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 _____	05/17/2017

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

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)
F 0246 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide reasonable accommodation of personal preferences in 1 of 1 (271) resident reviewed for choices in bathing. This failure placed the resident at risk for compromised personal hygiene, psychological harm and a diminished quality of life. Findings include: Resident 271 was admitted to facility on 04/24/17 with [DIAGNOSES REDACTED]. The resident was non-English speaking. A review of the clinical record showed the resident was on a shower schedule for every Tuesday and Friday. The resident received showers on the following dates: 04/28/17, 05/9/17, 05/10/17, and 05/12/17. According to the facility schedule, the resident should have received showers on the following dates 04/25/17, 05/2/17, 05/5/17, and 05/16/17. The resident needs extensive assistance with bathing per care plan. There was no additional documentation to indicate why the resident had not received the scheduled showers. In an interview on 05/16/17 at 10:43 AM with the resident's family member, he stated the resident does not get enough showers. They were visiting with the resident during the weekend and he stated she was stinking. The family requested to have a shower for the resident but was told that the shower aide was not there and resident could not have a shower that day. In an interview on 05/16/17 at 11:17 AM with Staff T, Nursing Assistant (NA), she stated the NAs talked with the supervisor if more showers were requested by a resident or resident's family, but they needed to be scheduled with the shower NA according to their schedule in order to receive a shower. The aides would not give a shower to the resident since the shower aides were to complete that task. In an interview on 05/16/17 at 11:19 AM with Staff E, Licensed Nurse (LN), he stated the residents could tell a staff member if they wanted more showers and a form needed to be completed to add the resident to the shower schedule for additional showers. The NAs could use interpreter services to help determine the needs of the residents who did not speak English. In an interview on 05/17/17 at 11:50 AM, the DNS stated if a resident requested a shower on a different day other than the scheduled day, they should receive a shower. WAC 388-97-0860 (2)
F 0248 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide activities to meet the interests and needs of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to individualize and implement an activities plan for 1 of 1 resident (114). This failure placed the resident at risk for isolation and diminished quality of life. Findings include: RESIDENT 114 admitted to the facility on [DATE] with Left Sided Weakness from a Stroke and [MEDICAL CONDITION] (Inability to speak). In an observation on 05/09/17 at 11:01 AM, observed the resident lying in bed watching TV. At 2:35 PM, observed the resident lying in bed sleeping. In an observation on 05/10/17 at 09:16 AM observed the resident lying in bed watching TV. At 11:24 AM, observed the resident lying in bed watching TV. In an observation on 05/11/17 at 11:27 AM, observed the resident lying in bed watching TV. At 2:38 PM, observed the resident lying in bed sleeping. Activity calendar was posted on the wall. When resident was asked if he could see or read the activities program, shook his head. In an observation on 05/12/17 at 9:24 AM, observed the resident lying in bed watching TV. At 11:27 AM, observed the resident lying in bed sleeping. At 1:44 PM, observed peri-care with Staff A Nurses Assistant (NA). Staff changed resident undergarment and massaged resident's back and spoke with the resident briefly. The resident responded to staff member by holding the staff member's gloved hand and kissing her hand. No one to on activities was done during the resident's peri-care. In an observation on 05/15/17 at 8:33 AM, observed the resident lying in bed watching TV. At 2:14 PM, observed the resident in lying in bed sleeping. At 3:03 PM, observed resident lying in bed watching TV. In an interview on 05/15/17 at 3:09 PM, Staff D (NA), stated she has been working in the facility for a few years and was familiar with the resident's care needs. Staff D stated the resident was bed bound and when asked if the resident participated in any activities, staff D replied not that I am aware of. At 3:10 PM, Staff E, Licensed Nurse (LN) stated The resident pretty much stays in bed and does not get up much. When asked if the resident participates in activities, Staff E stated that he did not. 05/16/17 at 11:17:09 AM, Staff A (NA) who stated that the resident does not get up or participate in any activities. At 2:28:31 PM Spoke to Staff E (LN), stated the resident is bed bound and had never seen the resident involved in any individual or group activities. At 1:59:35 PM Staff F Activities Assistant (AA) stated for a residents who were verbal, alert and oriented sensory contact was made by, reading, puzzles, magazines, building blocks and ball toss etc. When asked how activities for non-verbal residents were scheduled, Staff F stated they tried to get to everyone when they could. When asked how they knew what kind of activity was needed for each non-verbal resident, Staff F stated they found out by trying different activities the resident would respond to. Staff F stated they did not have access to the resident's care plans or MDS (Minimum Data Set) to know what was preferable for the resident. Staff F stated they had tried to speak with Resident 114 who was unable to communicate his needs and there have not been any activities with the resident because of the resident's communication barrier. At 2:20 PM Interview with Staff G, Social Services Director (SSD) stated that the resident was an artist and a barber. Staff G stated that he was estranged from his immediate family but had a cousin who visited him from time to time and was also his primary guarantor. Review of the residents quarterly MDS dated [DATE], revealed the resident answered Very important to the following questions. 1. How important is it to you to listen to music you like? 2. How important is it to you to do your favorite activities? 3. How important is it to you to go outside to get fresh air when the weather is good? 4. How important is it to you to participate in religious services or practices? Review of the resident's Care Plan Progress Note dated 7/28/16 revealed the resident is receiving 1:1 visits with recreation one to two times a week. Progress note entry made on 1/26/17, stated the resident was receiving 1:1 visits with recreation

