| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505243 | A. BUILDING _____ B. WING _____ | 01/29/2014 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **EVERGREEN NURSING & REHAB CENTER** | **430 LILLY ROAD NORTHEAST OLYMPIA, WA 98506** |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
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| F 0246<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Reasonably accommodate the needs and preferences of each resident**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br><br>. Based on observation, interview, and record review, it was determined the facility failed to provide reasonable accommodations for 2 of 3 (#s 86 & 105) current sampled residents reviewed for choices. The failure placed the resident at risk for a reduced quality of life. Findings include: RESIDENT #105 Resident #105 was admitted on [DATE] with [DIAGNOSES REDACTED]. Quarterly Minimum Data Set (MDS) an assessment tool dated 12/16/13 indicated that Resident #105 was assessed to be cognitively intact, required extensive 2 person assist for bed mobility, and did not exhibit rejection of care per admission MDS dated [DATE] and most recent MDS dated [DATE]. The care plan dated 09/11/13 an in-room care directive (a facility document that guides provision of resident care delivered by staff) dated 9/13/13 indicated frequent turning, turn reposition every 2 hours and as needed, max remobilization, air mattress, provide Range of Motion (ROM), elevate heels pillow under lower legs, instruct and encourage repositioning self at 15-20 minute intervals. <RESTORATIVE CARE> On 01/28/14 at 10:22 a.m., LN I confirmed that Resident #105 was currently on a restorative program which included 15 minutes of therapy 6 days a week. On 01/27/14 at 12:15 p.m., Resident #105 stated that he was pleased with physical therapy and thought he was making progress, but since it concluded (on 10/09/14), staff have not come in enough to work his legs. For the past month staff have not moved my legs, my legs are getting stiff. I am getting frustrated because I get to a certain point and then I take another step back, I want to get healed and go on with my life. I want to go swimming, there is a pool in Centralia and they have a lift. That's my goal. 01/28/14 at 11:28 a.m., NA G stated that s/he only worked Resident #105's legs three times performing range of motion (ROM) since the end of November. NA G stated, He {Resident #105} refused to have range of motion a few times and I know he didn't want to work with NA L {another restorative aid} so I assumed that he {Resident #105} just didn't want to work with me either. So I didn't go back. 01/28/14 at 12:30 p.m., when asked if he had refused ROM, Resident #105 stated, Oh ya! I refused all right; I refused once when there was a big football game on because I wanted to see the game. Then a few times at around 4:30 {p.m.} when I was really tired, I get tired by the end of the day, I would prefer to have range of motion in the morning when I am not so tired after breakfast. Resident #105 stated he did tell the restorative aid (NA G) and It didn't do any good the next time they just came back at whatever time it suited their schedule, I never did see them come after breakfast. Facility form entitled Restorative Detail Report indicated that Resident #105 refused ROM by NA G on 12/05/13 at 5:15 p.m., 01/03/14 at 3:41 p.m., and 01/07/14 at 4:55 p.m. <REPOSITONING> On 01/27/14 at 12:15 p.m., when asked about interventions utilized by staff to help with wound healing Resident #105 stated, The pillows they (staff) put under my lower legs are so thin and flat that my heels are on the bed anyways, so what's the use. On 01/27/13 at 1:30 p.m., when asked Resident #105 if staff have offered to reposition him every 2 hours the resident stated, Staff does not offer to reposition me every 2 hours, I have not had any conversation with staff about repositioning, I do not refuse to be repositioned and they do not come in to reposition me every 2 hours. On 01/28/14 at 9:31 a.m., when asked if s/he knew the reason why Resident #105 refused to be repositioned, LN B stated, We know why he doesn't want to be repositioned, it is right here (referring to Resident #105's quote on the PT-Therapist Progress & Discharge Summary dated 10/09/14) he feels that therapy and movement slows the healing process. On 01/28/14 at 9:58 a.m., when asked if s/he assessed the reason for this resident's refusal SSD stated, I talk more with his mom than him, I don't know why he refuses to be repositioned. Refer to F-314 <RESIDENT #86> Resident #86 was admitted with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS), an assessment tool, dated 10/13/13 the resident's functional status is documented as impairments on both sides for upper extremities (shoulder, elbow, risk and hands). The ADL/Mobility: Plan of Care form, first dated on 9/9/10 and most recently reviewed on 1/23/14, documents contractures to both hands On 1/23/14 at 2:30 p.m., the resident stated s/he kept the closet door open to keep the room door from closing and that s/he is not able to open the door on her own with the type of door knob that is currently on there. On 1/24/14 at 2:14 p.m., Resident #86 explained s/he no longer used the assisted dining room or the adjoining patio due to the same concern regarding the door knob. The resident stated s/he had asked staff to prop open the door leading to the hallway but was told, by the former Activities Director, it was not allowed because of the fire marshal. The resident is not able to open the door using the current door knob and would have to wait for someone to come open the door. The resident stated, I' ve been stuck in there.It's scary to be trapped in there. I stay out of there. On 1/27/14 at 10:52 a.m., the resident stated, No one has ever cared why I keep my closet door open or offered a different door knob. I can't open it if the wind closes it. I don't want to be trapped. On 1/28/14 at 12:28 p.m., the Maintenance Staff (MS) stated, We try to accommodate everything we can. I will talk to the administrator if I'm not sure. I've changed lever latches before. The MS reported the resident stated to him s/he had given up on asking for the door knob before he came here. On 1/28/14 at 1:10 p.m., the Director of Nursing (DNS) stated she had never heard of it. The DNS didn't think the resident ever went in the assisted dining room and usually sat in the sun, out in the front parking lot. At 1:15 a.m., Licensed Nurse A stated, I've never seen (the resident) go in there, not even to get something from the fridge. At 1:48 p.m., the resident stated, They know, they absolutely know. I haven't been out there (the patio off the assisted dining room) in two years. I gave up asking way before MS got here because no one does anything about it. . |
