| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 154 SS=D | 483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS<br><br>The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.<br><br>The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on medical record reviews, and staff interview, the facility failed to ensure the resident's right to be fully informed in advance of treatment and prior to administering a purified protein derivative skin test to 1 of 1 resident (Resident #249) reviewed for treatment without signed consent.<br>The findings included:<br><br>The facility form titled, "Consent / Release Form" included Yes/No check boxes indicating the resident/responsible party received information provided in the facility admission packet regarding resident rights. When signed by the resident/responsible party, the form would also indicate the resident could be treated by a physician. The "Consent / Release Form" included, "10. Consent For Treatment By Physician. I voluntarily consent for Dr ...[a blank space to be filled in with the physician's name].. to be my attending physician and to receive nursing, routine diagnostic procedures, and routine medical treatment by him, his assistants, his designees or the nursing staff of the facility as | F 154 | University Place Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.<br><br>University Place Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, University Place Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. | 5/11/15 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 05/04/2015 |

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| F 154 | Continued From page 1<br>is necessary in his judgement." Item 10 on the form was followed by boxes to check YES or NO. The bottom of the form included places for the resident's signature, as well as the signatures of the responsible party and facility representative.<br><br>Resident #249 was admitted to the facility at 6:40 PM on 03/28/2015. Review of Resident #249's clinical record revealed it did not contain a "Consent / Release Form" signed by the resident or responsible party.<br><br>Further review of the medical record revealed a hand-written Medication Administration Record (MAR) that indicated Nurse #2 administered a purified protein derivative (PPD) skin test to Resident #249, on the 3-11 shift, 03/28/2015. This skin test helps determine if a person has ever been infected by the microorganism that causes tuberculosis.<br><br>During an interview on 04/08/2015 at 10:31 AM, the facility Administrator stated, "There is not a signed consent. He came in Saturday the 28th at 6:40 PM and left Sunday morning at 8:55 AM."<br><br>Nurse #1 was interviewed 04/08/2015 at 11:07 AM, regarding the admission paperwork she completed for Resident #249. Nurse #1 indicated she worked 7A-7P on 03/28/2015, and Resident #249 came in at 6:40 PM. She stated she helped with the paperwork by completing the Skin Assessment, Fall Risk Assessment, Wandering Risk Assessment, and the Pain Assessment. She added that she did not ask Resident #249 or his family member to sign any admission documents.<br><br>On 04/08/2015 at 11:34 AM, the Admissions Coordinator was interviewed about providing a | F 154 | F154 INFORMED OF HEALTH STATUS, CARE, & TREATMENTS<br><br>Resident #249 was discharged AMA on 3/29/2015.<br><br>100% audit of all Admissions was completed on 4/8/2015 by the Administrator. Any issues were addressed.<br><br>On 4/8/2015,the Administrator and Staff Facilitator initiated In Servicing to 100% of Staff Nurses and Social Workers regarding 1)obtaining Consent to Treat, Consent to provide flu vaccine and pneumonia vaccine on the first day of admission if after business hours or on the weekend using the Consent for Release forms. 2)Location of the consent forms are at each nurse's station. The in service will be completed by 5/4/2015. PRN staff will be in serviced prior to beginning their next scheduled shift. This in service will be included in the Nursing orientation for all newly hired nurses to educate them on the correct procedure for obtaining consent to treat after hours and on weekends.<br><br>The ADON/DON will audit the admission charts using the Monitoring Tool for Admission Consents for completion of the Consent for Release form daily for (2) two weeks, then (3) times a week x2, then weekly x 4 weeks, then monthly x 1 month. The completed audits will be reviewed by the Administrator. The audits | |

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| F 154 | Continued From page 2<br>new resident with a list of rights and the completion of documents signed at admission for permission to provide treatment. The Admissions Coordinator said, "I usually have the family come in and we go ahead and do the admission paperwork and make a bed offer." She indicated on 03/27/2015, the hospital had inquired about an available bed at the facility for Resident #249. The Admissions Coordinator said, "I made a bed offer [on 3/27/2015]. I didn't know when the doctor was going to discharge him." She indicated she did not meet the resident or family member. They were not provided with a list of rights, and a consent to provide treatment had not been signed. When asked about a resident who might be admitted on a weekend, the Admissions Coordinator stated, " Usually if they come in on a weekend the weekend Supervisor will call and tell me and if it is a reasonable time I will come in on the weekend to get the paperwork done." With regard to Resident #249 who was admitted at 6:40 PM on Saturday evening, the Admissions Coordinator indicated she had never gotten to meet him because the family member took him out of the facility the next morning. The Admissions Coordinator said, "I would have come in later on that Sunday."<br><br>Nurse #2 was interviewed on 04/08/2015 at 1:56 PM, regarding the PPD she administered to Resident #249. Nurse #1 indicated the resident was already in the facility when she arrived on shift at 7pm on 03/28/2015. She remembered Resident #249 was verbal, and able to make some needs known. Nurse #1 stated she administered the PPD and signed for it on the MAR per her supervisor's instruction. She stated, " he told me that was all that was left to do for this new admission." Nurse #1 stated the admitting | F 154 | will then be reviewed in the QA and A Committee Meeting monthly for further recommendations and follow up as indicated. | |