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

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 0248 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) three times a week. No other note regarding resident activity could be found in residents progress note. Documentation in the progress note did not define what type of recreation was implemented. Review of the One to One Activity/Recreation Program Documentation for May 2017 provided by the facility revealed the following: May 1, 3, 4, 8, 9, 12, 13, 14, 16 showed no activities for the resident were initiated. 05/02/17 showed (I) for independent activity for Television. 05/05/17 and 05/06/17 showed independent activity for television and visual stimulation. 05/07/17 showed activity for Passive socializing/conversing, Independent for television and passive visual stimulation. 05/10/17, 05/11/17 showed independent for television and passive socializing/conversing. May 15th showed passive for Socializing/conversing/visual stimulation and independent for television. Facility was unable to provide activity documentation for previous months. No other documentation was provided. WAC-388-97- -0940 (1)
F 0278 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure each resident receives an accurate assessment by a qualified health professional.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to accurately document resident's skin status on the comprehensive Minimum Data Set (MDS) assessments on 2 of 28 residents (67 and 199) reviewed for MDS accuracy. This failure to accurately assess and document skin status placed the residents at risk for unmet care needs and a decline in their condition. Findings include: RESIDENT 67 Resident 67 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident was hospitalized from [DATE]-04/27/17 for acute kidney failure and was readmitted to the facility on [DATE]. In review of the MDS assessment dated [DATE] it showed the resident was at risk for developing pressure ulcers and had surgical wounds. No other skin wounds were documented. In review of the clinical record it revealed a Patient Admission/Readmission Screen dated 04/27/17 documenting the resident had 2 left lower leg surgical incisions and a right lower leg open wound. In review of the care plan it was revealed no identified right leg wound or interventions. In an interview on 05/16/17 at 10:00 AM with Staff B, licensed nurse (LN), she stated there was no documentation of a wound on the right leg because it was not diagnosed as a venous stasis ulcer and treatment begun until the wound clinic's Advance Registered Nurse Practitioner (ARNP) had seen it on 05/02/17. Otherwise the wounds were listed as surgical until the [DIAGNOSES REDACTED]. RESIDENT 199 Resident 199 was admitted to the facility December 2016 with [DIAGNOSES REDACTED]. The resident was unable to move her legs and had limited movement in her arms. Per the Admission MDS assessment dated [DATE], the resident was cognitively intact and needed assistance of 2 or more staff to reposition or transfer to a wheelchair. The resident was at high risk for skin breakdown and the skin was intact. Review of the progress notes found: 12/24/16: sore on her left lower scapula (shoulder bone) and coccyx open and peeled off . 01/07/17: stage 2 on coccyx . There were no measurements of the scapula wound or the coccyx pressure ulcer in the clinical record. On 05/16/17 at 10:00 AM, the DNS was asked for documentation regarding the skin condition on the coccyx and left scapula. No further information was provided. WAC 388-97-1000(1)(b)(d), 2(l)
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 observation, interview, and record review the facility failed to ensure necessary care and services were provided to prevent the development of pressure ulcers in 2 of 3 residents (67 and 199) reviewed for pressure ulcers. Failure to timely identify and assess skin changes, follow and update the care plan and implement interventions to prevent skin breakdown caused harm to the residents who developed pressure ulcers. Findings include: Definitions of Pressure ulcer stages: Stage 3: Full thickness skin loss in which fat is visible in the ulcer. Slought and/or eschar may be visible. Stage 4: Full thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Unstageable Pressure Ulcer: Full thickness of skin and tissue loss in which the extent of tissue damage cannot be confirmed because it is obscured by slough or eschar Slough: soft, moist dead tissue. It may be white, yellow, tan, gray or green . Eschar: necrotic granulation tissue, muscle, fat tendon or skin. RESIDENT 67 Resident 67 was admitted to the factiliy on 04/07/17 with [DIAGNOSES REDACTED]. In the review of the admission Minimum Data Set (MDS) assessment it was documented the resident had no pressure ulcers on admit, however she had Moisture Associated Skin Damage (MASD) related to incontinence. The MDS also documented the resident was at risk for developing skin breakdown due to impaired mobility and incontinence of bowels. The MDS documented the resident was not on a turning/repositioning program. The Care Area Assessment (CAA) documented the resident required staff assistance to move sufficiently to relieve pressure over any one site. In the review of the Social Service Assessment and History form dated 05/09/17 it was documented the resident was alert and oriented to person, time, and place and had a Brief Interview for Mental Status (BIMS) score of 13 which showed she was cognitively intact. Review of the resident's care plan dated 04/12/17 revealed the focus problems related to skin as follows: 1: risk for alteration in skin integrity with interventions to include barrier cream to peri-area/buttocks as needed (prn), encourage to reposition prn, float heels as able; pressure redistribution device on bed and chair; to provide preventative skin care routinely and prn and to use pillow/repositioning devices prn. 2: left lower leg wound with interventions to administer treatment per physician orders, encourage and assist to turn and reposition prn, special mattress/cushion on bed/wheelchair, and to use pillow and/or positioning devices prn. 3: moisture related blanchable redness to coccyx with interventions to administer treatment per physician's orders [REDACTED]. Review of the Nursing Assistant (NA) Kardex, which