| F 0250<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide medically-related social services to help each resident achieve the highest possible quality of life.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br><br>. Based on observation, interview and record review the facility failed to provide medically related social services to 3 of 3 residents (#s 105, 79 & 51) reviewed for social services. <Resident #79> Resident #79 was admitted on [DATE] with [DIAGNOSES REDACTED]. The quarterly MDS, an assessment tool, dated 11/23/13 documents identified the resident to require extensive two person assistance for Activities of Daily Living. On 1/28/14 at 1:08 p.m., the Director of Nursing (DNS) stated Resident #79 regularly refuses offers to be toileted. At 3:09 p.m., LN I stated the only program I have her on is active range of motion and she refuses all the time, pretty regularly. On 1/29/14 at 9:28 a.m., the SSD stated that when a resident repeatedly refuses care, a social services staff will go in with nursing or the residential care managers and try to persuade the resident to allow care to happen. The SSD stated that in care tracker it is documented Resident #79 is resistive to having vitals taken, taking medication and having dirty sheets changed and cleaned. At 9:30 a.m., the Social Services Assistant (SSA) stated all residents have a right to refuse, resident #79, even with a [DIAGNOSES REDACTED]. The SSA did not consistently get reports on the resident's behaviors. SSA indicated the resident was not in any type of crisis |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| F 0250<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>mode, I have not gone in specifically to talk about refusals with the resident. <Resident #105> Resident #105 was admitted on [DATE] with [DIAGNOSES REDACTED]. Quarterly Minimum Data Set (MDS) an assessment tool, dated 12/16/13, indicated Resident #105 was assessed to be cognitively intact, at risk for developing pressure ulcers, and required extensive 2 person assist for bed mobility. Resident #105 did not exhibit rejection of care per admission MDS dated [DATE] and most recent MDS dated [DATE]. On 01/27/14 at 4:18 p.m., LN B stated that Resident #105 refused to be repositioned by staff on multiple occasions. On 01/28/14 at 9:58 a.m., when asked if s/he assessed the reason for this resident's refusal SSD stated, I talk more with his mom than him, I don't know why he refuses to be repositioned. <RESIDENT #51> On 1/21/14 at approximately 11:00 A.M., Resident #51 stated she was admitted in March (2013) because she was dizzy. Her record indicated admission [DIAGNOSES REDACTED]. She was observed out of her room, well-groomed and walking independently. She made her own<br>care decisions and signed for full resuscitation measures if needed. She stated she was well now and anticipated going home soon. Review of the Social Services notes dated 12/16/13 revealed She (Resident) is unaware of home being sold as yet . Licensed Nurse G stated the Resident was not informed of her home being sold as staff determined she would likely not understand. Staff determined she would be discharged to an adult family home. No documentation was found to indicate the Resident was included in the decision to sell her home or where she would be discharged . . |
| F 0272<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Conduct initial and periodic assessments of each resident's functional capacity.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>. Based on observation, interview and record review, the facility failed to conduct thorough comprehensive and accurate assessments of functional capacity for 3 of 30 Sampled Residents (#'s 19, 86 & 58) reviewed. Failure to directly observe the conditon(s) of the residents disallowed an opportunity to discover any problems that could potentially impact the resident's condition. This failure placed residents at risk for decline in health status and diminished quality of life.<br>Findings include: <PHYSICAL FUNCTIONING AND STRUCTUAL PROBLEMS> 1) Resident #19 was admitted to the facility on [DATE] with<br>[DIAGNOSES REDACTED]. The resident's Minimum Data Set (MDS) December 2013 indicated the resident was moderately cognitively<br>impaired, required extensive assistance with most activities of daily living and was at risk for pressure ulcers. Resident #19's MDS (Minimum Data Set) assessments for June, September and December 2013 indicated the resident's functional status required extensive assistance with 2 persons. Resident #19's plan of care (11/29/13) was inconsistent with the MDS assessment. The assessment was not comprehensive and indicated the resident was independent to requiring one person assist for bed mobility. When staff was asked who was responsible for ensuring assessments were accurate and updated including the care plans, staff stated Licensed Nurses (Resident Care Managers) completed the care plans. The reident's care plan was last updated on 11/29/13. When Resident #19 was asked if staff assisted him in changing positions in bed, he stated they come in once a day to adjust him. The resident was observied in bed on his back at the following times: 1/27/14 at 8:54 a.m. propped up in bed and eating 10:01 a.m. in bed on back. 10:58 a.m. in bed on back 11:28 a.m. in bed on back 12:14 p.m. in bed on back 12:44 p.m. in bed on back 1:30 p.m. in bed on back 2:28 p.m. in bed on back 3:05 p.m. in bed on back 1:10 p.m the resident stated he wasn't sure why he stayed in his bed alot. At 1:05 p.m., when a staff member was asked which residents required frequent turning on the 300 hall, the staff member stated a list was made by a Licensed Nurse (LN) that morning. Another LN had suggested a list to assist with the turn schedule. Review of the list indicated Resident #19 was not on the list. 1:07 p.m. a LN looked at the list and added 3 more residents to the list. Nursing Assistants (NAs) B & C stated they normally look at the yellow dots placed at the residents' doors to know who to turn. The resident was not on yellow dot program. NAs stated they did not necessarily turn the resident and thought he was independent with bed mobility and could sit up in bed on his own. The NA indicated he was not on a 2 hour respositing schedule while he was in bed. 2) Resident #86 was admitted with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS), an assessment tool, dated 10/13/13 the resident's functional status is documented as impairments on both sides for upper extremities (shoulder, elbow, risk and hands). The ADL/Mobility: Plan of Care form, first dated on 9/9/10 and most recently reviewed on 1/23/14, documents contractures to both hands On 1/23/14 at 2:30 p.m., the resident stated s/he kept the closet door open to keep the room door from closing and that s/he is not able to open the door on her own with the type of door knob that is currently on there. On 1/24/14 at 2:14 p.m., Resident #86 explained s/he no longer used the assisted dining room or the adjoining patio due to the same concern regarding the door knob. The resident was not able to open the door using the current door knob and would have to wait for someone to come open the door. The resident stated, I' ve been stuck in there.It's scary to be trapped in there. I stay out of there. On 1/27/14 at 10:52 a.m., the resident stated, No one has ever cared why I keep my closet door open or offered a different door knob. I can't open it if the wind closes it. I don't want to be trapped. On 1/28/14 at 12:28 p.m., the Maintenance Staff (MS) stated, We try to accommodate everything we can. I will talk to the administrator if I'm not sure. I've changed lever latches before. The MS reported the resident stated to him s/he had given up on asking for the door knob before he came here. On 1/28/14 at 1:10 p.m., the Director of Nursing (DNS) stated she had never heard of it. The DNS didn't think the resident ever