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| F 154 | Continued From page 3<br>paperwork was completed by the prior nurse and supervisor.<br><br>The Weekend Supervisor was interviewed on 04/08/2015 at 3:42 PM, and he indicated the Consent form was given to the resident prior to admission by the Personnel Department. The Weekend Supervisor said he did not assist with the admission papers, only the clinical part of the admission. He added it was his understanding that all of the consent forms had already been obtained by the Admissions Coordinator.<br><br>During an interview on 04/09/2015 at 5:16 PM, the Director of Nursing (DON) said a nurse would need a signed consent to render nursing care and administer any medication to a newly admitted resident. The DON added that when a resident is admitted, the signed consent should have been already completed by the Admissions Department.<br><br>During an interview on 04/09/2015 at 5:18 PM, the Administrator stated, "I did a plan to correct that last night. Our expectation is that a consent form would be done on the day they are admitted. " | F 154 | | |
| F 242 SS=E | 483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES<br><br>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. | F 242 | | 5/11/15 |

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| F 242 | Continued From page 4<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and resident and staff interviews, the facility failed to honor resident preferences related to baths and showers for 2 of 4 residents sampled for resident shower preferences (Resident #154 and Resident #173). The facility also failed to honor resident preferences related to wake up time for 1 of 1 resident sampled for wake up times (Resident #9).<br><br>Findings included:<br><br>1. Resident #154 was admitted to the facility 08/28/14. Diagnoses included dementia.<br><br>A significant change MDS dated 09/04/14 indicated it was very important to the resident to be able to choose between a bed bath, a tub bath, and a shower.<br><br>A quarterly Minimum Data Set (MDS) dated 01/14/15 indicated Resident #154 was cognitively intact, required total assistance from one staff member for bathing, and did not refuse care.<br><br>A review of Resident #154's care plan, revised 01/28/15, was conducted. The care plan indicated resident required assistance of one staff member for bathing.<br><br>Resident #154 was interviewed on 04/07/15 at 11:18 AM. He stated he was not able to choose how many times he received a shower each week. He explained he received two showers each week but would like to have more. | F 242 | F242 SELF-DETERMINATION-RIGHT TO MAKE CHOICES<br>Residents #154, #173 received showers with regard to their preference by the Nurse Assistants. Resident #9 will be awaken regarding her preference.<br><br>100% of the Residents or Responsible Parties were interviewed by the DON, ADON and Scheduler to determine shower preferences, frequency and time desired using an audit tool completed on 4/24/2015. A new shower schedule was initiated on 4/29/2015 to incorporate resident preferences into the shower schedule for the audit results on 4/24/2015. A 100% audit of the Residents or Responsible Parties were interviewed by the DON, ADON and Scheduler to determine the Wake Up preference on 4/30/2015. The Admissions Coordinator will review shower preferences and Wake up preference with all newly admitted residents upon admission and document the resident's preference on the shower preference sheet/wake up preference sheet. The Admission Coordinator will give the shower preference /wake up preference sheet to the DON upon completion. The DON will review the shower preference/wake up preference sheet and revise the assignment sheet kept at each Nurse's Station according to the newly admitted resident's preference.<br><br>100% of the nursing staff were in-serviced | |

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| F 242 | Continued From page 5<br>Facility documentation of Resident #154's showers between 03/24/15 and 04/08/15 was reviewed. The documentation indicated Resident #154 had received one shower on 03/27/15 and bed baths on all other days.<br><br>An interview was conducted with Nurse Aide (NA) #5 on 04/08/15 at 3:20 PM. She explained there was a shower team that did showers on day shift. She stated all residents in A beds were offered showers on Mondays, Wednesdays, and Fridays, and all residents in B beds were offered showers on Tuesdays, Thursdays, and Saturdays.<br><br>A follow-up interview was conducted with Resident #154 on 04/08/15 at 3:24 PM. He stated he had told the nurses he wished to have more showers but still did not receive them.<br><br>An interview was conducted with the Director of Nursing (DON) on 04/08/15 at 3:58 PM. She stated residents were assigned shower days on admission. She explained if the resident was in an A bed, the resident received a shower on Monday, Wednesday, and Friday, and if a resident was in a B bed, the resident received a shower on Tuesday, Wednesday, and Saturday. The DON further stated if a resident wanted a shower on different days, that information would be communicated to the MDS Nurses so it could be placed in the care plan.<br><br>An interview was conducted with MDS Nurse #2 on 04/08/15 at 4:06 PM. MDS Nurse #2 stated residents were told on admission what days they would receive a shower, and they were asked if that is fine with them. She stated if the resident had a problem with the shower days, the resident's preferences would be honored in the | F 242 | by the Staff Facilitator on the new shower schedule and procedure to follow in the event residents refused or missed their assigned shower to be completed on 5/4/2015. The procedure for showers are as follows: The CNA will know who is due for a shower by reviewing the shower sheet kept in the Shower Book daily during their assigned shift. The CNA will document all showers given, missed and refused on the shower sheet during their assigned shift and give the shower sheets to the Charge Nurse prior to the end of their shift. The CNA will verbally notify the Charge Nurse of all refused, missed showers or change in preference. The Charge Nurse will review the shower sheets and document all shower refusals in the progress notes and notify the Responsible Party. The Charge Nurse will turn in the completed shower sheets to the DON prior to the end of their shift. The DON, ADON, and Weekend Supervisor will review the shower sheets daily for completion and to identify all residents that refused or missed a shower the previous day. The DON, ADON, and/or Weekend Supervisor will revise the shower sheet kept in the Shower Book to reflect any residents that missed or refused a shower the previous day to ensure a shower is offered the following day or refused or missed. 100% of the Licensed Nurses were in-serviced on the use of a QI tool used to report any shower refusals and/or missed showers by the Staff Facilitator by 5/4/2015.<br><br>The Nursing Assistant will notify the | |

