STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505473	A. BUILDING _____ B. WING _____	03/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSITY PLACE REHABILITATION CENTER	5520 BRIDGEPORT WAY WEST UNIVERSITY PLACE, WA 98467

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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide medical treatments as ordered and as considered safe nursing practice for two of five residents (Resident #'s 37 and 431) reviewed for treatment administration. This failure placed residents at risk for worsening of condition and possible infection. Findings included . RESIDENT #37 Resident #37 had been a resident in the facility since July 2019. In an observation on 03/14/20 at 1:00 PM, Resident #37 had dry, flaking skin around his hair, on his face, and in his beard. In an interview on 03/14/20 at 1:05PM, Resident #37 stated the doctor had prescribed him a medicated shampoo to help the dryness and itching. Resident #37 said he was directed to use the shampoo two times each week, on his shower days that were scheduled for every Tuesday and Friday. In the same interview, Resident #37 stated he had not been consistently using the shampoo because he had not been receiving his showers. Resident #37 stated he had not had two showers in the same week during the entire nine months that he had been in the facility. Resident #37 stated he usually he did not receive the scheduled Tuesday shower, and that sometimes staff would tell him they would be back before lunch to do it, but then never return. Additionally, Resident #37 stated he did not receive the shampoo for a two week period at the end of February and beginning of March because staff could not find his bottle of shampoo. Review of Resident #37's medical record showed a physician's orders [REDACTED]. The physician documented the shampoo was to treat seborrhea [MEDICAL CONDITION], a skin disorder that causes the skin to be red, scaly and itchy. An observation on 03/14/20 at 1:30 PM showed the medicated shampoo was sitting on a table in Resident #37's room, labeled with his name and the physician's directions. Review of Resident #37's Treatment Administration Record (TAR) for February and March 2020 showed nursing staff had been documenting their initials every Tuesday and Friday, indicating the shampoo treatment had been done two times each week as ordered. Review of Resident #37's medical record showed the Kardex, where staff documented when a resident received a shower. When reviewed on 3/18/20, Kardex would only show showers given over the previous 30 days. Of the previous 30 days, Resident #37 had only received four showers (one shower per week). The Kardex did not have documentation that Resident #37 had ever been offered an additional shower or that he had ever declined. In an interview on 3/19/20 at 9:35 AM, Staff O, Registered Nurse/Resident Care Manager (RN-RCM), was asked why nursing staff had documented administering the medicated shampoo eight times in the past 30 days, but the resident had only received four showers. Staff O, RN-RCM, stated she would interview staff, as the charting between the nursing staff and nursing assistants did not match. In an interview on 3/20/20 at 9:00 AM, Staff O, RN-RCM, stated she had interviewed nurses who initialed administering the medicated shampoo and found that they were documenting that it was being given even though they had not checked to ensure it was actually done. Staff O, RN-RCM, stated the nurses involved would receive disciplinary action and education related to medication administration and documentation, as well as nursing assistants being educated on ensuring all showers are being offered and completed as directed in the resident's plan of care. Nursing staff documented that they were providing a treatment as prescribed by the physician, without actually providing, and assumed that a different staff member was doing it without confirming the treatment was done while in the shower. This failure of professional nursing practice placed Resident #37 and risk for continued symptoms on red, flaky, itching skin on his face and head, which also placed him at risk for decreased self-esteem. RESIDENT #431 Review of the admission Minimum Data Set (MDS, a required assessment tool) dated 12/20/19, showed that Resident #431 admitted on [DATE] and was receiving intravenous (IV) medications. Review of the March 2020 physician orders [REDACTED].#431 had a peripherally inserted central catheter (PICC) line (IV access that can be used for long periods of time to administer fluids, medications and other substances into the blood stream), and that the dressing was to be changed in the facility every week and as needed. Review of the March 2020 medication and treatment administration records showed that the PICC dressing change had been signed off by the nurse as being completed on 3/19/20 at 10:45 AM. An observation on 3/19/20 at 12:55 PM showed Resident #431's PICC dressing was dated 3/11/20. In an interview on 03/19/20 at 1:00 PM, Staff O, RN-RCM, stated that the nurse should not have signed that the PICC dressing had been changed if it had not been done. WAC Referrence 388-97-1060 (3)(b) .