went in the assisted dining room and usually sat in the sun, out in the front parking lot. At 1:48 p.m., the resident stated, They know, they absolutely know. I haven't been out there (the patio off the assisted dining room) in two years. I gave up asking way before MS got here because no one does anything about it. <DENTAL> 3) Resident #58 was admitted from the hospital to the facility on [DATE] with multiple medical [DIAGNOSES REDACTED]. On 1/22/14 at 11:00 A.M., the Resident's spouse stated the Resident had an old injury to her jaw and teeth about 4 years ago. The Resident had extensive dental care with upper and lower bridge implants in an effort to keep as many teeth as possible. He stated: She needs good oral care so all the work done won't be wasted . Review of the Comprehensive Admission assessment dated [DATE], failed to indicate a dental/oral status examination was done. Other documentation of the Resident's dental care needs was not found. Review of the quarterly assessments dated March 29 and December 20/2013 failed to indicate the Resident's dental/oral status. On 1/24/14 at 11:35 A.M., the Resident's teeth were observed with Licensed Nurse (LN G). The Resident allowed her teeth to be examined by the LN. The Resident had upper and lower bridges secured in place with white debris on all teeth. The bridges appeared to cover most of her upper and lower jaw with some natural teeth noted. The LN was new to the facility and was not aware the Resident had extensive dental work and she could not find any documentation in the record to support the resident had an accurate dental/oral assessment completed since admission.<br><br>. |
| F 0309<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Provide necessary care and services to maintain the highest well being of each resident**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, it was determined, the facility failed to provide care and services to attain or maintain the highest possible level of functioning and well-being for 2 of 20, (# 74 & 79) current sampled residents reviewed for care and services. This failure placed residents at risk for decline in functional status. Findings include: <Resident #79> Resident #79 was admitted on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set<br>(MDS), an assessment tool, dated 11/23/14 documented potential for improvement in Activities of Daily Living (ADLs). Toilet use was documented as extensive assistance, two-plus person physical assist. Moving from seated to standing position, moving on and off toilet and surface to surface transfer were documented as not steady, only able to stabilize with staff assistance. According to the facility incident reports, the resident had five (5) falls since being admitted to the facility. The Fall/Injury Assessment: Prevention and Management Plan of Care in the resident chart also documented the falls. A fall on 11/1/13 resulted in a right leg fibula fracture. The intervention dated 11/1/13 on the Fall/Injury Assessment: Prevention and Management Plan of Care was for Pt (patient) to wear non-skid foot gear when out of bed. A Nursing-Therapy Communication form was completed on 11/5/13. The nursing communication portion of the form documented the resident was showing a change of condition in the following areas: toileting, transfers, ambulation, falls, following directions, memory and safety/judgment. The therapy portion of the form communicated the resident may benefit from skilled therapy intervention of PT (physical therapy). The Multi-Disciplinary Therapy Screening Tool signed on 11/12/13 noted no current restorative programs and the resident may potentially benefit from skilled therapy interventions. A restorative program for communication and active range of motion (ROM) were started on 11/15/13. Both programs were scheduled for six |

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| F 0309<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 2)<br>(6) days a week for 15 minutes per day. No restorative programs were started for toileting, transfers or ambulation to address the change in condition noted on the Nursing-Therapy Communication from 11/5/13. A second fall occurred on12/7/13. The resident was found on the floor near the toilet in the resident's bathroom. Resident #79 stated s/he was attempting to transfer to the chair and fell . The intervention on the plan of care for 12/7/13 was to offer toileting every 2 hours. A third fall occurred on 1/1/14 when the resident was found by staff after being heard yelling for help. The resident was on the floor in the residen's bathroom. The resident stated she fell while trying to transfer to the toilet. Intervention dated 1/1/14 on the plan of care was for toileting before and after meals and if patient refuses re-offer 1 hour later. On 1/27/14 at 10:23 a.m., Nursing Assistant (NA) I stated Resident #79 toilets on his/her own, We try to catch (the resident) to help but usually (s/he) goes herself. (S/he) usually makes it to the toilet without a problem. At 12:38 a.m., Resident #79 stated no one had offered to help him/her with going to the bathroom after lunch. At 2:09 p.m. the resident was observed exiting the bathroom on his/her own with no staff present. The resident then stood behind and pushed his/her wheelchair to the wall opposite the bed and walked back to the bedside unassisted. On 1/28/14 at 10:09 a.m., When asked who completes the Nursing-Therapy Communication form, the DNS stated that the Resident Care Managers oversee updates to the care plan. They are updated quarterly or if there is a change in condition. The Therapy Communication form was completed as a result of the fall. At 10:29 a.m., Licensed Nurse (LN) J stated the resident does self-toilet but s/he should have assistance, Her stability isn't that great. At 1:12 p.m. LN F stated, the resident had been fairly independent before some functional decline. If the resident were to have another fall the IDT would be involved and work with restorative and therapy to try to help with safety. At 3:09 p.m., LN I, stated the resident is only on the active ROM program and s/he refuses all the time. The transfer, ambulation and toileting programs are different programs. I reevaluate the programs monthly. I get the recommendation for programs from the therapies department or the Resident Care Managers. At approximately 3:30 p.m., the Director of Physical Therapy (DPT) stated, no therapies had begun because they were waiting for the resident to have an orthopedic appointment to ensure the resident could do weight bearing therapies. The therapy department had not heard back from nursing yet but they were anxious to help the resident. At 4:09 p.m. the DNS, stated that s/he self-toilets so we wouldn't have her on a toileting program and no ambulation and transfer programs are needed, the residents gate is stable. S/he doesn't need anything else, s/he is on active ROM, and I have the resident going every day. We are waiting for an orthopedic consult, now that I think of it that would be an ambulation issue. On 1/29/14 at 10:55 a.m., LN F stated s/he had called to make an orthopedic appointment that morning as soon as the office opened and it was schedule for 02/05/14. After the appointment they could then start the resident officially on weight bearing programs as oppose to what s/he was doing now and ambulating on her own. Refer to F-tag 323 <Resident #74> Resident #74 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident's Minimum Data Set (MDS), an assessment tool,<br>dated 12/11/13 indicated the resident required supervision to extensive assistance with activities of daily living.