directed the resident's care, revealed instructions to report new skin alterations, suspend heels, and to turn and reposition (FYI). No turning/reposition frequency was specified. On review of the NA task there was list no documentation of floating the residents heels or turning the resident found. Review of the clinical record revealed the resident was readmitted to the hospital on [DATE] for acute kidney failure. She readmitted to the facility on [DATE]. In the review of readmission MDS dated [DATE] it showed documentation the resident had no pressure ulcers. Review of the admission nursing skin assessment document no pressure ulcers or MASD. Review of the hospital records from 04/20/17 - 04/27/17 documented the resident's coccyx area was intact with no open areas. Review of the clinical records revealed the resident went to the Emergency Department (ED) on 05/05/17 for an evaluation due to declining health, poor oral intake and resident request to go to the ED. There was no documentation from the ED that the resident's skin was not intact upon discharge. There was no documented skin assessment found upon her return to the

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F 0314 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) facility. Review of the clinical record showed a nursing progress note dated 05/08/17 which documented staff had reported an open area to the coccyx. No further follow up or documentation of an assessment was found of the coccyx. Review of the clinical record revealed the wound care team identified a deep tissue injury (DTI) on the left heel on 05/09/17 during a skin assessment. There was no status documentation of the open area on the coccyx that was documented on 05/08/17. Review of the care plan showed it was not updated with the new problem of the heel DTI, wound care interventions, or protective boots. The Treatment Administration Record (TAR) was updated with the wound care procedure, but the procedure did not include monitoring the use of the protective boots, heel floating, or repositioning. Review of the nursing progress note dated 05/16/17 revealed the resident had 2 new open areas, one on the right buttock and the other open area on the left ischial area (lower buttock). The wound team assess and documented the right buttock wound as a Stage 3 pressure ulcer and the left ischium wound as a rash with an open wound bed. Wound care, a microclimate manager mattress overlay and a new temperpedic wheelchair cushion were ordered. Review of the care plan revealed it was updated on 05/15/17 with documentation of the new problem of open areas to the buttocks, but the left heel deep tissue injury was not addressed. Review of the NA Kardex (care directives) showed no updates on skin care or positioning for the coccyx wounds. In an observation done on 05/12/17 at 10:09 AM Staff A, Licensed Nurse (LN), performed wound care on the left heel ulcer. A dark purple color injury was observed on the posterior heel. The heels were floated and the prevalon boots were placed after the wound was done. The following observations of positioning were made on 05/15/17: 8:44 AM: resident in bed on back with heels bridged and boots on. 9:58 AM: resident in bed on back with head of bed elevated at about 30 degrees, heels bridged. 10:51 AM: resident in bed on back with head of bed flat, heels bridged. 11:38 AM: resident sitting up in wheelchair, prevalon boots on. 1:39 PM: resident sitting up in wheelchair sleeping. In multiple observations on 05/11/17, 05/12/17, 05/15/17, and 05/16/17 the resident was observed to be lying on her back or sitting in her wheelchair. No staff was observed entering the resident's room to encourage or assist the resident to shift her position when she was either in bed or up in her wheelchair. In an interview on 05/12/17 at 8:32 AM, Staff B, Assistant Director of Nursing stated that skin assessments were done weekly and kept at the nurse's station in a notebook. Wounds other than pressure ulcers are documented on the Skin Alteration Record. Pressure ulcers are documented on the Pressure Ulcer Scale for Healing (PUSH tool). The patient just developed the pressure ulcer on her heel this week so she had a new PUSH tool filled out by the wound nurse on 05/09/17. In an interview on 05/12/17 at 1:47 PM, Staff A stated the Nursing Assistants (NA) should be documenting that they are turning residents, floating their heels and putting their protective boots on. They do their charting in the kiosk and that information goes on the task sheet. In an interview on 05/12/17 at 2:14 PM, Staff C, NA stated the NAs don't chart if the resident's heels are kept elevated but we do chart repositioning in the task tab in the kiosk for residents on turning schedules. In an interview on 05/12/17 at 1:54 PM, Resident 67 stated the staff tried to keep her heels elevated with pillows but only turned her when she asked them to. I just got these boots to wear when they found that ulcer on my heel. My tailbone hurts from pressure, I don't know if it's open but it gets painful when I'm on my back too long. In an observation on 05/15/17 at 11:12 AM, wound care was observed to the buttocks area. The wound care was performed by Staff A, LN. Two open areas were observed, one on the right buttock and one on left ischial area (lower buttock area near crease of leg). The right buttock wound had reddened skin surrounding it. Both wounds were in common pressure point areas. During the wound care procedure Staff A. LN, stated these wounds are new, just noted today. We received wound care orders from the doctor and got the resident a new wheelchair cushion. In an interview on 05/15/17 at 2:30 PM, the Director of Nursing Services (DNS), stated that the buttocks wounds were new. She was not aware of the nursing progress note documenting an open area in the coccyx area on 05/08/17 and did not know why there was no follow up. She stated she would look to see if there was anymore documentation of the resident's skin other than the wound care nurses progress notes. She would also look for documentation of the resident being turned or repositioned. In an interview on 05/16/17 at 10:00 AM, the DNS, Staff B, and Staff D. The DNS stated the resident should be on a turn schedule. We are also getting a new mattress for her with climate control because she has so many comorbities and skin issues. Staff B stated the resident had gone to the Emergency Department on 05/05/17 for assessment and was there all day probably lying on her back the whole