F 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide activities to meet all resident's needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to deveop adequate assessments with a care plans, based on the assessments, and provide activities as identified in the assessments and care plans for two of four residents (Resident#s 12 & 1) reviewed for activities. This failure placed the residents at risk for isolation, impaired mood and a decreased quality of life. Findings included . RESIDENT #12 Resident #12 admitted to the facility in April 2019. In an interview on 3/15/20 at 12:49 PM, Resident #12's family member reported she had never seen Resident #12 involved in activities in the facility. Daily observations of Resident #12 showed she was in bed, per her preference, but did not have music or television on. Review of Resident #12's Minimum Data Set (MDS, an assessment tool) dated 09/22/19, showed an activities assessment had been completed. The MDS indicated it was very important to Resident #12 to have books, magazines, and newspapers. Additionally, the MDS indicated music was very important to Resident #12, that she did not care for group activities, and doing her favorite activities were also very important to her. Review of Resident #12's medical record showed activities assessments that were done when she admitted to the facility in April 2019, and then quarterly since. The most recent assessment dated [DATE] indicated Resident #12 prefered activities in her room and being in bed watching TV. Review of Resident #12's record showed a progress note dated 04/12/20 which stated that Resident #12 enjoyed television and musicals. Review of Resident #12's activity care plan dated 04/05/20 (potential typo as the date is in the future) and last revised on 1/15/20, showed a goal of participating in activities. The interventions included, modify daily schedule to accommodate activities, may leave activities at any time, is able to make her needs known, and resident needs assistance to activities. Review of the most recent activities assessment dated [DATE] indicated Resident #12's activity care plan had been reviewed. The assessment indicated the interventions were effective at reaching goals, and remained appropriate. In an interview on 03/18/20 at 9:15 AM, Staff O, Activities Director (AD), stated that Resident #12 did not like to do any activities that involved her getting into her wheelchair. Staff O, AD, explained that Resident #12 got anxiety when up in her chair so she did not like to attend activities. Staff O, AD, was asked if it was possible to do activities with Resident #12 in her room. Staff O, AD, stated activities staff could do things with Resident #12 in her room and should document the activities. An observation on 03/14/20 at 9:45 AM, showed Resident #12 was lying in bed, wearing a hospital gown. There were no books or magazines on her bedside table. There was a book on her nightstand, however it was not in her visual field and was out of reach. The television was not on, and no music in the room. An observation on 03/17/20 at 1:00 PM, showed Resident #12 laying in her bed, talking, repeating the same phrase. No TV or music in room. The book and magazine remained on the night stand out of line sight and out of reach. An observation on 03/18/20 at 9:35 AM, showed Resident #12 in bed asleep wearing a hospital gown. Her TV was not on, the book and magazine remained on the nightstand out

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 0679 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) of sight and out of reach. The sound from her roommate's television could be heard, but the privacy curtain was pulled closed between them, keeping her roommate and the television out of sight. An observation on 03/19/20 at 11:03 AM, showed Resident #12 in bed. There was no television or music in the room, the privacy curtain was pulled closed so her roommate was out of sight. There was a book on her night stand which was out of sight and out of reach. Review of Resident #12's record showed a section Kardex where staff documented activities. The Kardex showed activities done over that last 30 days, divided into three categories: group activities, one to one activities, and independent activities. The Kardex showed the following for the last 30 days: One to one activities - no documentation Group activities - 2/22/20 Bingo -resident was not available 2/26/20 Music - resident actively participated 2/29/20 Bingo - resident refused Independent activities - one day marked TV/Video. All other days were marked resting/relaxation. The Kardex showed, in the previous 30 days, Resident #12 was only offered an activity that involved interaction on three occasions, two of the occasions were for BINGO, a group activity, that Resident #12's MDS assessment showed she did not like. Resident #12 had an activities care plan that did not include the activities that had been identified as her favorites. The 30 day look back of Resident #12's activities showed she had only actively participated one time, during music, which was identified as one of her favorite activities. There was no further documentation to show Resident #12 had ever been offered activities since. Failure to provide activities that are important to the resident placed her at potential for isolation and decreased quality of life. Review of the admission MDS dated [DATE], showed that Resident #1 admitted on [DATE] with [DIAGNOSES REDACTED]. The Care Area Assessment (CAA, a required care planning tool) done with the MDS, dated [DATE], showed that Resident #1 was assessed for her activity preferences and that a care plan specific to Resident #1's activity needs would be completed. Review of Resident #1's medical record on 3/17/20 showed no additional comprehensive activities assessment, apart from the MDS, was completed. Review of Resident #1's care plan on 3/17/20 showed no activities care plan had been completed. During an interview on 3/17/20 at 1:12 PM, Staff F, Activities Director, stated that every resident should have an activity assessment and care plan completed soon after admission, as well as updates on a quarterly basis. Staff F, Activities Director, further stated that Resident #1's assessment and care plan were not done as they should have been upon admission. Referrence WAC 388-97-0940 (1)(2) .