<br>Resident #74's care plan for [MEDICAL TREATMENT] dated 12/4/13 included interventions of [MEDICAL TREATMENT] treatment (3)<br>three times per week. According to the resident care plan, the facility was to complete the [MEDICAL TREATMENT] Center Communication Record prior to the resident's treatment and document weights, medications, laboratory results, vital signs and special instructions. Facility policy stated, upon the resident's return from [MEDICAL TREATMENT], facility nurses will review the [MEDICAL TREATMENT] Center Communication Record for pertinent information from the [MEDICAL TREATMENT] Clinic,<br>access vital signs, check access for bruit (or condition of access device) document on the resident's Treatment Administration Record (TAR), monitor for bleeding upon, monitor for signs of postural [MEDICAL CONDITION] (a form of low blood pressure that happens when you stand up from sitting or lying down), instruct resident to change position slowly for a short time to avoid dizziness and possible falls, and monitor the resident closely for signs and symptoms of toxic or adverse medication reactions, especially residents on cardiac medications as these resident may become toxic rapidly.<br>Record review of the resident's December and January Medication Administration Records showed Resident #74 was given [MEDICATION NAME] 50 mg, Atorvastatin 5 mg, [MEDICATION NAME] 25 mg, and [MEDICATION NAME] 5 mg, all of which are heart<br>medications with side effects of dizziness and/or drowsiness. Review of the [MEDICAL TREATMENT] Communication Records showed missing information as follows: On 01/27/14, 01/24/14, 01/08/14, 12/29/13, 12/18/13 and 12/16/13 the facility nurse failed to document the resident's vital signs on the [MEDICAL TREATMENT] Communication form upon return to the facility. On 01/22/14, 01/13/14, 12/24/13, and 12/20/13 the communication form lacked pre and post vital signs, medications given during treatment, or changes in condition/other pertinent information while at the [MEDICAL TREATMENT] center. On 01/28 14 at 4:27 p.m., Licensed Nurses (LN) D and C confirmed that when the resident returns to the facility after [MEDICAL TREATMENT], nurses are to take vitals, check for bleeding and document concerns in the [MEDICAL TREATMENT] book on the communication form. LN D and C stated if the communication form was returned without information from the [MEDICAL TREATMENT] center, the<br>facility nurses would call and ask them to fax over the information. At 4:28 p.m., the surveyor was unable to locate any faxed communication from the [MEDICAL TREATMENT] center to show the required communication between facility nurses and the<br>[MEDICAL TREATMENT] center had occurred for the above noted concerns. When LN C was asked about the lack of documentation,<br>the LN confirmed she could not locate the documentation either. On 01/29/14 at 10:49 a.m, LN B stated it is an expectation that the [MEDICAL TREATMENT] Center Communication Records are filled out completely. LN B stated if information is missing from the [MEDICAL TREATMENT] center, nurses should request the missing information from the [MEDICAL TREATMENT] center. LN<br>B confirmed if the book is not complete, then the information is not available to all staff. LN B looked for documentation of communication from the [MEDICAL TREATMENT] center in chart notes regarding the incomplete communication form dated 01/22/14 and stated, I don't see anything in here. The surveyor and LN B reviewed Resident #74's care plan which documented the resident should be monitored for postural [MEDICAL CONDITION] post procedure. LN B stated, I believe that is being done at the [MEDICAL TREATMENT] center. Upon review of the communication form, LN D stated, It is not getting done. . |

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| F 0314<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | **Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>. Based on observation, interview and record review, the facility failed to follow and implement interventions consistent with recognized standards of practice as appropriate for 1 of 4 (#105) current sampled residents reviewed for pressure sores. This failure could have contributed to the development of a pressure sore after admission. Findings include:<br>Resident #105 was admitted on [DATE] with [DIAGNOSES REDACTED]. Quarterly Minimum Data Set (MDS) an assessment tool dated<br>12/16/13 indicated that Resident #105 was assessed to be cognitively intact, at risk for developing pressure ulcer, and required extensive 2 person assist for bed mobility. Resident did not exhibit rejection of care per admission MDS dated [DATE] and most recent MDS dated [DATE]. The following Care Area Assessment (CAA's) that were selected for further assessment and care planning included pressure ulcer and activities of daily living (ADL's)/rehabilitation potential. A Braden scale (an assessment tool used for predicting pressure ulcer) was completed on 09/11/13 with a score of 15 to18 which indicated that resident was at risk for developing pressure ulcers. The resident's hospital record (dated 8/22/13) and prior to facility admission indicated the resident was admitted with Bilateral ischial (hip) wounds described as cavernouse in size-approximately 10cm with irregular edges and both with approx 8cm undermining L (left) isch (ischial) from 8-12 o'clock and R (right) isch (ischial) from 12 - 4 o'clock. Bone palpated throughout the wounds. Red Base.<br>Observation of the pressure ulcers on right buttocks on 1/27/14 at 1:36 p.m. with Licensed Nurse H revealed the right buttock had an pressure ulcer of 6 x 4 x 2 cm and tunneling 6cm deep. The right hip area was 4.8 x 2.1 x 1 cm deep. The dressing on the coccyx had a green color and lightly sanguinous. The ulcer measured 2.8 x 1.5 x 3.1 cm deep. The left buttock ulcer measured 4 x 2.5 x 0.8 x 5.8cm deep. The resident's left and right heels had darkened to pink areas with some slight brownish skin with dry skin over the rop o dark skin. <DRESSING CHANGE> On observation during dressing change performed by LN H on 01/27/14 at 1:36 p.m., the following three breeches in practice were noted: first when removing dressing on left buttocks, rolling the outside of the dressing onto itself, secondly touching the spout of the spray bottle which contained the Wound Cleanser to the 4X4 sponge which was used to cleanse the inside of the open area on the left buttocks, and finally dragging the moist 4X4 sponge on the skin surface below the open area as the moist 4X4 was placed in the left buttocks open wound which was left in for the wound. 01/28/14 at 11:26 a.m., LN H stated that by removing dressing by curling the outside of dressing over the wound there would be potential to bring bacteria from skin into wound, and the same for the moist 4X4 sponge touching skin prior to inserting it into the wound, and finally with the 4X4 sponge touching the end of the Wound Cleanser spray bottle as all these practices could potentially introduce bacteria into the wound. |