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| F 242 | Continued From page 6<br>care plan.<br><br>An interview was conducted with Nurse #6 on 04/09/15 at 8:56 AM. She stated she expected the NAs to tell her when a resident refused a shower so she could document. She further stated Resident #154 hardly ever refused and had never mentioned to her he wanted more showers.<br><br>An interview was conducted with NA #8 on 04/09/15 at 10:25 AM. She stated there was no longer a shower team because those NAs had been assigned to the floor.<br><br>A follow-up interview was conducted with the DON on 04/09/15 at 3:49 PM. She confirmed the shower team had been suspended and the NAs were being assigned to a hall. She explained her expectation was the NAs assigned to the residents were responsible for completing showers as scheduled and fill out a shower sheet when the shower was complete. She stated resident preferences were to be honored. She could not explain why Resident #154's bath documentation included only one shower from 03/24/15 to 04/08/15. The DON provided one sheet entitled "QI Shower/Bath Sheet" that indicated the resident received a shower or a bath on 04/01/15. She was unable to determine whether the resident received a bath or whether the resident received a shower from the sheet.<br><br>2. Resident #9 was admitted to the facility on 12/12/07. Diagnoses included anxiety, depression, and bipolar disorder.<br><br>A quarterly Minimum Data Set (MDS) dated 02/13/15 indicated Resident #9 was cognitively | F 242 | Charge Nurse of any resident that did not receive their shower on their scheduled shower day. Any resident that did not receive a shower on their scheduled day will be offered a shower the following day by a Nursing Assistant. The Licensed Nurse will review and initial the completed shower sheets for the Nursing Assistants for any refused or missed showers for all residents scheduled for a shower to include residents #154 and #173. Upon completion of the audit tool, the Charge Nurse will turn the shower sheets into the DON.<br><br>The resident's preference for wake up times will be documented on the assignment sheet. The Nursing Assistant will initial the assignment sheet when the resident is gotten up or awaken. The assignment sheets will be turned into the DON for review.<br><br>The DON, ADON, or Weekend Supervisor will review and initial the shower sheets and assignment sheets 7x week times 4 weeks, then monthly x 2 months for completion and accuracy. Each Tuesday the DON, ADON, and facility Scheduler will review concerns and/or refusals to make adjustments to accommodate the preferences/choices of our residents as indicated. The QA & A Committee will review these audit tools monthly x4 to determine the need for continued monitoring. | |

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intact and required extensive assistance of one staff member with bed mobility and transferring.

A care plan revised 03/02/15 was reviewed. The care plan identified a transfer deficit problem, a goal of the resident receiving assistance, and an intervention of providing physical assistance of one person with transferring.

An interview was conducted with Resident #9 on 04/06/15 at 12:47 PM. She stated she wanted to get up before breakfast, but staff normally get her up after breakfast. She explained she had let the staff know her preference.

On 04/09/15 at 11:06 AM, Resident #9 was observed to be up in her wheelchair and dressed appropriately. A follow-up interview was conducted at this time. She verified it was her preference to get up before breakfast. She explained the nurse aides usually got her up around 10:00 AM and had not gotten her out of bed before breakfast.

An interview was conducted with Nurse Aide (NA) #8 on 04/09/15 at 11:56 AM. She stated she was regularly assigned to Resident #9's hall and was aware of the resident's preference to get up before breakfast. NA #8 was not usually able to help her due to other duties that had to be performed at that time, such as getting other residents up and performing morning care for all of her residents.

An interview was conducted with the Director of Nursing on 04/09/15 at 3:49 PM. She stated it was her expectation for resident preferences to be honored.

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2. Resident #173 was admitted to the facility on 04/25/13.

Diagnoses included cerebral artery occlusion with infarct, hemiplegia, hypothyroidism, depressive disorder, hypotension, encephalopathy, dysphagia, malignant hypertension, hyperlipidemia, and alcoholism.

Review of a quarterly minimum data set (MDS) dated 01/02/15 revealed Resident #173 was assessed with severely impaired cognition. The MDS also assessed Resident #173 as requiring total staff assistance with activities of daily living (ADL) to include bathing and hygiene and the assistance of two staff persons with transfers due to immobility from hemiplegia.

Resident #173 was observed on 04/06/2015 at 1:44 PM, 04/07/15 at 10:54 AM, 04/08/15 at 12:37 PM and 04/09/15 at 11:57 AM seated in his wheel chair in his room, dressed in pants and a long sleeved shirt, with soft boots to both feet.

Review of the facility's grievance log on 04/09/15 at 11:59 AM revealed a family member filed a grievance dated 02/14/15 which included concerns that Resident #173 did not receive showers routinely. The family member expressed that during a visit to the facility on 02/14/15, Resident #173 was found with a body odor and that the family member had to bathe him. Follow up documentation to this grievance was recorded by the director of nursing (DON) and included that nursing assistants (NA) received an in-service regarding ADL for dependent residents.