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to monitor, assess, and intervene related to hydration and nutrition status for for two of five residents (Resident #s 12 and 51) reviewed for nutrition/hydration. These failures placed the residents at risk for dehydration, unwanted weight loss, medical complications [REDACTED]. Findings included . RESIDENT #12 Resident #12 admitted to the facility in April 2019. In an interview on 03/15/20 at 12:49 PM, Resident #12's family member reported concerns related to the resident's weight because her dentures did not fit well, she was not eating well, and the facility had recently changed her diet to a blended texture. Review of the facility's policy titled Weight Monitoring, dated November 2017, showed residents who were not at risk (for nutrition concerns or weight loss) should be weighed at least monthly. Review of Resident #12's care plan dated 10/07/19 showed that she had been identified as being at risk for dehydration related to poor nutrition. The interventions listed on the care plan included to monitor her for weight loss. Review of Resident #12's medical record on 03/18/20 showed she had been weighed at regular intervals from the time she admitted in April 2019 until November 2019. However, there were no weights documented for December 2019, January, and February 2020. Review of Resident #12's medical record showed a physician's orders [REDACTED]. In an interview on 03/18/20 at 10:00 AM, Staff O, Registered Nurse-Resident Care Manger (RN-RCM), reviewed Resident #12's record and stated that she should have had monthly weights since she was admitted , which she could not find documentation for, and that in February when the doctor wrote the order for weekly weights, staff should have documented them in the record, but she could not find documentation that the weights had been done. Staff O, RN-RCM, reviewed the weights and stated there had been no weights documented from November until 3/17/20. Additionally, previous to the November weight check there had not been a weight documented for the previous two months. An observation on 03/14/20 at 9:45 AM, showed Resident #12 sitting in her bed, her bedside table over her legs, with nothing to drink available. Continued observations on 03/16/20 at 11:00 AM, on 03/17/20 at 1:00 PM, on 03/18/20 at 9:35 AM, on 03/19/20 at 11:03 AM, and various observations throughout the survey showed Resident #12 in bed, with her bedside table over her legs and nothing to drink in her room, and no empty cups to show evidence that she been offered fluids. In an interview on 03/18/20 at 12:48 PM, Staff O, RN-RCM, stated that Resident #12 could have liquids such as water or juice in her room and that she was safe to have thin liquids unsupervised. Staff O, RN-RCM, was made aware of the multiple observations of Resident #12 not having fluids available. The following day, on 03/19/20 at 11:03 AM, Staff O, RN-RCM, stated she had been interviewing staff about offering fluids to residents and found that the facility did have a system of delivering a cart of fresh water to each room on every shift, however, that practice had dropped off sometime in the last year or two. Failure to ensure residents that are assessed as safe to do so, have adequate liquids available to them between meals placed residents at risk for potential dehydration. RESIDENT #51 Review of the significant change Minimum Data Set (MDS, a required assessment tool), dated 01/28/20 showed that Resident #51 admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. The MDS further showed that Resident #51 had had a significant weight loss in the previous six months. During an interview on 03/14/20 at 2:38 PM, Resident #51's family member stated that Resident #51 needed assistance and encouragement to eat, and that she had lost weight over the past several months. Review of the weight history showed that on 03/10/20, Resident #51 weighed 98.6 pounds (lbs), on 12/09/19 she had weighed 105.2 lbs, and on 11/12/19 she had weighed 106.2 lbs. Review of the March 2020 physician orders [REDACTED]. No other dietary interventions had been ordered since, and Resident #51 continued with a weight loss of 7.6 lbs. During an interview on 3/17/20 at 12:47 PM, Staff O, RN/RCM, stated that the facility should have identified Resident #51's weight loss, and there should have been documentation in the chart that indicated awareness and/or interventions implemented to address the weight loss. WAC Reference 388-97-1060 (3)(h)(i) .