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| | 505243 | A. BUILDING _____ B. WING _____ | 01/29/2014 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| EVERGREEN NURSING & REHAB CENTER | 430 LILLY ROAD NORTHEAST OLYMPIA, WA 98506 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0314<br><br>**Level of harm** - Actual harm<br><br>**Residents Affected** - Few | (continued... from page 3)<br><REPOSITIONING> The care plan dated 09/11/13 and in room care directive (a facility document that guides provision of resident care) dated 9/13/13 indicated frequent turning, turn reposition every 2 hours and as needed, max remobilization, air mattress, provide Range of Motion (ROM), elevate heels pillow under lower legs, instruct and encourage repositioning self at 15-20 minute intervals. Record review on 01/27/14 at 1:03 p.m. indicated that air mattress was not ordered by physician, additionally the physician ordered to float heels, and encourage supine (a more flat position) positioning while in bed. Multiple observations during survey found the resident in bed in the sitting position with head of bed elevated from 40 to 60 degrees. Heels were flat on bed and Resident #105 stated, The pillows they {staff} put under my lower legs are so thin and flat that my heels are on the bed anyways, so what's the use. The following dates and times are reflective of observations in which Resident #105 was in a sitting position with head of bed elevated with heels directly on air mattress. On 01/21/14 at 3:00 p.m., 01/22/14 at 1:15 p.m., 01/23/14 at 8:56 a.m., 9:26 a.m., 01/27/14 at 9:18 a.m., 10:40 a.m., 11:53 a.m., 12:15 p.m., 1:30 p.m., 2:38 p.m. and 4:18 p.m., and 01/28/14 at 9:29a.m. Progress notes dated 10/14/13 reads that the Pt {patient} reviewed during Interdisciplinary Team meeting related to need for a repositioning/turning program. Pt cannot independently reposition self therefore staff needs to reposition Q 2 hr {every 2 hours}and PRN {as needed} to ensure good care. Resident #105's progress notes from 12/10/13 through 01/13/14 indicated that resident refused to be bridged and repositioned on multiple occasions. On 01/28/14 at 3:40 p.m., when asked if staff offered to reposition Resident #105 every 2 hours, LN B stated, Staff still need to go in and offer to reposition this resident, and the resident can refuse it, it's his choice. They (staff) still need to check under him. 01/27/14 at 2:40 p.m., when asked NA F if s/he repositioned Resident #105 every 2 hours on the night shift (approximately 10 p.m. to 6 a.m. timeframe), NA F stated, He {Resident #105} usually goes to sleep around 10:30 p.m. and then I go in around 2 a.m. and he is usually snoring on first round, so I empty his catheter and leave. NA F also stated that she usually does two rounds during the night shift, a first round at approximately 2:00 a.m. and a second round at approximately 5:00 a.m., and that Resident #105 is usually awake on second round when she empties his urinary catheter again. The facility failed to assess reasons for care refusals and possibly implement alternate interventions to mitigate the development of pressure ulcers for Resident #105. Refer to F-155. <PRESSURE ULCER ASSESSMENT> During observation of dressing change on 01/27/14 at 1:36 p.m., wound was observed to<br>have full thickness tissue loss with granulation at base of wound that included tunneling at 12 o'clock that was 3.1cm deep. Facility Skin Grid-Pressure/[MEDICAL CONDITION] Ulcer form indicated that the midline coccyx pressure ulcer was a Stage 2. On 01/29/14 when asked how s/he identified the staging of the midline coccyx pressure ulcer for Resident #105, LN H stated, I would call it {midline coccyx pressure ulcer} more of a Stage III than a Stage II, but I do depend on my RCM {Resident Care Managers} to accurately Stage pressure ulcers, because they {Resident Care Managers} have more experience with than I do. 01/29/14 when asked who filled out the Skin Grid- Pressure/[MEDICAL CONDITION] Ulcer form for Resident #105's midline coccyx pressure ulcer, LN B stated, I did. Then when asked how she identified Resident #105's as being a Stage II LN B stated, I have not seen the pressure ulcer myself. S/he then stated that s/he relied on the information that is provided to him/her by the nurse who performed the dressing change. <LABORATORY VALUES> Laboratory values dated 11/12/13<br>indicated that hemoglobin (10.9 g/dL) and hematocrit (35.4 %) were below normal. physician's orders [REDACTED]. On 01/28/14 at 3:40 p.m., when asked about follow up blood work results for hemoglobin and hematocrit, LN B stated blood work was not completed and no results were available. . |
| F 0323<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, it was determined, the facility failed to identify and implement interventions to reduce fire hazards in 22 of 58 resident rooms observed for environmental hazards. The facility failed to ensure entry/exit areas where residents smoke was safe for Residents #9 & 120. This failure placed residents at risk for injury from fires. The facility also failed to ensure the the environment for 2 of 3 residents (#s 86 & 79) reviewed for safety devices, supervision and was free of hazard related to the implementation of a transfer pole for Resident #86. This failure placed residents at risk for injury. Findings include: <HEATER SAFETY> On 1/22/14 at 1:43 p.m., the Administrator (ADM) and a surveyor toured each hall in the facility to discuss concerns regarding items placed in front of the baseboard heaters in resident rooms. The ADM stated, they have an 18-inch rule and staff had been in-serviced on keeping items away from the baseboard heaters. The ADM further explained resident's care partner staff members help to monitor for items that are too close to the baseboard heaters. The ADM also stated there is no system in place to keep cognitively impaired resident from turning heaters up and placing combustible items on or near to the heater. No. I see what you are saying. We will fix it right away. The manufacturer's warning label on the heaters stated that combustible items should be kept 12 inches away from the baseboard. The electric baseboard owner's guide provided by the facility stated, Heater must be kept clear of all obstructions: minimum of 12 inches in front and above, 6 inches on both sides. On 01/22/14 from 12:30 p.m. to 2:00 p.m., the following observations were made in the 200 hall: Room 200 - Tubing from the air conditioner was touching the baseboard heater. Room 212 - A wood chair was observed touching the baseboard heater. Administrator acknowledged the contact and moved it. Room 214 - A wood bookshelf was observed touching the baseboard heater. Room 213 - Wood shelves and a plastic garbage can were observed within 3 inches of the baseboard heater. Room 211 - A wood chair was observed touching the baseboard heater. The ADM acknowledged the chair touching the baseboard heater and moved it. Room 209 - A slipper was observed within 3 inches of the heater Room 207 - A wood dresser was observed touching the heater. At 1:27 p.m. Resident #48 stated his/her roommate turns up the thermostat. She controls it. At 1:30 p.m. Resident #82 stated s/he controls the thermostat in the room. At 1:44 p.m., LN J stated, residents in the in the 200 hall are able to turn up their heat if they want to. I often walk into rooms and it is 80 to 90 degrees in there. LN J then stated, Things should not