time but we should have been assessing her. No further medical documentation was provided during the survey. RESIDENT 199 Resident 199 was admitted to the facility December 14, 2016 with [DIAGNOSES REDACTED]. The resident was unable to move her legs and had limited movement in her arms. Per the admission MDS assessment dated [DATE], the resident was cognitively intact, needed assistance of 2 or more staff to reposition or transfer to a wheelchair, was at high risk for skin breakdown and her skin was intact. The Care Area Assessment (CAA) a tool used to assist in developing a care plan dated 12/21/16, identified the rationale for Care Planning for the prevention of pressure ulcers was that the resident was dependent on staff with bed mobility and new [DIAGNOSES REDACTED]. There was no skin issue at that time, but remained a risk for breakdown. The CAA also identified that devices that could cause pressure including an indwelling catheter tubing. A Care Plan was developed and included the following interventions: Barrier cream to peri area/buttocks as needed, observe skin condition with care daily, have a pressure redistributing device on bed, and provide preventative skin care routinely and as needed, use pillows and repositioning devices as needed. The Care Plan was revised on 12/27/16 to include no briefs in bed, chucks only when in bed. The care plan did not agressively document how the facility was going to ensure the resident did not develop skin breakdown. Discharge orders from the hospital directed facility staff to turn the resident every 2 - 3 hours overnight while lying in bed, and every reposition every 15 minutes for pressure relief when up in a wheelchair. The discharge instructions also identified the resident as a Patient at risk for: Pressure ulcers A review of the Nursing Assistant (NA) documentation found that during a 24 hour period for the 18 days of December the resident should have been turned 8 to 12 times. Documentation showed she was turned 1 time on 3 days, 2 times on 6 days, 3 times on 6 days, and 4 times on 3 days. There was no documentation of refusals. During the Month of January documentation showed the resident was turned 1 time on 1 day, 2 times on 8 days, 3 times on 15 days, 4 times on 6 days, and 5 times on 1 day. Documentation also showed that 15 times the same NA documented the resident refused to be turned by the same NA. Review of the NA task list directed staff to turn and reposition the resident every 2 to 3 hours overnight and when lying in bed. Review of the physician and nursing progress notes found on: 12/20/16 the resident complained of soreness on her tailbone, redness was noted. The LPN repositioned the resident at bedside to reduce pressure on her tailbone, but there was no other documented actions taken. 12/23/16 the physician documented the resident reported a sore on her right upper inner thigh. The physician observed it to be a 3 cm x 4 mm linear, pink, clear fluid filled, blister on her right upper inner thigh. The physician ordered antibiotic ointment to be applied two times per day for 7 to 10 days or until healed. 12/24/16 sore on her left lower scapula (shoulder bone) and coccyx (tailbone) open and peeled off There were no other documented interventions put into place. 12/25/16 .new areas of redness on R buttock. Dressing on L posterior shoulder and R medial thigh cleaned and dressing changed. 12/26/16 has redness on left side on brief line that requires monitoring and skin protectant barrier to prevent further breakdown.

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F 0314 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) A letter was written to the facility on [DATE], by a physician from the Harborview Medical center which stated the resident expressed a concern to me today that she begun to develop skin breakdown from her catheter tubing and in her sacral area. I would like to ask that you follow the utmost care to perform frequent repositioning and prevention of firm objects resting against her skin. She has poor sensation and cannot report if compression is damaging her skin.[MEDICAL CONDITION] from skin breakdown is a serious source of morbidity and mortality in spinal cord injury patients. 12/29/17 patient is being provided with wound care for a blister on upper right leg and on bottom side of rt lower half for redness. 01/02/17 pt has some redness and skin breakdown noted on the right side of bottom area, being treated with z-guard (a zinc oxide-white petroleum paste used to treat skin irritation by forming a barrier on the skin to protect it from irritants/moisture). 01/04/17 has a stage two pressure ulcer on her right upper thigh related to pressure from her foley cath. 01/07/17 stage 2 on coccyx .blister on front rt thigh 01/9/17 the Physician's Assistant Certified (PAC) documented to nursing: Please encourage patient to reposition often to avoid ulcerations (the resident needed a two person assist to turn) 01/13/17 dressing changed on open blister posterior right thigh . 01/18/17 the PAC documented: the resident was concerned about the pressure ulcers on her right hip and buttocks and does not want them to get worse. The PAC also ordered an approval for a wound care clinic consult. 01/19/17 wound on upper right thigh. Wound bed is 4 centimeters (cm) x 3 cm. Area was a blistered area that has now worsened and has an area of brown tissue in the center and slough noted to rest of wound. Depth unknown. 01/21/17 .Dressing change to the coccyx and tight thigh was done as well the wound on coccyx appeared black in the center and red around. Thigh wound was open with drainage and red. 01/21/17 the PAC documented: follow up visit regarding her pressure ulcers, states she was advised she didn't qualify for outside visit to wound care clinic, stated it had something to do with transportation. Will discuss with nursing to see how she can get transportation to the wound care clinic covered. 01/23/17 the PAC documented: she still requests to be able to go to the wound care clinic, per nursing, she does not qualify for transportation. I will discuss with the nursing supervisor to see if there are any options. 01/25/17 Wound team assessed resident's right upper back of thigh, area is an unstageable pressure sore, measures 4.0 x 2.0 cm, wound is 90% eschar and 10 % slough . 