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to act on the consultant pharmacist's Medication Regimen Review (MRR) recommendations for one of five residents (Resident #72) reviewed for unnecessary medication use. Failure to act on the pharmacist's recommendations placed the residents at risk for experiencing adverse side effects, medical complications [REDACTED]. Findings included . Review of Resident #72's quarterly Minimum Data Set (MDS, a required assessment tool) dated 02/27/20, showed Resident #72 admitted on [DATE] with multiple health conditions including high blood pressure, [MEDICAL CONDITION] Fibrillation (an abnormal heart rhythm), diabetes, urinary tract infection and depression. The MDS further showed that the resident was able to make needs known and required extensive assistance with activities of daily living. Review of a document titled, Consultation Report, dated 11/18/19, showed that the pharmacist recommended Resident #72's regularly scheduled constipation medication (Senna-[MEDICATION NAME]) and another ordered constipation medication ([MEDICATION NAME]) be reviewed. The pharmacist's recommendation was to stop the Senna-[MEDICATION NAME] and start taking Senna (another medication for constipation). In addition, the pharmacist recommended to change the [MEDICATION NAME] order to half the scheduled dosage and mix with water. The document further showed that the provider accepted the pharmacist's recommendation and ordered the medications to be implemented as written. Review of Resident #72's Medication Administration Record [REDACTED]. During an interview on 03/18/20 at 11:06 AM, Staff B, Director of Nursing Services (DNS), stated that it was her expectation that if the pharmacist had made a recommendation and the provider agreed, then the order should have been changed. WAC Reference: 388-97-1300(4)(c) .
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is**

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) **necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor for effectiveness and side effects of medications for three of five residents (Resident #s 1, 12 and 68) reviewed for unnecessary medications (antipsychotic medication), target behaviors and orthostatic blood pressures (blood pressure while lying, sitting and standing). The facility's failure to monitor orthostatic blood pressure placed the residents at risk for adverse side effects, medical complications [REDACTED]. Findings included . The facility policy titled, Behavioral Health Services, dated February 2019, showed that the facility required staff training regarding behavioral health services to include implementing care plan interventions that were relevant to the resident's [DIAGNOSES REDACTED]. The document showed that when medications were prescribed for behavioral symptoms staff were to discuss potential risks and benefits with the resident or their representative. The staff were also to monitor for efficacy and any adverse consequences. An additional document titled, Antipsychotic Medication Use, dated December 2016, showed that staff were to monitor for and report side effects and adverse consequences of antipsychotic medication to the provider to include orthostatic [MEDICAL CONDITION]. RESIDENT #68 Review of the quarterly Minimum Data Set (MDS, a required assessment tool) dated 0[DATE], showed that Resident #68 admitted to the facility on [DATE] with multiple [DIAGNOSES REDACTED]. The MDS showed the resident was able to make needs known. Review of the facility's March 2020 Medication Administration Record [REDACTED]. The MAR further showed that the provider had originally ordered the antipsychotic medication on 06/13/19. Review of Resident #68's March 2020 Monitors Record, a document that Licensed Nurses (LNs) recorded any adverse reactions or behavioral changes that occurred, showed no antipsychotic monitoring was being conducted or documented for the [MEDICATION NAME] to include orthostatic blood pressure monitoring. Review of Resident #68's Electronic Health Record (EHR) on 03/19/20 at 10:30 AM showed the medical record lacked monthly orthostatic blood pressure documentation. During an interview on 03/18/20 at 10:03 AM, Staff E, Social Services Director (SSD), stated that the LN's were to obtain a signature (informed consent) from either the resident or the resident's representative for the administration of the ordered