be placed within inches of the heater. You want to keep it clear because it is a fire hazard. At 1:49 p.m. Maintenance Staff (MS) stated residents can control the heat source in their rooms and items should not be within 18 inches of the baseboards. When the surveyor and MS entered room 202 regarding a surveyor's observation of furniture touching the baseboard heater the MS stated, Oh yeah, that is touching On 01/22/14 from 1:00 p.m. to 2:00 p.m. the following observations were made on the 300 hall: Room 306 - A plastic trash can was observed two inches from the baseboard heater. Room 309 - Wood furniture was observed one inch from the baseboard heater and the heater was on. Residents #73 and 38 stated they both adjust the heater. Room 313 - A plastic trash can was observed 3 inches away way from the baseboard. The resident in the room stated the heater makes popping sounds at times and gets pretty warm. Room 315 - A wood television stand and cords were observed against the baseboard heater. Resident #64 stated she can adjust the temperature control. The ADM acknowledged the objects in contact with the heater and stated, I see what you are talking about. Resident #89 stated, I just turned it up. It works real good. Resident #19 stated, I can control the heater on my own. Resident #159 and 87 stated they are both able to control the heater. At 1:44 p.m., NA C stated some residents adjust the heater controls on their own. The furniture should not be close to the baseboard. At 1:46 p.m., NA K stated if a resident is ambulatory they can adjust the thermostat on their own. I believe objects needs to be 18 inches from baseboard. If it is too close we have to inform the resident and move it before we can turn the heat on. On 01/22/14 from 1:00 p.m. to 2:00 p.m., the following observations were made in the 400 hall: Room 405 - A wood chair was observed two inches from the front of the baseboard heater. The ADM acknowledged the chair was too close to the heater. Room 410 - A wood chair and dresser were observed six inches away from the baseboard heater. Room 414 - A wood dresser and chair were observed 5 inches from the front of the baseboard heater. Resident #160 stated s/he is able to adjust the heater control himself. Resident #147 stated, I can control the heat. Resident #158 stated s/he can adjust the heater control himself. On 1/22/14 from 1:00 to 2:15 p.m. the following observations were made on the 500 hall: Room 500 - The heater was observed on and a wood chair touching the heater. The ADM acknowledged the chair being too close to the heater and moved it. Room 501 - The heater was on with a chair one inch from the front of the heater. The ADM acknowledged the chair and moved it. Room 504 - The heater was on and a garbage can was 1 inch from the front of the heater. Room 506 - The heater was on and a wood dresser was 6 inches from the heater. Room 511 - A wood chair and paper gift bag with tissue paper 1 inch in front of the baseboard heater. The ADM acknowledged the items in front of the heater and moved the chair. The resident was alert and oriented and able to adjust the heater control. Room 512 - A dresser was two inches from front of the baseboard. The ADM acknowledged the furniture being too close to the baseboard. Room 513 - The heater was on and a wood chair was one inch from the front of the heater. Room 514 - The heater was on and a dresser was 4 inches from the front of the baseboard. The ADM acknowledged the furniture being too close to the heater. |

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| F 0323<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 4)<br>Room 517 - The heater was on and a wood table placed two inches from the front of the heater. The ADM acknowledged the table was too close to the heater. At 1:30 p.m. NA G stated, When furniture is close to heaters we will pull it back a foot. At 1:45 p.m. LN G stated, they try to keep items back from heaters 1 to 3 feet. LN G stated some of the residents could possibly use the heaters. <ENTRANCE/EXITs> On 1/23/14 at 4:30 P.M., the Fire Marshall stated residents were smoking at the entry door to the 400 unit and the Specialized Rehabilitation Unit. Review of the facility map did not indicate a designated resident smoking area. Signage at the main entrance, the 400 unit entrance/exit, and other entry/exits to the facility indicated: This is a non-smoking campus. Residents #9 and #120 were observed smoking about 2 feet away from this entry/exit door. Resident #120 stated if he had not been allowed to smoke he would not have admitted himself to the facility. Resident #120 stated he could come and go without assistance any time of day or night and had gone outside by himself to smoke as late as midnight. Wheelchair bound Resident #9 was unable to move farther away from the building because, once off the sidewalk, the area was without a cover, uneven and had a gravel area around a table. The cast iron cigarette collection container was broken and placed against the facility wall directly below the window to the residents' speech therapy space/dining area. The 4-feet sidewalk was the only covered area with a corresponding canvas overhang connected to the facility wall and covered the sidewalk from the door to the parking lot. Because of the close proximity of smoking by the doors and windows, once opened, smoke filled these areas when entering/exiting the facility. On 1/24/14 at noon, inspection of this area with the Administrator revealed lack of adequate safety equipment for smoking. This area was a designated entry/exit to residents' 400 unit living spaces and the resident's specialized rehabilitation unit, not a designated smoking area. The area was not easily visible to staff members and adjoins a driveway/parking lot. On 1/29/14 at approximately 11:00 A.M., the smoking area was inspected with the Director of Nursing Services (DNS). A new red tin-like waste container was placed near the wall and was found to have white tissues and used cigarettes in it. The sign above this container indicated: This is a non-smoking campus. The DNS stated residents in the adjacent assisted living complex used this area to smoke as well because they were not allowed to smoke on their own campus. Review of the Resident Council monthly meeting minutes between June 2013 and January 2014 indicated residents did not like the smoke entering the facility and the cigarette butts left around. <TRANSFER POLE> Resident #86 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident's MDS, dated [DATE] indicated the resident required extensive assistance with personal hygiene, tolieting, transferring and bed mobility. On 01/22/2014 at 12:09 PM Resident #86's transfer pole placement was observed to be less than 12 inches from the edge of his bed creating an unsafe gap between the pole and bed. The resident's record lacked a current physician order [REDACTED]. Licensed Nurse (LN) F stated he completed a safety evaluation for 1/4 side rail. No safety evaluation was found for the transfer pole. The Resident's safety device plan of care lists a 1/4 side rail. It did not list a transfer pole. <FALLS> Resident #79 was admitted on [DATE] with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS), an assessment tool, dated 11/23/14 documented potential for improvement in Activities of Daily Living (ADLs). Toilet use was documented as extensive