Review of documentation of showers for Resident #173 provided by the DON on 04/10/15 at 6:38

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PM revealed he received a shower on 01/30/15, 03/31/15 and 04/03/15. Additionally, review of documentation titled "Type of Bath" dated 03/28/15 - 04/10/15 recorded either a partial or a full bed bath for each day; there was no documentation of a shower for Resident #173.

During an interview on 04/10/15 at 6:39 PM, the DON stated she received a grievance from a family member of Resident #173 in February 2015 stating he was not being showered. The DON stated she in-serviced two NAs (NA #9 and #10) who routinely worked with him and conducted monitoring for 1 week after the in-service to ensure Resident #173 received showers. The DON stated she was not aware that Resident #173 had only received 3 showers since January 2015 and could not explain why there was no documentation of showers for Resident #173 in February 2015.

During an interview on 04/10/15 at 6:56 PM, NA #4 stated she used to work with Resident #173 regularly during the 3 - 11 PM shift, but this was the first time she worked with him in about 2 months. NA #4 stated she did not provide showers to Resident #173 because he was assigned to be showered on the 7 AM - 3 PM shift. NA #4 stated she provided partial bed baths to Resident #173 when she was regularly assigned to care for him.

During an interview on 04/10/15 at 7:01 PM, NA #9 stated she worked with Resident #173 for the last 2-3 months on the 3 - 11 PM shift. NA #9 stated Resident #173 was assigned to receive showers on the 7 AM - 3 PM shift, and she gave him partial/full bed baths on her shift. NA #9 confirmed she received an in-service in February

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2015 regarding ADL for dependent residents.

During a telephone interview on 04/13/15 at 09:34 AM, nurse #7 stated the routine care giver on the 7 AM - 3 PM shift for Resident #173 was NA #10 and she routinely gave Resident #173 "good bed baths". Nurse #7 also stated that most of the time, she observed NA #10 in Resident #173's room with a wash basin giving him a good bed bath. Nurse #7 stated that when NAs told her they did not have time to give a resident a shower, she told the NA to give a "good bed bath" and to let the 3 - 11 PM shift NA know that a shower was not given so that if more staff were available on that shift, the shower could be given.

During a telephone interview on 04/13/15 at 09:42 AM, NA #10 stated she worked with Resident #173 regularly on the 7 AM - 3 PM shift. NA #10 stated that she "usually gave Resident #173 a full bed" because she did not usually have time to give him a shower. NA #10 further stated that sometimes she did not have time to give everybody on her assignment a shower, so she would tell the nurse. NA #10 stated the nurse told her to give the resident "good bed bath." NA #10 confirmed she received an in-service in February 2015 regarding ADL for dependent residents.

During a follow up telephone interview on 04/13/15 at 9:11 AM, the DON stated there was no additional documentation of showers for Resident #173 available. The DON stated Resident #173 was scheduled to receive showers Monday, Wednesday and Friday on the 7 AM - 3 PM shift, and as needed, but stated that "it can vary for him." The DON stated she could not explain why Resident #173 routinely received bed baths instead of showers, but that she expected

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| F 242 | Continued From page 11<br>him to be showered as scheduled. | F 242 | | |
| F 274 SS=D | 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE<br><br>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to comprehensively assess a change in condition for 1 of 5 (Resident #47) sampled residents reviewed with a decline in activities of daily living.<br>Finding included:<br><br>Resident #47 was admitted to the facility 04/18/14 and expired 01/26/2015. The resident's diagnoses included renal insufficiency, osteoporosis, and Alzheimer's disease.<br><br>The quarterly Minimum Data Set (MDS) dated 10/16/14 indicated Resident #47 required only supervision for Bed Mobility, Dressing, Toileting and Hygiene. The next quarterly MDS dated | F 274 | F274 COMPREHENSIVE ASSESS AFTER SIGNIFCANT CHANGE<br><br>Resident #47 died on 1/26/2015.<br><br>100% of the Residents were audited using the Assessments Warning Report. Any concerns were addressed immediately.<br><br>On 4/30/2015 the Care Plan Team was in serviced by the Administrator to report a decline or improvement of Activities of Daily Living or cognition of any resident.<br><br>The MDS Coordinator and MDS Nurse will review the Activities of Daily Living | 5/11/15 |

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| F 274 | Continued From page 12<br>12/18/14 indicated the resident's activities of daily living (ADLs) had declined to the point that she required extensive assistance with Bed Mobility, Dressing, Toileting and Hygiene. A Significant Change in Status Assessment was not completed for Resident #47.<br><br>MDS Coordinator #1 was interviewed on 04/09/2015 at 9:03 AM about this resident's significant change in ADLs. She indicated Resident #47 would get urinary tract infections and would return to the prior level of functioning after receiving treatment. MDS Coordinator #1 indicated Resident #47 was being treated for pneumonia in December and said, "She would just get sick and bounce back but this time she got sick and she died. We were waiting for her to bounce back. The MDS Coordinator reviewed ADL documentation in the electronic record for the period of time from December 2014 into January 2015 and indicated the resident still required extensive assistance with the ADLs. She confirmed a change in condition had occurred and the quarterly MDS dated 12/18/14 should have been handled as a significant change assessment and subsequently had comprehensive assessments completed. | F 274 | Significant Change Report weekly x 4 and then monthly x3. The completed Assessments Warnings Reports will be reviewed in the QA & A Committee Meeting monthly for further recommendations and follow up as indicated. | |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract | F 315 | | 5/11/15 |

