STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505319	A. BUILDING _____ B. WING _____	08/15/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANOR CARE HEALTH SERVICES	3701 188TH STREET SOUTHWEST LYNNWOOD, WA 98037

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F 0309 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide care and services for highest well-being for one of one resident (#1) reviewed for pain management. Although some initial interventions were implemented, the facility failed to thoroughly assess the etiology of the resident's pain and functional limitations. Failure to perform complete ongoing pain assessments and develop appropriate nursing and treatment interventions delayed timely treatment for [REDACTED]. These failures caused harm to Resident 1 by not being able to have satisfying or sufficient pain relief so she could participate in turning and repositioning. Findings include: Review of a policy flowchart titled Pain Practice Guide Flowchart (boxes with lines attaching to other boxes) on 8/4/16 at 8:30 am, which the Administrator stated that staff use, began with the word Assess. Under Assess it directed staff to complete the Pain section of the Patient Admission / Readmission screen, the MDS (minimum data set) assessment and pain CAA (Care Area Assessment). The flow chart also indicated that after the CAA, staff were to plan care, implement and then evaluate. Review of the CAA showed that it was not a thorough assessment and consisted of being approx. three sentences, which did not follow the facility pain policy. On 8/15/16 at 12:15 pm, the pain policy that directed staff in detail, on how to handle residents with pain. The policy directed staff to use a pain scale of 0-10 to evaluate pain, (zero being no pain and 10 being the worst pain). Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The record showed an initial nursing note and an assessment indicated the resident was alert and oriented, and was able to communicate her needs. It was also noted that on admit the resident had no pain at that time, but would have pain with movement or position change. On 5/19/16, per the facility pain policy, a Patient Admission / Readmission Screen was completed by the Resident Care Manager (RCM). The Patient Admission / Readmission Screen showed that sections F - M were blank and had not been completed even though the resident indicated that she would have pain on movement. These sections included subjects: What exacerbated the pain, what relieved the pain, how the pain negatively affected daily life and non-pharmacological interventions that worked. These were all blank. The Patient Admission / Readmission Screen also included a section for a Pain Care Plan, which the RCM documented the goal for Resident 1 was to: express that pain management was within acceptable limits. One of the interventions was to: Notify the physician if the pain frequency / intensity was worsening or if current [MEDICATION NAME] regimen had become ineffective. Review of the progress notes and Medication Administration Records for 5/18/16 to 6/16/16, for Resident 1, showed inconsistencies of a pain management program. For example, the resident was admitted on [DATE] and on 5/19/16 a progress note indicated the resident had no pain at the time of interview, but the resident reported that if she were repositioned her pain could become a 5 to an 8 on a pain scale of 0 - 10. The Flow chart did not direct staff how to document or assess to determine if the resident reached her goal of no pain. A review of the progress notes showed that when a pain pill was given for pain, the Licensed Nurses (LNs) would not do a thorough assessment of how the resident responded to the intervention. Instead they would document effective or ineffective and not use 0-10 as directed in the facility pain policy. Review of physician's orders [REDACTED]. Give 1/2 tablet every 6 hours as needed for a pain level of 3-6 or. Give 1 tablet every 6 hours as needed for a pain level of 6-10. Tylenol 500 mg every 4 hours as needed for pain. [MEDICATION NAME] apply to back one time per day for back pain. There was no documented clarifications on what to do if the resident's pain level was 6, considering both orders included a pain level of 6 and the pain policy did not direct staff on what to do. There was also no clear directions on when to give Tylenol vs. [MEDICATION NAME]. Progress notes dated 5/19/16 to 6/19/16 also showed that the resident's pressure ulcer was not progressing as planned along with her pain escalating. On 5/24/16, a Weekly Skin rounds note indicated the resident's wound had increased and the resident preferred be flat on her back due to pain (see F 314). There