assistance, two-plus person physical assist. Moving from seated to standing position, moving on and off toilet and surface to surface transfer were documented as not steady, only able to stabilize with staff assistance. According to the facility incident reports, the resident had five (5) falls since being admitted to the facility. The Fall/Injury Assessment: Prevention and Management Plan of Care in the resident chart also documented the falls. A report dated11/1/13 stated the resident had a fall in the resident's bathroom resulting in a right leg fibula fracture. Urine was noted to be on the bathroom floor. The intervention dated 11/1/13 on the Fall/Injury Assessment: Prevention and Management Plan of Care was for Pt (patient) to wear non-skid foot gear when out of bed. A Nursing-Therapy Communication form was completed on 11/5/13. The nursing communication portion of the form documented the resident was showing a change of condition in the following areas: toileting, transfers, ambulation, falls, following directions, memory and safety/judgment. The therapy portion of the form communicated the resident may benefit from skilled therapy intervention of PT (physical therapy). According to a report the resident had a second fall on 12/7/13. The resident was found on the floor near the toilet in the resident's bathroom. Resident #79 stated s/he was attempting to transfer and fell . The intervention on the plan of care for 12/7/13 was to offer toileting every 2 hours. A third report dated 1/1/14 stated, the resident was found by staff after being heard yelling for help. The resident was on the floor in the residen's bathroom. The resident stated she fell while trying to transfer to the toilet. Intervention dated 1/1/14 on the plan of care was for toileting before and after meals and if patient refuses re-offer 1 hour later. On 1/27/14 Resident #79 stated no one had offered to help him/her with going to the bathroom after lunch. On 1/27/14 Nursing Assistant (NA) I stated Resident #79 toilets on his/her own, We try to catch (the resident) to help but usually (s/he) goes herself. (S/he) usually makes it to the toilet without a problem. At 2:09 p.m. the resident was observed exiting the bathroom on his/her own with no staff present. The resident then stood behind and pushed his/her wheelchair to the wall opposite the bed and walked back to the bedside unassisted. At 10:29 a.m., Licensed Nurse (LN) J stated the resident does self-toilet but s/he should have assistance, Her stability isn't that great. At 1:08 p.m., the Director of Nursing (DNS) stated, a toileting program would be done individually. If s/he had another fall in the bathroom we might do 1 hour checks, a safety device and as a last resort any kind of alarm. The Interdisciplinary Team (IDT) reviews falls so it's not just one person making the decision. At 1:12 p.m. LN F stated, the resident had been fairly independent before some functional decline. If the resident were to have another fall the IDT would be involved and work with restorative and therapy to try to help with safety. At 4:09 p.m. the DNS, stated that s/he self-toilets so we wouldn't have her on a toileting program and no ambulation and transfer programs are needed, the residents gate is stable. S/he doesn't need anything else, s/he is on active ROM, and I have the resident going every day. We are waiting for an orthopedic consult, now that I think of it that would be an ambulation issue. . |
| F 0328<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Properly care for residents needing special services, including: injections, colostomy, ureostomy, ileostomy, tracheostomy care, tracheal suctioning, respiratory care, foot care, and prostheses**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>. Based on observation, interview and record review, the facility failed to ensure 1 of 2 residents reviewed (#58) received proper nursing care and treatment for [REDACTED]. Failure to implement care and treatment place Resident #58 at risk for decline. Findings include: 1) Resident #58 was admitted to the facility on [DATE] with multiple medical [DIAGNOSES REDACTED]. According to the Minimum Data Set, (MDS), an assessment instrument, dated 3/29/13, the Resident required extensive assistance of one staff person for all personal hygiene activities. On 1/22/14 at 11:00 A.M., the Resident's spouse state: She needs good oral care so all the (dental) work done won't be wasted. The spouse told staff of the need for the Resident to receive good oral care. Examination of the Resident's teeth with Licensed Nurse (LN G) on 1/24/14 at 11:35 A.M. revealed extensive upper and lower bridge implants and some natural teeth. The LN was new to the facility and stated she was not aware of the Resident's dental status and was unable to find more documentation in the record regarding the necessary care was provided. The care plan, initiated on admission and updated through March 2014, indicated the resident required physical assistance with oral care but current documentation was not provided to include direction to staff regarding the resident's extensive dental/oral care needs. . |
| F 0329<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>. Based on interview and record review, it was determined, the facility failed to provide necessary medication monitoring for 2 of 5 residents (#74, 161) reviewed for unnecessary medication. This failure placed residents of experiencing negative side effects of medications and/or an increase in falls. Findings include: <Resident #74> Resident #74 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident's Minimum Data Set (MDS), an assessment tool, dated 12/11/13<br>indicated the resident required supervision to extensive assistance with activities of daily living. The resident's Medication Administration Records (MAR) for December 2013 and January 2014 indicated Resident #74 had received [MEDICATION<br>NAME] 50 mg, Atorvastatin 5 mg, [MEDICATION NAME] 25 mg, and [MEDICATION NAME] 5 mg, all of which are heart medications<br>with side effects of dizziness and/or drowsiness. The resident's December MAR indicated the resident was given [MEDICATION |

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| F 0329<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 5)<br>NAME], an anti-psychotic medication with a side effect of postural [MEDICAL CONDITION], (a form of low blood pressure that happens when you stand up from sitting or lying down and can make you feel dizzy or lightheaded.) The resident was administered [MEDICATION NAME], an anti-depressant with a side effect of dizziness and [MEDICATION NAME], an anti-anxiety<br>medication with side effects of [MEDICAL CONDITION], dizziness, and confusion. On 1/27/14 at 2:52 p.m., The Director of Nursing Services stated residents taking psychoactive medication should have orthostatic blood pressures (BP) taken monthly to monitor for postural [MEDICAL CONDITION]. On 01/29/14 at 11:55 a.m., Licensed Nurse (LN) B stated, per facility policy, residents taking psychoactive medication are required to have an orthostatic BP taken monthly and stated sometimes more often. The LN stated a resident's MAR would indicate if an orthostatic BP should be done. The surveyor and LN B reviewed Resident #74's MAR and the LN confirmed a monthly orthostatic BP was not listed on the Resident #74's MAR. <Record Review of Falls for