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| F 315 | Continued From page 13<br>infections and to restore as much normal bladder function as possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, resident interview and staff interviews, the facility failed to secure the catheter tubing to prevent excessive tension for 1 of 2 sampled residents (Resident #99) with indwelling catheters.<br>The findings included:<br>Resident #99 had diagnoses that included urinary retention, Alzheimer's disease and aphasia. A review of the most recent Minimum Data Set (MDS) dated 02/02/2015 revealed Resident #99 was severely cognitively impaired, required extensive to total assistance with bed mobility and transfers and had an indwelling urinary catheter.<br><br>Resident #99's Care Plan, (updated 2/24/15) included, "ensure that drainage tubing is secured with anchoring device, i.e., leg strap, to prevent tension or accidental removal"<br><br>On 04/08/2015 at 12:57 PM, Resident #99 was observed as Nursing Assistant (NA) #1 finished dressing the resident and transferred her from the bed into a wheelchair. Nurse #3 was also in the room. Resident #99 did not have a strap or any device that secured the tubing to the resident's leg to prevent tension or accidental removal of the indwelling catheter.<br>.<br>On 04/09/2015 at 2:15 PM, NA #2 was interviewed as she provided care to Resident #99. Again, Resident #99 did not have a strap or any device that secured the catheter tubing to the resident's leg. NA#2 indicated she had provided | F 315 | F315 NO CATHETER, PREVENT UTI, RESORE BLADDER<br><br>Resident #99 was assessed and a leg strap was applied on 4/8/2015.<br><br>On 4/8/2015 a Foley audit was completed by the MDS Nurses and ADON. Any concerns were addressed immediately using a Foley Catheter Strap Audit tool.<br>On 4/9/2015 100% of the Treatment Nurses and Med aides were in serviced on documenting on the Treatment Record and ensuring that a Foley leg strap was in place daily.<br><br>On 4/8/2015 100% of the Nursing staff to include Nursing Assistants were educated by the Staff Facilitator regarding 1) ensuring a Foley leg strap was in place on residents with a Foley in place, 2) Nursing Assistants notifying the Charge Nurse if a Foley leg strap is not in place. New employees will receive the training in orientation.<br><br>The ADON/DON will review the Foley leg straps placement using the Foley leg strap audit tools for placement daily x 2 weeks, then 3 x week x 2 weeks, then weekly xc 4 weeks, then monthly x 1 month using the Foley Strap Audit Tool. The completed audits will be reviewed by | |

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| F 315 | Continued From page 14<br>morning care and dressed Resident #99 but had not applied a strap to secure the tubing. NA#2 stated it was the nurse's responsibility to apply a strap to secure the tubing. When asked, NA #2 said she did not know where the straps were kept and had not notified the nurse that there was no strap in place.<br><br>During an interview on 04/09/2015 at 2:20 PM, Unit Coordinator (UC) #1 indicated it was facility policy to have the catheter tubing secured for stability. UC#1 stated a strap could be applied by either nursing assistants or nurses, and nurses were supposed to check the catheters each shift to be sure the catheter was secured.<br><br>Nurse #3 was interviewed on 04/09/2015 at 2:25 PM. Nurse #3 stated she had not checked to see if Resident #99's catheter tubing was secured on 04/08/2015, and had not checked it yet for the 7-3 shift this day. Nurse #3 stated a strap to secure a catheter tubing should be in place at all times.<br><br>On 04/09/2015 at 2:59 PM, NA #3 indicated she had provided care for Resident #99 on 04/08/2015 during the 7-3 shift. When asked about a strap to secure the catheter tubing, NA #3 said, "I know they are supposed to have one but I really don't remember."<br><br>On 04/09/2015 at 3:10 PM, NA #4 stated she had provided care for Resident #99 during the 3-11 shift on 04/08/2015. NA #4 said, "She (Resident #99) didn't have a leg strap on. I've never seen one on her at all."<br><br>During an interview on 04/09/2015 at 5:18 PM, the Administrator stated it was her expectation and facility policy indicated catheters were to be | F 315 | the Administrator. The audits will then be reviewed in the QA & A Committee meeting monthly for further recommendations and follow up as indicated. | |

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| F 315 | Continued From page 15<br>secured with a strap to prevent trauma. | F 315 | | |
| F 333 SS=D | 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS<br><br>The facility must ensure that residents are free of any significant medication errors.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on an observation, staff interviews, a physician's interview, pharmacist interviews and medical record review, the facility failed to administer significant medications (anti-seizure and an anti-coagulant) per physician's order to Resident #249 for 1 of 6 sampled residents reviewed for unnecessary medications.<br><br>The findings included:<br><br>Review of the medical record revealed Resident #249 was admitted to the facility from the hospital on 03/28/15 after 6:00 PM and discharged from the facility on 03/29/15 at 08:55 AM against medical advice (AMA).<br>.<br>Diagnoses included seizure disorder, grade 3 aplastic astrocytoma (brain cancer), status post resection/chemotherapy radiation, ventriculoperitoneal shunt (surgically implanted pressure relieving device), chronic migraine headaches, chronic neck pain, depression, and wheel chair bound status.<br><br>A review of the hospital Medication Administration Record (MAR) dated 03/27/15 documented administration of the following anticoagulant (used to prevent deep vein thrombosis) for | F 333 | F333 RESIDENTS FREE OF SIGNIFICANT MED ERRORS<br><br>Resident #249 was discharged AMA on 3/29/2015.<br><br>A 100% audit of the new admissions from 3/30/2015 to present for Medications given on Admission was completed on 3/30/2015.<br><br>100% of the Licensed Nurses were in serviced on 5/4/2015 by the Staff Facilitator on getting New Admissions medications from the Emergency Kit, Walgreens or the back up to Walgreens if Neil Medical Pharmacy is unable to get the medications to the facility timely. The Staff Facilitator will cover this in orientation of all new Licensed Nurses. The Consultant Pharmacist will provide an in service on Pharmacy Policies for Ordering and Obtaining Medications on 5/20/2015.<br><br>The DON/ADON/Unit Managers will audit all New Admissions to ensure medications are started upon admission daily x 2 | 5/11/15 |