was no documentation of an intervention or change in care planning to resolve the resident's pain, even though they documented they encouraged her to be out of bed more. Review of the care plan showed that the goals for the resident's pain were that the resident would express pain management was within acceptable limits, the resident's pain goal was 0 and Pain or [MEDICATION NAME] would not affect the resident's participation in activities of daily care. There was no documentation to show this happened. The care planning goal was for the resident to have zero pain and nowhere in the progress notes was there any documented assessment after administration of the pain medication where the resident was at zero and able to function or that the [MEDICATION NAME] or medications were relieving the pain. Instead documentation showed that the resident would not move or reposition due to pain. In another part of the care plan documented under Behaviors the resident was resistive or noncompliant with treatment, care or getting out of bed, or allowing staff to reposition her related to: Pain or the belief that the treatment was not needed or working. The interventions did not address the pain, instead indicated the resident had behaviors instead of pain. On 6/6/16 Resident complained of level 6 pain at the sacrum after the dressing change. The LN administered [MEDICATION NAME] even though the care plan directed staff to adjust times of treatments after pain medication was given and had taken effect. On 6/9/16 a care conference was documented in the progress notes with the resident and family present. There was no documentation regarding the resident's repositioning, or pain management program. Review of a Pain Evaluation dated 6/13/16, four weeks after the resident was admitted , showed that the resident reported her pain at a 10, but there was no revisions to her pain plan. 6/13/16 notified physician of resident's pain from back. Requesting orders for routine pain medication (in addition to the as needed pain medication orders) There was no documentation of any medication changes until 6/15/16. Review of the MARs for June of 2016, showed that even though the resident reported her pain at a level 6 or even a 10 on 6/12, she was given Tylenol. On 6/16/16 an LN documented, the resident was transferred to the hospital for treatment. On the same day another entry indicated the resident's pain meds had been increased to address the resident's increasing pain. On 6/17/16 the Social Worker (SW) documented a late entry, for an unknown date, that the resident was refusing to get out of

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0309 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) bed and reposition. The resident was made aware of the consequences of such behavior in affecting her home transition plan. There was no documentation by the SW as to any interventions in regards to the resident's pain. On 08/11/16, Resident 1's family member reported that every time she came to visit, the resident complained of pain. The family would report the pain to the LNs, but the family did not feel that the LNs responded appropriately. She would lie in pain for hours The resident called the family member one and reported that the head nurse had told the resident she was going to die if she did not move, but the resident stated that she was in pain. In an interview on 08/15/16 at 11:10 am, Resident 1 stated that she had been in horrible pain while at the facility. It was so bad that she could not move. She also stated that one nurse told her if she did not move she was going to die. A progress note date 6/13/16 showed that an RN documented that risks gone over with pt as to refusal of repositioning and getting out of bed up to and including death. The resident went on to say that after she was admitted to the hospital she was given pain medication and her pain was relieved. She also stated that she now is not having as much pain and is able to move and turn as needed. The prn narcotic pain medication orders indicated the medication was to be given based on the resident voicing a pain level/already having pain which did not necessarily mesh well with Resident 1's pain management plan of care intervention to adjust the times of ADLs (i.e. frequent turning/repositioning) and treatment activities so that occur after [MEDICATION NAME] benefits have been achieved. There was no documented indication whether a routinely administered pain medication, in addition to the [MEDICATION NAME], had been considered in terms of possibly achieving consistent management of Resident 1's pain, so that pain and/or the anticipation of pain did not interfere with movement and/or repositioning.