Resident<br>#74> On 12/18/13, a resident stated that Resident #74 staggered in, grabbed the door handle and fell on to his knees. Resident #74 indicated his knees buckled and he went down. On 12/20/13 - staff heard a noise and found the resident on the floor. On 01/06/14 - the resident was found on the bathroom floor. On 01/26/14 Resident #74 was found in the bathroom on the ground. A progress note indicated the resident attempted to use the bathroom, felt dizzy, lost his balance and fell . <Resident #161> Resident #161 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident's MDS, dated [DATE] indicated the resident was moderately cognitively impaired and required extensive assistance with dressing and personal hygiene and supervision for other activities of daily living. Record review showed Resident #161 had been taking [MEDICATION NAME], an anti-anxiety medication with side effects of dizziness, unsteadiness and [MEDICAL CONDITION], and Risperdone, an anti-psychotic medication with a side effect of orthostatic [MEDICAL CONDITION]. The resident's Mood and Behavior Symptom Care Plan listed an intervention to monitor for [MEDICAL CONDITION] and have orthostatic BPs taken. January physician orders [REDACTED]. As of 01/27/14, an orthostatic blood pressure had not been taken in January and was not listed on the TAR as a treatment to be completed in January. Orthostatic blood pressures were listed on the resident's December MAR and were completed weekly. On 1/27/14 at 11:06 a.m., LN G stated, The resident should still be getting orthostatic blood pressures. The LN reviewed the TAR and stated it had not been done in January. The LN confirmed the only treatment order located in the resident's January TAR was for pain management. . |
| F 0371<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Store, cook, and serve food in a safe and clean way**<br><br>. Based on observation, interview and record review, it was determined the facility failed to store and serve food in a sanitary environment and failed to serve meals at the proper temperatures. These failures placed residents at risk of consuming contaminated food and potential weight loss due to meals being served at inadequate temperatures residents found to be unappetizing. Findings include: <DINING ROOM> On 1/28/14 at 11:45 a.m, meal service in the assisted dining room was observed. Nursing Assistant (NA) I came directly from the kitchen with an insulated warming plate for Resident #63. The warming plate was not warm and the food temperatures were checked. The mashed potatoes and gravy were 110 degrees F; the pork chop was 84 degrees F, the cooked cabbage was 100 degrees F. Since the hot food was served directly from the kitchen to this nearby dining room and was found to be below the 135 degrees F serving requirement, NA I went to the kitchen to retrieve another tray. This tray was not Resident #63's ordered diet so all the pureed food on this tray was immediately checked with the Administrator present. The insulated warming plate was barely warm. The pureed meat was 120 degrees F; mashed potatoes and gravy were 118 degrees F and the cabbage was 120 degrees F. The NA went to the kitchen to retrieve another meal for the resident. The warming plate was barely warm. When asked if the food was hot enough, the resident stated not really, mildly warm.and the meat is too tough to eat. During interviews with Residents #'s 73, 94, 105 and 109, all commented about cold food. Review of the Resident Council Meeting Minutes for November 2013 and January 2014 indicated residents had reported cold food.<br><br><KITCHEN> On 01/21/14 at 9:25 a.m., dry commodities, including sugar and flour in the food storage area were observed to be stored without a lid/cover. When asked where the lids were, Kitchen Staff (KS) 1 stated the lids had been taken off for cleaning and were drying on a rack outside. Surveyor observed the lids being air dried outside of the building. At 9:30 a.m., KS 2 stated the lids had been taken off for cleaning about 30 minutes prior as part of a deep cleaning. On 01/28/14 at 11:32 a.m., the surveyor observed uncovered pudding, cake and apple crisps placed on an open storage rack. The food items were not covered and were approximately ten inches above the floor. At 11:43 a.m., the Registered Dietician (RD) stated the uncovered food was too close to the floor and stated, It is a high traffic area, those should be covered. At 11:52 a.m. KS 1 stated the trays are usually not that full and we don't normally need to place food on the bottom shelves. When asked about the 01/21/14 observation of the uncovered flour and sugar, KS 1 stated they don't cover the flour and sugar while the lids are being washed. Uncovered food items are at risk of exposure to airborne contaminants and pests. Improper drying of dish/food storage lids in undesignated drying areas, such as outside, may cause exposure to contaminants. . |
| F 0431<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.**<br><br>Based on observation and interview, it was determined the facility failed to store medication under sanitary conditions in 1 of 2 medication storage areas and 3 of 5 medication carts. This failure placed residents at risk exposure to medication that was not sanitary and increased the chance of the spread of infectious organisms. Findings include: On 01/24/14 at 10:53 a.m., medication cart on 400 hall B was observed to have multiple dried white particles along with dust and dried medication. Hair was found on top of cart with marks of dried spills. LN K stated, the medication cart drawers are not clean and the top of the cart needs a good cleaning. At 11:09 a.m., medication cart on 300 Hall A had dried reddish sticky spills with paper stuck to it in the bottom of the third drawer (third from the top). LN L stated that it was probably Geri-tussin and he should probably clean the medication cart because it was dirty. At 11:25 a.m., medication cart on 500 hall was observed to have thick dark brownish debris under a metal divider in the second drawer from the top. The bottom of the third drawer had whitish powder along with a hair and a silver plastic medication wrapper. LN J stated that usually night shift cleans the medication cart. When asked what the whitish powder was, LN J stated, They (staff) must be pouring Miralax powder over the open drawer. The cart (medication cart on 500 hall) is dirty and I try to clean it but it takes time and I'm busy with residents. At 11:40 a.m., the following were observed in medication storage room on 500 hall: refrigerator had dust debris and particles with some dried yellowish thick sticky solution on bottom in the refrigerator next to the wall. LN J stated, It's like something fell from the top shelf like the thickened apple juice. A big rusty colored spill was noted between refrigerators in 500 hall medication storage room. At 11:50 a.m., medication cart on 300 B hall had large dried particles from pinkish colored liquid along with dust and debris. LN A stated, That's probably from dried Phenytoin liquid. At 12:08 p.m., ADM and LN B were shown the medication carts on 300 hall B, 500 hall and medication storage room on 500 hall. LN B stated that medication carts should be deep cleaned once a month and then every week checked for expired medications. LN B stated, There's been improvement but could use some fine tuning. . |