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| F 333 | Continued From page 16<br>Resident #249 prior to admission to the facility:<br>· Lovenox 40 milligrams (mg) per 0.4 milliliters (ml) injection subcutaneous (SQ) each night at bedtime (qHS), routine, stop date 04/03/15; administered 40 mg at 2126 (9:26) PM<br><br>Also, the hospital MAR dated 03/28/15 documented administration of the following anti-seizure medications for Resident #249 prior to admission to the facility:<br>· Vimpat 100 mg 2 tablets oral, 2 times a day (BID), routine, stop date 04/05/15; administered 100 mg at 0825 (08:25) AM<br>· Depakote 125 mg delayed release (DR) capsule, 500 mg per 4 capsules, BID, routine, stop date 04/03/15; administered 500 mg at 0825(08:25) AM<br><br>A nursing admission assessment dated 03/28/15 documented Resident #249 arrived to the facility at 6:40 PM. The assessment documented that Resident #249 required total staff assistance with activities of daily living and assistance of two staff persons with transfers.<br><br>A review of the physician's admission orders dated 03/28/15 documented the following medications and the frequency with which they were to be given:<br>· Depakote DR 125 mg, 4 cap = 500 mg BID; 0900 (9:00 AM) and 2100 (9:00 PM)<br>· Vimpat 100 mg tablet BID; 0900 (9:00 AM) and 2000 (8:00 PM)<br>· Lovenox 40 mg/0.4 ml injectable, SQ qHS; 2100<br><br>Review of the facility MAR revealed there was no documentation that the anti-seizure medications or the anticoagulant were given on 03/28/15 or | F 333 | weeks, 3x week x2 weeks, weekly x 2 months. The completed audits will be reviewed in the QA & A Committee Meeting monthly for further recommendations and follow up as indicated. | |

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| F 333 | Continued From page 17<br>03/29/15.<br><br>During an interview on 04/08/2015 at 10:38 AM, the administrator stated Resident #249 arrived to facility on Saturday, 03/28/15 at 6:40 PM. The administrator stated she received a phone call on Sunday, 03/29/15 about 07:30 AM from weekend supervisor (WS) #1 to advise that Resident #249 would be removed from the facility AMA by the family despite encouragement to allow the Resident to stay for physician assessment.<br><br>During a telephone interview on 04/08/2015 at 11:06 AM, nurse #1 stated that she worked on Saturday, 03/28/15 from 7AM - 7 PM. She stated that Resident #249 arrived to the facility at 6:40 PM and she stayed past the end of her shift to complete the nursing admission papers and the Resident's body assessment. Nurse #1 stated Resident #249 could talk, denied pain and that she did not administer any medications to him before leaving shift. Nurse #1 stated on Sunday morning around 7:30 AM, a family member for Resident #249 approached her during medication administration and complained that the Resident had not received any of his medications thus far. Nurse #1 stated she had received report from the previous nurse that the Resident's medications had not been delivered yet, but she had not had an opportunity to determine the status of the medications, so she reported these concerns to the WS #1. Nurse #1 also stated that she offered to give the Resident what medications she could, but the family member communicated she was removing Resident #249 from the facility. Nurse #1 stated Resident #249 was discharged from the facility on Sunday, 03/29/15 around 8:55 AM without receiving his morning medications and with no signs/symptoms of distress or | F 333 | | |

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neurological changes.

During a telephone interview on 04/08/2015 at 1:56 PM, nurse #2 stated she worked Saturday, 03/28/15 from 7 PM - 7 AM and received report from nurse #1 that Resident #249 was verbal and able to make some needs known. Nurse #2 stated she was informed by nurse #1 that the nursing admission paperwork was completed by nurse #1 and a list of medications was faxed to pharmacy by WS #1. Nurse #2 also stated that the Resident's medications were not in the facility at the time she arrived on shift and WS #1 told her the medications would come in later that night (03/28/15) from pharmacy. Nurse #2 further stated that by the time her shift ended on 03/29/15 at 7:00 AM, she reported to the oncoming nurse, nurse #1, that the medications had not arrived. Nurse #2 also stated she did not administer any medications to Resident #249 because his medications did not arrive from pharmacy and she was not aware that some of his medications were available in the emergency drug kit. Nurse #2 further stated she did not contact pharmacy to determine the status of the Resident's medications or to determine if arrangements were made to receive any of the Resident's anti-seizure or anti-coagulant medications from back-up pharmacy.