01/25/17 the PAC documented: Per resident, she was told she did not qualify for outside wound care visit, she asked to speak to the administrator. States the administrator and another person from corporate level told her she would be able to have outside visit to the wound care clinic and the facility would provide transportation. Hopefully, an appointment with the wound care clinic will be scheduled soon. 01/30/17 the PAC documented: states the wound care team has evaluated her right hip ulcerations and has initiated treatment. 02/07/17 wound team assessed resident's right upper back of thigh, area is an unstageable pressure sore, measures 4.0 x 3.0 cm with depth of 1.0 cm, wound is 100% mix of eschar and slough Measurements of the pressure ulcer on the posterior right thigh were documented weekly in the progress notes and on the Pressure Ulcer Healing Chart. There were no measurements of the scapula wound or the coccyx pressure ulcer in the clinical record. The facility did not provide further information regarding the scapula wound or the coccyx pressure ulcer. There was no decrease in size of the pressure ulcer prior to Resident 199's admission to the hospital. On 02/07/17 the resident was discharged to a hospital for fever and respiratory distress. Review of the 02/07/17 hospital admission/discharge records found Resident 199 had [DIAGNOSES REDACTED]. Upon admission to the hospital on [DATE], Resident 199 had an unstageable pressure ulcer to the right ischial tuberosity that had breakdown (down to muscle or bone) that was debrided at the hospital and was identified as a stage 4. There was also a second wound to sacro-coccygeal area. In an interview on 05/12/17 at 1:47 PM, Staff A stated the Nursing Assistants (NA) should be documenting that they are turning residents, floating their heels and putting their protective boots on. They do their charting in the kiosk and that information goes on the task sheet. In an interview on 05/12/17 at 2:14 PM, Staff C, NA stated the NAs don't chart if the resident's heels are kept elevated but we do chart repositioning in the task tab in the kiosk for residents on turning schedules. In an interview on 5/16/17 at 1:10 pm, at a current facility, the resident stated that she got the pressure ulcers while she was at the old facility. The one sore developed from the foley catheter drainage tubing that was about ½ inch long by ¾ of an inch and there was not much depth. The nurse on day shift looked at it and did not know what to do so after a couple of days they got the nurse practitioner. During the same interview the resident's husband stated they were getting scared about the wound not healing. They (staff) were not trying to turn her. By Februaary 1, 2017 there were two pressure ulcers. On 05/16/17 at 10:00 AM, the Director of Nursing Services, (DNS), and Staff D, Licensed Nurse, were interviewed. They said, when the pressure ulcer on the posterior upper right thigh was identified on 01/19/17, the Care Plan was updated to include daily skin observation, a wound team referral, and a new pressure reducing mattress was ordered. On 12/27/16 No briefs in bed, Chucks only when in bed were added to the Care Plan. The resident was hospitalized before the wound care team saw the resident and before the new pressure reducing mattress arrived. No further information was provided by the DNS. Resident 199 has been identified as being part of a past non-compliance. WAC 388-97-1060 (3)(b)
F 0315 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure 1 of 4 residents (67) reviewed for urinary catheters had medical justification for the continued usage. Failure to ensure there was adequate indication for the use and to plan for the timely removal of the indwelling urinary catheter placed the resident at risk for urinary tract infections and a decline in normal bladder function. Findings include: Resident 67 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. In the review of the admission Minimum Data Set (MDS) assessment dated [DATE] it was documented the resident had an indwelling urinary catheter (tube placed into bladder to drain urine) on admission. In the review of the physician's admission orders [REDACTED]. Review of the care plan dated 04/12/17 showed a focus problem of use of an indwelling urinary catheter with interventions to change catheter per physician order [REDACTED]. In review of the nursing progress notes and assessments no bladder assessment or evaluation was done. On multiple observations of resident from 05/09/17 through 05/16/17 the resident had a indwelling catheter in place. In an interview on 05/15/17 at 2:30 PM with the Director of Nursing, (DNS), she stated that yes there should be clarification of what is causing the [MEDICAL CONDITION] and medical justification for its continued use. It should be assessed. In an interview on 05/16/17 at 10:00 AM with the DNS she stated that she had looked at the hospital records and the catheter had been placed in the hospital to obtain accurate intake and output records. We got an order to discontinue the catheter and to do post void residuals (measure the amount of urine in the bladder after a person urinates) now. WAC 388-97-1060(3)(c)
F 0318 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Make sure that residents with reduced range of motion get propertreatment and services to**

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F 0318 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) **increase range of motion.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain and effective range of motion program for 1 of 2 resident's (114). This failure placed the resident at risk for further decrease in function of his Right arm, increase in Rihgt hand contracture and diminished quality of life. Findings include: RESIDENT 114 admitted to the facility on [DATE] with Right Sided Weakness from a Stroke and [MEDICAL CONDITION] (Inability to speak). The resident had limited use of his right right arm related to the stroke and had a contracture to his right (R) hand. In an observation on 05/11/17 at 11:27 AM, observed resident lying in bed. The resident's right hand was placed on his stomach with no splints or assistive devices in place. At 2:38 PM, observed the resident lying in bed with Right (R) arm and right hand contracture placed across his stomach, with no supportive devices in place. Observation of the resident's room did not reveal an exercise sheet staff were required to use for residents daily range of motion (ROM) exercises as directed by the care plan. In an observation on 05/12/17 at 9:24 AM, observed the resident lying in bed, R hand was placed over stomach with no assistive devices in place. Inspection of the resident's room did not