee will audit for 3 months or until compliance is maintained. Audit results will be reviewed at quarterly QA meeting. 5. DNS is responsible for sustained compliance. 6. 6/5/13	6/5/13	

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F 441	<p>Continued From page 56</p> <p>(c) Linens Personnel must handle, store, process and 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 ensure an effective infection control program. The facility failed to analyze microorganisms, identify trends and implement corrective actions regarding facility acquired infections. These failures detracted from staffs ability to identify trends and implement interventions, placing residents at risk for nosocomial (facility acquired) infections.</p> <p>Findings include:</p> <p>REVIEW OF INFECTION CONTROL REPORTS</p> <p>OCTOBER 2012 Review of October 2012 Infection Control (IC) documents revealed no listing of or analysis of microorganisms. While staff identified 14 Urinary Tract Infections (UTIs), they identified no significant variance in trends noted. Similar findings were identified for November 2012.</p> <p>DECEMBER 2012 According to facility IC documents, resident UTIs were identified with the following microorganism breakdown: one morganella morganii (associated with fecal matter), three enterococcus (associated with fecal matter), two escherichia</p>	F 441		

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

PRINTED: 04/24/2013
FORM APPROVED
OMB NO. 0938-0391

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F 441	<p>Continued From page 56 coll (associated with fecal matter) and two staphylococcus aureas.</p> <p>Facility staff failed to identify 75% of UTIs were caused by fecally transmitted microorganisms most often encountered in nosocomial UTIs.</p> <p>Staff analysis concluded, "no real pattern noted... education planned/in service provide... continue with good universal precaution, cont(inue) to encourage fluids, water pitchers were implemented."</p> <p>JANUARY 2013 January IC documents documented a 38% increase from eight to 11 UTIs from December to January. According to the IC report, five of six UTIs on the third floor had causal microorganisms associated with the gastrointestinal tract. Staff identified the second floor had three cultures, two of which were associated with gastrointestinal microorganisms.</p> <p>There was no analysis of resident's level of independence with toileting or possibility of staff's provision of pericare impacting UTI microorganisms</p> <p>FEBRUARY 2013 February IC documents reflected the total number of different types of infection, but no analysis of those numbers and no evidence staff determined culture results or considered their possible significance in UTI rates. Similar findings were identified for March IC documents.</p> <p>In an interview on 04/18/13 at 1:00 p.m. Staff B (Director of Nursing) confirmed there was no</p>	F 441			

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

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F 441	Continued From page 57 evaluation of microorganism/culture information. Staff B indicated some months included this information because different staff did the review. When asked the significance of some of the microorganisms mentioned in the IC reports (escherichia coli , proteus and enterococcus) Staff B stated, "It could reflect poor pericare...". When asked, Staff B confirmed there was no analysis of residents with colonized organisms, if residents with microorganisms associated with fecal matter were independent or dependent on staff for pericare or consideration of staff inservice based on this information. For March 2013 the IC report indicated, "inservice handwashing and good pericare", but Staff B indicated that was a standard inservice and not based on any critical analysis of data collected.	F 441			
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	F514 – Documentation 1. Unable to correct past practice on residents # 159, 100, 57, 47,23, 3, 91, 6, 122, & 100. Resident # 27 & 159; area of concern corrected. Resident # 161 discharged. 2. All residents could be affected; new admits and each resident on roster reviewed and corrective action completed.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514	<p>Continued From page 58</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure a system in which resident's records were complete and accurate. Failure to ensure documents, including assessments, care plans and physician's orders were complete and accurate placed residents at risk for unmet needs.</p> <p>Findings include: CFR 483.25(l)(1), F329, Unnecessary drugs CFR 483.60, F425, Pharmacy Services</p> <p>ORDERS NOT TRANSCRIBED Resident #159's record contained a PO for a follow up lab test scheduled for 03/27/13. There was no indication the lab was performed. In an interview on 04/19/13 at 8:20 a.m., Staff C stated the facility obtained a verbal order to discontinue the lab test but never wrote the order. Staff C stated there should have been documentation in the record to support why the lab was never obtained.</p> <p>For Resident #s 100, 57, 3 and 91 staff failed to ensure new POs for parameters associated with diuretics and cardiac medications were transcribed on the Consolidated monthly POs and MARs.</p> <p>INACCURATE Record review revealed Resident #161 admitted to the facility with orders for three medications all for metoprolol succinate. The record contained a consent form signed indicating the medication was for metoprolol succinate and aspirin. In addition, staff initiated target behaviors the</p>	F 514	<p>3. Medical records to audit lab orders weekly and notify ADON with discrepancies. ADON will complete appropriate follow up.</p> <p>LN will be in-services on completing a reconciliation of medications and diagnosis at time of re-admission. Discrepancies will be clarified.</p> <p>LN will be in-serviced on accurate documentation of administration of medications according to the parameters of BP & P and accurate documentation for monitoring of Fentanyl patch placement.</p> <p>LN will be in-serviced on updating care plans and notifying ADON when assistive device need changes.</p> <p>Social services will ensure psychotropic meeting documentation and care plans of resident on psychotropics are complete.</p> <p>Dietician to update care plan with diet order changes.</p> <p>4. ADON to turn lab audit and corrections into DNS weekly to ensure compliance x 30 days.</p>		