F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility failed to identify and/or prevent and treat pressure ulcers for one of three resident's (#1) reviewed for pressure ulcers. Failure to consistently implement individualized interventions to attempt to stabilize, reduce or remove underlying risk factors such as pain with movement and immobility, monitor the impact of interventions, and timely modify interventions for an existing pressure sore resulted in harm to Resident #1, who had significant worsening of her existing pressure sore. In addition, the facility failed to ensure consistent thorough wound assessments were completed for 2 of 3 sample residents (#2, and #3) which placed Resident 2 & 3 at risk for unrecognized changes in pressure ulcer status. Findings include: See also F 309 for additional information. Resident 1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. An initial nursing note and assessment indicated the resident was alert and oriented, was able to communicate her needs, and had a Stage 2 pressure sore on her coccyx (tailbone area). The resident had pain with movement and position change. The resident had no strength, required 2 person assist with bed mobility, and used a mechanical lift to get in/out of bed. The record also indicated the resident developed several other additional potential skin at risk factors which included a urine infection, treated from 5/2416 to 5/30/16. Episodes of diarrhea between 5/26/16 to 5/31/16. Wound measurements: On 5/18/16, the day of admit the facility documented the size of the wound was 2 cm x 0.8 cm. On 5/24/16 a wound round note indicated the wound area was 3 cm x 0.8 cm. It was also noted the resident declined to get out of bed most shifts and the resident preferred to lie flat on back due to pain (see F 309). On 6/2/16 during weekly wound rounds the facility documented the size of the wound as 3.1 cm x 0.8 cm. There was no weekly wound round note for the week of 6/5 to 6/11. On 6/13/16 during weekly skin rounds, there was a hugh increase, the facility documented the size of the wound was 8.75 cm x 6.8 cm and it was noted that the resident has refused to get out of bed or reposition, and prefers lying flat or go all day without repositioning (due to pain see F 309). Medical Practitioner The Medical Practitioner (MP) notes showed that on 5/19/16, 6/3/16, 6/6/16, 6/8/16, 6/13/16 the MP requested that nursing: Please nursing, assessment for skin issues On 6/13/16, when the wound was at its largest, the MP documented in a note, unable to visualize today due to dressing. There was no documentation that nursing was communicating with the MP about the wound getting worse until that day, even though they were documenting in the progress notes, but the MP continued to ask for an assessment. In addition, there was no documentation that the MP ever assessed the wound. In a progress note dated 6/9/16 during the evening shift there was a large amount drainage the wound bed was dark in color, the skin around sore was swollen. The LN shared concerns to physician for re-evaluation/treatment adjustment. A License nurse documented in a progress note dated 6/13/16 that they requested an order from the MP for the wound care center (WCC) to consult with the wound because the resident refused to get out of bed or to be repositioned, the resident spent all her time in bed and the wound was much worse. On 6/16/16 spoke to medical practitioner about plan for coccyx wound. Appointment with WCC 6/16 Phone call received that resident to be transferred to hospital for treatment of [REDACTED]. During an interview with 2 licensed nurses (LN A & LN B) on 7/15/16 at 1:15 p.m., the LNs were asked what a treatment order for 'Skin check for daily skin observation' entailed for a resident with a pressure ulcer. The LNs indicated that kind of order would include looking at the actual wound if the resident was scheduled for a dressing change/treatment to the wound. Otherwise, the order indicated an LN was to check to make sure the resident's wound dressing was in place and intact. LN A stated she would also look at the actual wound if she was unfamiliar with the resident to see what's there. The LNs said if they notice the wound getting worse, they would inform the facility managers, as the managers do the in-depth weekly skin rounds on residents with pressure ulcer/skin issues. Skin Check every evening shift for skin observation until pressure ulcer resolved: -The skin check was initialed as done 5/19 - 5/31. However, there were no daily nursing progress notes with mention/description of wound status, except for the weekly skin checks on 5/18 & 5/24. Check every evening for skin observation until pressure ulcer resolved: -The skin check was initialed as done June 1-15. However, there were no daily nursing progress notes with mention/description of wound status until 6/9/16 (except for the weekly wound rounds done on 6/2/16 & 6/13/16). An interview with a licensed nurse (LNC) on 6/29/16 at 11:30 a.m., the LNC indicated pressure ulcer management was difficult with regards to Resident 1. LNC said the resident came to the facility with an unstageable sore on her coccyx, and the resident didn't want to move, It could take 2-3 of us over 20 minutes to encourage her to sit on side of bed. We put an Alternating Pressure Mattress (APM) on her bed on admission due to having a pressure sore, and she also had special cushion on her chair. The resident could get up, but did not want to get up and out of bed. The resident often refused her dressing changes, and I talked to her several times regarding the need to move (reposition). The last time LN C discussed this with the resident, LN C said she really emphasized the possible negative outcomes from not moving and refusing to reposition. LNC said then Resident 1 ended up going to the hospital related to a low blood count and pressure sore. On 6/16/16 the progress notes showed a phone call was received from the resident's specialist for the resident to be transferred to hospital for treatment of [REDACTED]. Review of 6/16/16 hospital emergency department record indicated the resident had a sacral ulcer, Stage 4/unstageable with tunneling. The plan was for wound care consult, changes in current prn pain management as resident was with significant pain from the pressure ulcer, and plastic surgery for [REDACTED]. A 6/17/16 wound care consult indicated the pressure ulcer measured 9 cm x 8 cm x 3 cm (depth) with 100% slough. Although Resident 1 was totally dependent on staff for repositioning & needed tissue off-loading to assist with wound healing, there was no documented evidence that Resident 1's plan of care was consistently, adequately, and timely reviewed and/or revised when inconsistent or incomplete pressure off-loading (turning & repositioning in bed) and pain management plan related to repositioning were identified as ongoing concerns, and/or included consideration of whether the APM was

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F 0314 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) adequate to meet Resident 1's individualized needs, until the coccyx pressure sore was found to have significantly deteriorated (increased in size). RESIDENT 2 Resident 2's Minimum Data Set Assessment ((MDS) dated [DATE] revealed the resident had severe cognitive impairment, required extensive staff assistance with all ADLs, was at risk for developing pressure sores, and did not currently have any unhealed pressure sores. A Progress note dated 5/18/16 & 5/19/16 revealed Resident 2 had a sacral area redness with small open area. The physician was notified with an order to leave it open to air and monitor every shift. There were no further nursing notes regarding the sacral area redness/open area between 5/20 - 7/15/16, except a medical practitioner note dated 6/24/16 noted under physical exam for skin that per staffs has sacral ulcer. During an interview with LN D on 7/15/16 at 11:30 a.m., the LN stated Resident 2 did not currently have an open area on her bottom, but had small discoloration, never really had an open area. A 7/15/16 review of Resident 2's record did not indicate any electronic skin assessment form(s), skin alteration record and/or other documented evidence of ongoing thorough assessment of the 5/18/16 sacral open area with measurements/descriptive information (no information indicating whether the wound healed or not). On 7/25/16, a continued review of the resident's record revealed a 7/23/16 progress note that Resident 2 has open areas to her coccyx/sacral area measuring 1 cm x 0.5 cm and 2 cm x 1 cm red center with red and purple around the wound. During an interview with LN D on 7/25/16 at 2:15 p.m., the LN stated that Resident 2 was just found with an open area on her coccyx over the weekend. RESIDENT 3 Resident 3's MDS dated [DATE] revealed the resident was cognitively intact, required extensive staff assistance for most ADLs, was at risk for pressure sores, and did not have any unhealed pressure sores. Progress notes: On 6/21/16 documentation indicated Resident 3 had a sore on the right buttock that measured 1 cm x 1.5 cm, dark discoloration measuring 0.5 cm x 0.4 cm with a pink center; and sore on the left buttock measuring 2 cm x 2.5 cm. 6/24/16 L butt open sore pinkish red in color & R buttocks dry crusty skin. 6/26/16 R buttocks scant bleeding, pink & yellow center surrounding wound dry skin peeling & pink around; L buttocks with dry peeling skin. 6/29/16 progress note: L buttocks wound discoloration (resident) complained sore and c/o sore and painful area R buttocks pink center .scant drainage noted. A 7/1/16 progress note indicated the resident had a Left (L) buttock sore spot discoloration and dry skin peeling, and Right (R) buttocks open sore pink center and dry skin surrounding it. 7/16/16 buttocks sore spot (no further descriptive information). Review of the July 2016 Treatment Administration Record (TAR) revealed an order for [REDACTED]. On 7/25/16, there was only 1 skin sheet (Skin Alteration Record) observed in the unit treatment binder for Resident 3 with a single entry for 7/19/16 diagram circling the coccyx area noted as skin intact with peeling red skin. During an interview with LN D on 7/25/16 at 2:15 p.m., the LN stated that Resident 3 currently did not have an open area on her bottom, only peeling skin. Although there were TAR weekly skin assessments completed on 7/2, 7/9, and 7/16, there was no documented evidence of thorough assessments with detailed description(s) of both buttock areas indicating whether each buttock area had remained the same, worsened, improved, or healed between 7/2/16 - 7/18/16.