reveal an exercise sheet staff were required to use to assist the resident with range of motion (ROM) exercises as directed by the care plan. At 11:27 AM, observed the resident lying in bed sleeping with R arm and R hand placed across his stomach. Resident was not wearing assistive devices and a room inspection did not reveal any ROM daily exercise sheet. In a peri-care observation on 05/12/17 at 1:44 PM with Staff G, Nursing Assistant (NA) the resident was observed lying in bed with right arm placed over his stomach with no assistive devices in place. Staff G proceeded to change the resident's undergarment, rub his back and asked how the resident was feeling. Staff G gathered soiled items and exited the room. Did not observe Staff G performing ROM exercises or place assistive devices to the resident's weak arm. In an observation on 05/15/17 at 8:33 AM, observed the resident lying in bed, with R hand placed across his stomach with no assistive devices in place. At 2:14 PM, observed resident in bed with R arm across stomach and no assistive devices in place. In a joint observation of the resident's room at 2:27 PM with Staff E, Licensed Nurse (LN), R arm brace or exercise sheet could not be located or found. In an interview on 05/11/17 at 11:40 AM, Staff K (NA) who stated the facility did not have a Restorative Program and NA's on the floor provided the residents with daily ROM exercises. Staff K stated that information regarding the ROM exercises was provided by the Kardex (care plan used by NA's). Staff K stated not having a restorative program and sometimes got in the way of providing ROM exercises. At 1:46 PM, spoke to Staff L, Director of rehab services who explained the process of how a resident is placed on a restorative or maintenance program. Staff L stated when a resident was released from the PT program, a maintenance care plan was designed for the nursing team to continue the recommended exercises. Nursing would then monitor the progress or decline of resident function, of which then a referral is made back to PT to reassess the resident for further intervention. Staff L stated the exercises were documented in the in the resident's care plan and Kardex (care plan used by the NA's) In an interview on 05/12/17 at 1:21 PM, Staff M (NA) who was able to show how interventions are carried out through the Kardex system where aides document daily ROM or interventions on the residents. In an interview on 05/15/17 at 2:18 PM, Staff I (LN) stated he thought the resident's arm brace was only worn when he slept. Stated he had never seen the arm brace or an exercise sheet. At 2:19 PM, Staff H (NA) stated she had never seen the resident wear a R arm brace and was not aware of any exercise sheet. At 2:40 PM, Staff N stated the arm brace was originally prescribed to prevent any further hand contractures and would provide documentation for the arm brace prescription. Review of the residents care plan showed the resident was to wear a right hand/arm brace. Care plan did not specify what the goal of the arm brace was. Care plan also stated Encourage and assist patient with ROM exercise twice a day (see exercise sheet in patient room or in patient chart). Review of the residents chart did not reveal an exercise sheet that staff was required to perform ROM exercises on resident's right hand contracture as directed by the care plan. Review of the NA Kardex did not show documentation of NA performing daily R arm ROM exercises, or placement of R arm brace. Review of the current Physicians orders showed an order for [REDACTED]. Review of the Occupational Therapy (OT) Evaluation and treatment dated 11/4/16 revealed that the resident was able to get hand and wrist to neutral with the exception of ring and small fingers. Note dated 11/11/16 revealed the resident was able to tolerate the positioning device to his R hand for 2 hours with no indication of discomfort. The note also stated the resident was placed on a restorative program on 11/11/16 and had made consistent progress with skilled intervention and use of orthotic device. WAC- 388-97--1060 (3)(d)
F 0329 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure 4 of 5 residents (67, 42, 44, and 114) reviewed for unnecessary medications were free from unnecessary medication due to the failure to monitor for target behaviors and side effects, to obtain informed consent, updated care plans and appropriate and timely assessments in place to ensure that residents were administered medication safely and at the lowest effective dose. This failure placed the residents at risk for unnecessary side effects, medical complications, and a decreased quality of life. Findings include: RESIDENT 42 Resident 42 was admitted [DATE] with [DIAGNOSES REDACTED]. The resident was receiving [MEDICATION NAME] (an antipsychotic) and [MEDICATION NAME] (an antidepressant). Review of the individualized care plan found Resident 42 had a history of [REDACTED]. Interventions included evaluating effectiveness and side effects of medications for possible decrease/elimination of [MEDICAL CONDITION] drugs. Review of the April and [DATE] Medication Administration Records (MAR) and Treatment Administration Records (TAR) found no monitoring of targeted behaviors or medication side effects. Review of progress notes found sporadic mention of behavior concerns. On [DATE] at 10:36 AM, Staff E, Licensed Nurse (LN), said the targeted behaviors were written in the progress notes. The Social Worker tracts it. Side effects are monitored for 72 hours after a medication is started. On [DATE] at 10:00 AM, Director of Nursing Service (DNS), said monitoring of targeted behaviors and monitoring for side effects should be on the TAR. RESIDENT 44 Resident 44 was admitted to the facility in [DATE] with [DIAGNOSES REDACTED]. The resident was being administered [MEDICATION NAME] (for depression), [MEDICATION NAME] (for anxiety) and [MEDICATION NAME] (for anxiety). Review of the care plan found the resident demonstrated behaviors including resistance/noncompliance with care, calling out, looking for a deceased spouse and looking for a purse. Interventions included observing for mental status/behavior changes when new medication started or with changes in dosage and evaluating effictiveness and side effects of medications for possible decrease/elimination of [MEDICAL CONDITION] drugs as needed. Review of April and May MAR's and TAR's found no monitoring of targeted behaviors or of side effects. Review of progress notes found sporatic mention of targeted behaviors.