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

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F 514	<p>Continued From page 59 resident did not exhibit (resisting care and isolation). Staff further identified the antidepressant and antipsychotic medications were given for depression. Staff monitored behavior associated with depression as opposed to depression for which it was prescribed. In an interview on 04/19/13 at 8:20 a.m., Staff C acknowledged staff mistakenly documented diagnoses and behaviors the resident did not have.</p> <p>Review of Resident #8's March 2013 Medication Administration Record revealed staff documented checking the placement of a patch on all shifts in March except the day shift of 03/17 and 03/22/13. The patch was not available on to be placed on 03/20/13 until it was placed on 03/24/13. In an interview on 04/17/13 at 9:38 a.m., Staff B stated she believed this was a "documentation error" as staff would have removed the patch on 03/20/13.</p> <p>For Resident #s 122 and 100, Multidisciplinary Medication Management Committee notes were incomplete. They did not include dates, signatures of participating team members and/or complete plans for psychoactive medications and behavior management.</p> <p>RESIDENT #3 Review of POs revealed an order for hold every day, "hold if ... SBP <110." Review of the March MAR revealed the SBP and BP entries were not always the same. For example on 03/01 staff noted the SBP was 120 and the BP was 132/66. Similar findings were noted on multiple days throughout March and April.</p>	F 514	<p>ADON will complete admission audit to include reconciliation on all readmissions.</p> <p>ADON will randomly audit documentation weekly regarding administration directions of cardiac medication and their BP & P parameters to ensure compliance x 30 days.</p> <p>ADON will randomly audit Fentanyl placement documentation weekly to ensure compliance x 30 days.</p> <p>ADON will ensure showers are documented in Point of Care accurately on a weekly basis</p> <p>Administrator will audit social services psychotropic documentation monthly for compliance x 3 months or until compliance is maintained. Audit results will be reviewed at quarterly QA meeting.</p> <p>Director of Food Services will audit diet orders and care plans monthly for compliance x 3 or until compliance is maintained. Audit results will be reviewed at quarterly QA meeting.</p> <p>DNS or designee will audit nursing concerns for 3 months or until</p>	

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F 514	<p>Continued From page 60</p> <p>On 04/16/13 at 1:14 p.m. Staff C asked Staff T to explain why the blood pressures were different. Staff T said she often pushed a button, a "bypass", indicating she "didn't check the BP", and used the prior BP reading. Failure to accurately document blood pressure readings placed the resident at risk for unidentified hypertension.</p> <p>Review of Resident #91's physician's orders revealed parameters associated with the cardiac medication Carvedilol that read, hold if pulse is greater than 60. In an interview on 04/16/13 at 12:41 p.m., Staff C stated that was a typo and the order should read "hold if pulse is less than 60."</p> <p>CARE NOT DOCUMENTED</p> <p>Staff failed to document bathing was performed as scheduled for Resident #47. Bathing records revealed the resident was scheduled to receive a shower on 03/27, 03/30 and 04/05/13 however there was no indication they were offered, refused or provided.</p> <p>In an interview on 04/18/13 at 1:53 p.m., Staff C stated each resident's specific shower schedule was programmed in the computer. She stated for Resident #64 it appeared staff entered the shift as night shift rather than for the day. This created a system in which the shower triggered on the wrong day so staff charted not applicable. Staff would then give the shower on the scheduled day, but did not document it as the computer had not been set up to allow for changes in the schedule. The facility failed to accurately record care when provided.</p> <p>Similar findings were identified for Resident #23</p>	F 514	<p>compliance is maintained. Audit results will be reviewed at quarterly QA meeting.</p> <p>5. DNS is responsible for sustained compliance with nursing issues.</p> <p>Administrator is responsible for sustained compliance with social services concerns.</p> <p>Director of Food Services is responsible for sustained compliance with diet/care plan concerns.</p> <p>6. 6/5/13</p>	4/5/13

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F 514	<p>Continued From page 61 for who staff consistently documented "not applicable" but stated they gave showers on other days without documenting them.</p> <p>CARE PLAN NOT UPDATED RESIDENT #27 On 04/16/13 at 12:26 p.m. Resident #27 was observed seated in a standard wheelchair. According to the 03/28/13 care plan, Resident #27 was to be seated in a gerichair. In an interview on 04/18/13 at 8:44 a.m. Staff C said the gerichair was attempted for alternate positioning and pressure relief on 03/18/13. It was discontinued because Resident #27 did not tolerate it. The care plan was not revised to reflect the change.</p> <p>Review of Resident #159's care plan revealed direction to staff to "offer cottage cheese and yogurt" with meals. A PO directed staff to provide a "low lactose" diet. In an interview on 04/19/13 at 8:20 a.m., Staff C stated the care plan was inaccurate.</p>	F 514		