During an interview on 04/8/15 at 4:00 PM, WS #1 stated that Resident #249 came to the facility via hospital transport on Saturday, 03/28/15 around 6:00 PM. WS #1 stated that since both he and nurse #1 were about to leave shift, they divided the admission responsibilities and he reviewed the hospital discharge summary, called the on-call physician's office, spoke to the nurse practitioner to verify physician's orders, and faxed

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pharmacy the Resident's list of medications. WS #1 stated he informed nurse #2, the on-coming nurse, that he faxed the list of medications to pharmacy and to expect delivery later that night. WS #1 stated the emergency drug kit would have included Depakote 125 mg and Lovenox 60 mg, which were medications scheduled for Resident #249 that evening and should have been given; any additional medications should have been given once received from pharmacy. WS #1 further stated that he did not call pharmacy to request medications from back-up pharmacy, as per the policy, but rather faxed over the list of medications because he expected the medications would be delivered that evening by pharmacy between 6:30 PM - 8 PM.

A review of the facility document "Emergency Drug Kit", undated and an observation of the facility's emergency supply of medications on 04/09/15 at 5:15 PM revealed the following medications were available for administration:

· Depakote DR 125 mg capsules, 4 capsules or 500 mg
· Lovenox 60 mg/0.6 ml injectable syringe, 4 syringes

During an interview on 04/9/15 at 5:16 PM, the director of nursing (DON) stated that the expectation to receive medications for a resident admitted to the facility after 5:00 PM would be to call pharmacy to advise what medications were ordered by the physician and if any significant medications were needed that night. The DON further stated that the pharmacy would contact the facility's back-up pharmacy to order them and the medications could be picked up by a staff member later that evening. The DON also stated that if any medications were available in the

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emergency drug kit, the medications should also be given as ordered. The DON stated that once nurse #2 realized that the medications had not been delivered that evening by pharmacy, she should have called the pharmacy to make arrangements with the back-up pharmacy to obtain the medications.

During a telephone interview with the assistant manager from the pharmacy on 04/10/2015 at 10:11 AM, the interview revealed that the facility faxed over a list of medications for Resident #249 on Saturday, 03/28/15 after 5:00 PM. The assistant manager stated this request would not have been processed until Sunday, 03/29/15 for delivery to the facility between 8:00 - 9:00 PM. The assistant manager stated that if the nurse called the pharmacy and selected a specific number on the telephone keypad, the nurse would be transferred to the after hours pharmacy services to obtain medications via a backup pharmacy for pickup the same day.

During a telephone interview with the consultant pharmacist on 04/10/2015 at 10:25 AM, the consultant pharmacist stated she spoke to the facility after Resident #249 was discharged and discussed with the facility the policy for obtaining medications via backup pharmacy and administering any medications that were available through the emergency drug kit. The consultant pharmacist stated that not administering anti-seizure medications to a resident would place the resident at risk for breakthrough seizure activity and that medications should be administered as ordered.

During a telephone interview on 04/10/2015 at 10:53 AM the physician stated that due to the

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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 |
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| F 333 | Continued From page 21<br>possibility of low serum levels of anti-seizure medications on admission and the Resident's active seizure history it would have been important to provide the anti-seizure medications to Resident #249, because not having received these anti-seizure medications would have placed the Resident at greater risk for breakthrough seizure activity. The physician further stated that since Resident #249 was on two anti-seizure medications, this would indicate to him (physician) that Resident #249 was at greater risk for seizures, and concerned him that Resident #249 did not receive the evening doses of these anti-seizure medications as ordered to prevent seizures. The physician also stated that the anti-coagulant, though significant, was ordered as a prophylaxis and would not have been as concerning that it was not administered. | F 333 | | |
| F 334 SS=D | 483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS<br><br>The facility must develop policies and procedures that ensure that --<br>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;<br>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;<br>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and<br>(iv) The resident's medical record includes documentation that indicates, at a minimum, the | F 334 | | 5/11/15 |

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following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5

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| F 334 | Continued From page 23<br>years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and staff interviews, the facility failed to offer an annual influenza vaccine to 1 of 5 sampled residents (Resident #207) reviewed for immunizations.<br>The findings included:<br><br>Resident #207 was admitted to the facility on 01/08/2015. The Admission Minimum Data Set (MDS) dated 01/15/2015 revealed Resident #207 was moderately cognitively impaired. It also indicated the resident had not received the influenza immunization after admission to the facility but there was no reason coded as to why the vaccine was not given.<br><br>Review of the of the MDS dated 01/21/2015 and the MDS dated 02/03/2015 indicated the influenza vaccine had not been given and the reason coded was that the vaccine had not been offered.<br><br>Review of the Medication Administration Record (MAR) for January 2015 revealed the influenza vaccine was scheduled to be given on the date of admission but it was not initialed as given. The vaccine was not scheduled on the February and March 2015 MARs.<br><br>An interview was conducted on 04/09/2015 at | F 334 | F334 INFLUENZA AND PHEUMOCOCCAL IMMUNIZATIONS<br><br>Resident #207 was admitted January 8, 2015 from the hospital. The facility was unable to validate whether or not the resident received the Flu vaccine prior to admission. The resident is a ward of the state and resides in the contained Alzheimer's unit. Throughout the Flu season the resident showed no signs or symptoms. On 4/13/2015 the Attending Physician's Nurse Practitioner advised the facility not to administer the Influenza vaccine at this point and time.<br><br>On 4/13/2015 a 100% audit was completed by ADON to ensure all residents have been offered an influenza vaccine. Any residents who were not offered an influenza vaccine was discussed with the Attending Physician Nurse Practitioner and advised the facility not to administer the influenza vaccine at this point.<br><br>The Staff Facilitator reeducated 100% of all Licensed Nurses in offering the influenza vaccine to all new admissions | |