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F 0329 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) On [DATE] at 10:00 AM, the DNS said monitoring of targeted behaviors and monitoring for side effects should be on the TAR. RESIDENT 67 Resident 67 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the clinical record revealed physician's orders [REDACTED]. The resident also had orders for [MEDICATION NAME] (a pain medication) which she received as needed for pain control. In the review of the clinical record it showed an informed consent signed for [MEDICATION NAME] dated [DATE]. The consent was signed by the resident's spouse however, the statement of consent was not marked as I DO consent or I DO NOT consent to the use of the drug. In addition, the drugs [MEDICATION NAME] and [MEDICATION NAME] were hand written on the same form even though they were ordered at a later date. The correct dates these medications were ordered were not listed on the consent nor was the correct drug class or side effects for the [MEDICATION NAME] identified. There also were no signatures from the resident or spouse on the dates those medications were ordered. In further review of the clinical record there was no Abnormal Involuntary Movement Scale (AIMS) assessment (a rating scale that measures involuntary movements, a known side effect of antipsychotic medications) done on the resident to establish a baseline when the [MEDICATION NAME] was ordered. Having a baseline of the resident's condition helps to ensure timely recognition for any adverse side effects to the antipsychotic medication. In review of the resident's care plan dated [DATE] the focus problem of depression/sadness was identified by social services (SS) on [DATE]. The care plan was not updated when the antidepressant and antipsychotic medications were added to the resident's treatment plan and did not address what side effects to monitor for. Additionally, the Medication Administration Record [REDACTED]. In the review of the clinical record it was also determined the resident had gone from [DATE] through [DATE] with no bowel movement. Constipation is a side effect of the [MEDICATION NAME] (pain medication) the resident was taking frequently to control her pain. The resident's care plan dated [DATE] identified an alteration in bowel elimination: constipation due to lack of exercise and medications as a focus problem. The goal was the resident would have a bowel movement at least every 3 days to notify the physician of any changes in bowel function. Review of the facility bowel protocol revealed the facility should give Milk of Magnesia (MOM) if no BM in 3 days. If no results in 6 hours give [MEDICATION NAME] suppository x1. If no results in 24 hours the facility was to notify the physician. There was no documentation in the record that the facility protocol was followed or the physician notified. In an interview on [DATE] at 1:23 PM with the DNS, she stated that if a resident doesn't have a bowel movement in 3 days the bowel protocol should be initiated. If no BM is charted for 3 days by the Nursing Assistants (NA) it automatically gets flagged on the clinical dashboard and the nurse follows up on the issue. She also agreed that the target behaviors and side effects of [MEDICAL CONDITION] medications should be documented consistently and on an ongoing basis. In an interview on [DATE] at 1:47 PM with Staff A, LN, she stated that when [MEDICAL CONDITION] medications are ordered the nursing staff gets the consent then the nursing staff does alert charting (charting every shift) for 7 days. We don't chart daily after that but we monitor for any changes when we are working with the resident and chart those changes in the progress notes and report it to the charge nurse. We don't use the MAR for that. With constipation management if the resident doesn't have a BM for 3 days an alert goes out in the electronic clinical record and the charge nurse is notified and should follow up. In an interview of [DATE] at 2:15 PM with Staff F, Social Services, she stated that when residents are started on [MEDICAL CONDITION] medications social services list target behaviors in the 24 hour book and then the staff charts in the progress notes for 72 hours or up to a week. After that there is not daily documentation unless something abnormal is noted with the resident. She also stated that AIMS tests should be done when an antipsychotic medication is first started then done quarterly. She was unable to locate an AIMS test in the resident's clinical record. In an interview on [DATE] at 2:30 PM with the DNS she stated they should be monitoring and documenting for target behaviors and side effects for residents daily as long as they remained on the medications, not just when they were first ordered. In an interview on [DATE] at 10:00 AM with the DNS, Staff B and Staff D, Staff B stated the consents for [MEDICATION NAME] and [MEDICATION NAME] should have been on separate forms and also agreed that a baseline AIMS should have been done when the [MEDICATION NAME] was first ordered, even though she had not received a dose of the drug. A baseline is still needed as it is to be given as needed for nausea. We did one on her yesterday and it's in the chart. I am also following up on the her not having a BM for 5 days with no bowel protocol started. In an interview on [DATE] at 11:08 AM with Staff B she stated she couldn't find anything on the bowels. The care plan and protocol weren't followed. RESIDENT 114 admitted to facility on [DATE] with a [DIAGNOSES REDACTED]. In an interview on [DATE] at 3:10 PM Staff O, Social Services director (SSD), stated an Inter-disciplinary team (IDT) met once a month to conduct a resident [MEDICAL CONDITION] meeting. Staff O stated the IDT consisted of a Pharmacy consultant, Social Services Director, Recreation director, Unit managers, Director of Nursing to discuss goals, clinical use, ongoing monitoring and dose reduction of resident [MEDICAL CONDITION] medications. In an interview and joint observation on [DATE] at 1:50 PM, spoke to Staff E to show Surveyor the [MEDICAL CONDITION] Drug monitoring tool called the AIMES test in the resident's chart. Staff E flipped through sections of the chart and could not locate the AIMES test. Staff E then asked Staff P from medical records who also flipped through sections in the resident's chart and stated she could not find the test. Staff P then stated that she would look elsewhere and provide documentation of the AIMES test later. At 2:40 PM, to Staff P who stated that she could not locate any of the AIMES tests and would consult with another nurse for it. At 2:48 PM, Staff Q, DNS who was able to locate AIMES test for the dates [DATE], [DATE] and [DATE]. When asked how often the AIMES tests were completed, the DNS stated that she was not sure but would find out. Also stated I just happened to find these AIMES test. At 2:57 PM, Staff E (LN) and Staff O (SSD) stated that the AIMES test should have been located in the chart but were not present. At 3:00 PM spoke to Staff Q, DNS who stated that the AIMES test should have been located in the resident's chart and was not sure why it was not available and was not sure what the policy was regarding completing AIMES tests. The DNS stated an AIMES for the month of August was located and would provide documentation to surveyor. At 3:19 PM, Staff P who stated that Staff R, DNS confirmed that the last entry made for the AIMES test was completed on [DATE] and there were no other entries completed after that date. At 3:41 PM, Staff Q, DNS stated that AIMES tests were completed every six months as stated on the AIMES form and stated they are completing one on him right now. Review of the residents care plan revealed that an AIMES testing was to be completed per facility guidelines. Reveiw of the resident chart showed there was no documentation available for a current AIMES test. Review of the AIMES test sheets revealed that the AIMES test was to be completed every six months Review of the resident's Medication Aministration Record (MAR) for the month of March, April and May revealed that the resident was taking the Anti-psychotic medication Aripiprazole. WAC-,[DATE]--1060 (3)(k)(i)
F 0334 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop policies and procedures for influenza and pneumococcal immunizations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer the pneumococcal (pneumonia) and influenza vaccines to 1 of 5 (143) residents reviewed for immunizations. Failure to provide influenza and pneumonia vaccines placed Resident at increased risk of acquiring, transmitting, or experiencing complications from respiratory infection. Findings include: Resident 143 Resident 143 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident 143 is over [AGE] years of age. Review of the medical record for Resident 143 showed signed consents for pneumonia and influenza vaccinations. However, no record of pneumonia or influenza vaccines given, nor a refusal or other explanation documented.

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F 0334 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 6) In an interview on 05/16/17 at approximately 3:15 PM, Staff E, Licensed Nurse, stated I am not able to find any documentation that resident 143 received any immunizations here at facility or prior to admit to facility. WAC 388-97-1340
F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to employ accepted standards of infection control practices for 1 of 1 (132) resident reviewed for isolation precautions. Failure to protect the resident with risk factors, by cohorting (sharing a room) with a resident on contact precautions, placed the resident at increased risk of contracting the infection. Findings include: Resident 132 was admitted to the facility in January 2017 with [DIAGNOSES REDACTED]. The resident was readmitted on [DATE] after being hospitalized for [REDACTED]. The resident had risk factors placing him at increased risk of acquiring infections including ESRD requiring dialysis, decline in nutritional status, and an indwelling device (urinary catheter). Review of the Centers for Disease Control (CDC) recommendations for contact precautions with patients with known or suspected Methicillin Resistant Staphylococcus Aureus (MRSA) colonization or infections stated patient placement in Long term Care Facilities should use single rooms when available, cohort patients with the same MRSA infection in the same room, or place patients in rooms with patients who are at low risk for acquisition of MRSA and associated adverse outcomes. In general, in all types of healthcare facilities it is best to place patients requiring Contact Precautions in a single room. The recommendations further stated if unable to cohort with another patient with same organism the other option is to place an infected patient with a patient who does not have risk factors for infection. Review of the article Aspects of Immune Dysfunction in End-stage Renal Disease published August 2008 in the Clinical Journal of the American Society of Nephrology showed that ESRD is associated with significantly increased morbidity and mortality resulting from infections. It further stated this may be possible this is linked to alterations in the immune system in ESRD. The article further stated the the major causes of death in ESRD patients are cardiovascular disease and infections. Review of the progress notes revealed the resident's orientation would vary for confused to oriented to self and day. Progress notes documented resident often stayed in room all day in wheelchair, in bed, or would move about the facility in his wheelchair independently. Review of the care plan revealed the following focuses: 1: Risk for increased agitation and confusion due to underlying [DIAGNOSES REDACTED]. 2: Nutritional status as evidenced by actual weight loss related to inadequate intake with altered mental status 3: Use of Secure Care Bracelet due to increased confusion and independent mobility with wheelchair. 4: Self care deficit related to physical limitations and [DIAGNOSES REDACTED] require assist with toileting, daily hygiene. Uses wheelchair for locomotion. In multiple observations throughout the survey resident was observed up in his wheelchair in his room or in the hallway. The resident was observed to pass by his roommate's bed, often touching the bed frame, mattress or bedding as he passed. The resident's roommate was observed throughout survey in bed on top of covers with dressings on his lower extremity or up in his wheelchair. In an interview on 05/15/17 at 2:40 PM with the Director of Nursing Services (DNS), she stated that Resident's 132 roommate was on contact precautions for MRSA in his lower extremity wound. She stated that normally they do not allow residents with draining wounds or stool that is hard to contain to share rooms but in this case the wound drainage was contained. I know that (Resident 132) is on dialysis and has a indwelling catheter but because his roommate's wound drainage is contained it's fine. In an interview on 05/16/17 at 2:33 PM with Staff S, Licensed Nurse (LN), he stated Resident 132 and his roommate did share a bathroom and the resident would sometimes go in there alone. His roommate has MRSA in his wound and they are now moving him to another room. He is still on contact precautions. WAC 388-97-1320 (2)(b)