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| F 334 | Continued From page 24<br>3:32 PM with Nurse #5 who worked the unit to which Resident #207 was admitted. Nurse #5 did not know why the resident had not been administered the influenza vaccine.<br><br>On 04/09/2015 at 4:19 PM, Unit Coordinator (UC) #2, who oversaw the 500 Hall was interviewed about monitoring the MAR to see if the influenza vaccine was administered to Resident #207. UC #2 said, "No I did not even see that."<br><br>During an interview on 04/09/2015 at 5:28 PM, the Administrator indicated she expected the influenza immunization to be offered at admission during the flu season. | F 334 | prior and during the Flu season if there is no evidence that they have not had one during influenza season.<br><br>The DON, ADON or Unit Manager will review each New Admission to ensure that they have been offered a influenza vaccine using the Influenza Vaccine Audit tool daily x 1 week, then weekly x 3 weeks, then monthly x 2 months. The completed audits will be reviewed in the QA & A Committee Meeting monthly for further recommendations and follow up as indicated. | |
| F 353 SS=E | 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS<br><br>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.<br><br>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br><br>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.<br><br>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of | F 353 | | 5/11/15 |

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| F 353 | Continued From page 25<br>duty.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and resident and staff interviews, the facility failed to honor resident preferences related to insufficient nursing staffing for 3 of 5 residents sampled for resident preferences (Residents #154, #173, and #9).<br><br>Findings included:<br><br>This tag is cross-referred to:<br><br>1. F 242 : Right to Self-Determination : Based on record reviews and resident and staff interviews, the facility failed to honor resident preferences related to baths and showers for 2 of 4 residents sampled for resident shower preferences (Resident #154 and Resident #173). The facility also failed to honor resident preferences related to wake up time for 1 of 1 resident sampled for wake up times (Resident #9).<br><br>An interview was conducted with NA #7 on 04/09/15 at 10:25 AM. She stated there was not enough staff to get all the work done that needed to be done in a shift, such as showers. She explained there were many days where staff called out and the other staff were moved around. NA #7 stated the facility had gotten rid of the shower team and assigned the NAs on the shower team to halls because the facility was so short-staffed. She further stated she had told administrative staff she was unable to complete her assigned work due to not having enough help. | F 353 | F353 SUFFICIENT 24-HOUR NURSING STAFF PER CARE PLANS<br><br>Residents #154, #173 and #9 preferences for Showers and wake up time will be honored.<br><br>100% of the Residents or Responsible Parties were interviewed by the DON, ADON, and Scheduler to determine Shower Preferences and wake up times. We are hiring and having orientation to increase staff to accommodate the shower preferences and wake up times<br><br>The Staff Facilitator will educate all nursing staff in the Procedure for Showers and getting residents up at their preferred wake up time. This will also be included in the orientation of all new nursing staff.<br><br>The DON and ADON will audit the Staffing and the Showers and Wake Up Time Preferences using the Staffing and Resident Care Monitoring tool daily x 2 weeks, 3x week x 2 weeks and then weekly x 2 months. The results of the completed audit will then be reviewed by the QA & A Committee monthly for further recommendations and follow up as indicated. | |

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An interview was conducted with Resident #9 on 04/09/15 at 11:06 AM. She stated she felt the NAs usually could not get her up at her preferred time before breakfast because the NAs did not have enough help.

An interview was conducted with NA #8 on 04/09/15 at 11:56 AM. She explained she could not complete all of her assigned duties, like showers, oral care, or nail care, in her shift because the facility was short-staffed. NA #8 stated she was often asked to sign up for extra shifts or called in on her day off. She explained she had talked about being short-staffed in meetings, but she felt no improvements had been made.

An interview was conducted with the DON on 04/09/15 at 3:49 PM. She confirmed the shower team had been suspended and the NAs were being assigned to a hall. She stated her expectation was that NAs assigned to halls were to give showers since there was no longer a shower team. The DON explained she had hired a large group of NAs to start the following week and hoped to implement the shower team once those NAs were through orientation. She further explained she felt the NAs were adjusting to the change of not having a shower team. She could not confirm the facility was short-staffed.

A telephone interview was conducted with Nurse #7 on 04/13/15 at 09:34 AM. She stated there were fewer Nurse Aides (NAs) on day shift lately to give scheduled showers. She explained if the NAs told her they did not have time to give a resident a shower, she expected them to give a "good bed bath" and let the evening shift know

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that a shower could not be given. Nurse #7 also stated, "We should do it for everybody, but if we don't have the time, we make sure residents get a good bed bath and see if the shower can be given on second shift."

A telephone interview was conducted with NA #10 on 04/13/15 at 09:42 AM. NA #10 stated she worked regularly on day shift. She explained when she is assigned 15 to 18 residents, she sometimes she did not have time to give everybody on her assignment a shower and would often give residents bed baths. She stated she would tell the nurse, who told her to give the resident a "good bed bath". NA #10 also stated that if the resident required minimum assistance or supervision with showers, she tried to make sure the resident got a shower. She continued to explain if the resident required two staff to transfer to a shower bed or chair, it was really hard to find another staff person to help with the transfer because everybody was busy.