antipsychotic medication. In addition, Staff E, SSD, stated that informed consent listed the risks and benefits of the medication as well as any adverse reactions. Furthermore Staff E, SSD, stated that the consent should have been obtained as well as any potential adverse side effects and monitoring documented for the [MEDICATION NAME]. During an interview on 03/18/20 10:10 AM, Staff P, Residential Care Manager/Licensed Practical Nurse (RCM/LPN), stated that it was her expectation that the LNs obtained an informed consent prior to administering any antipsychotic medications. In addition, Staff P, RCM/LPN, stated that adverse side effects of the [MEDICATION NAME] were to be monitored, but it appeared that it was not done for Resident #68. During an interview on 03/18/20 at 11:08 AM, Staff B, Director of Nursing Services (DNS), stated that it was her expectation that the LNs obtained a (informed) consent, created a care plan to include any goals and interventions that were needed to monitor like orthostatic blood pressure monitoring and any other the adverse side effects of the antipsychotic medication Ability. RESIDENT #1 Review of the admission MDS dated [DATE], showed that Resident #1 admitted on [DATE] with [DIAGNOSES REDACTED]. The MDS further showed that Resident #1 received antipsychotic medications daily. Review of the March 2020 physician's orders [REDACTED].#1 received [MEDICATION NAME] (an antipsychotic medication) daily at bedtime. Review of Resident #1's care plan on 3/18/20 showed that the facility was to monitor for side effects of antipsychotic medication, including orthostatic [MEDICAL CONDITION]. Review of Resident #1's medical record on 3/18/20 showed no documentation of orthostatic blood pressures being monitored. During an interview on 03/18/20 at 9:11 AM, Staff O, RCM, stated that she did not see an order for [REDACTED]. RESIDENT #12 Review of Resident #12's medical record showed a physician's orders [REDACTED]. The medical record showed that a pharmacy review of Resident #12's medications, including the antipsychotic medication, had been completed on 02/13/20. The review dated 02/13/20 identified the use of the anti-psychotic medication and recommended that the physician decrease the amount of medication by only administering one time daily instead of two. The psychiatrist who ordered the medication declined to make the change due to Resident #12 having made improvements in mood and behavior since being on the medication. In an interview on 03/17/20 at 2:05 PM, Staff P, Licensed Practical Nurse/Unit Manager (LPN/UM), stated that if a resident received an anti-psychotic medication, staff were expected to monitor for side effects of the medication, including taking orthostatic vital signs monthly. Review of Resident #12's medical record on 03/19/20 showed no documentation of orthostatic blood pressure monitoring. The medical record showed a physician's orders [REDACTED]. Review of Treatment Administration Records (TARs) showed that the monitoring had not yet been done since it was ordered, and was not scheduled to start until 04/01/20, two weeks after the order. Failure to monitor orthostatic blood pressure changes placed Resident #12 at potential risk for unrecognized side effects, such as drops in blood pressure when changing positions, which can contribute to dizziness and falls. When the failure was identified, staff obtained a physician's orders [REDACTED]. WAC Reference 388-97-1060(3)(k).
F 0883 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures for flu and pneumonia vaccinations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer influenza and pneumococcal vaccinations to one of five residents (Resident #1) reviewed for influenza and pneumococcal vaccination offering and administration. This failure placed the resident at risk for communicable disease, medical complications [REDACTED]. Findings included . Review of a facility policy titled, Influenza Vaccination, dated March 2020, showed that each resident would be offered the influenza vaccine, annually, from October 1st through March 31st. In addition the policy showed that the resident's medical record would include documentation that the vaccination was offered and that the resident received it or did not receive it due to medical contraindication or refusal. Review of a facility policy titled, Pneumococcal Vaccine (Series), dated 03/09/20, showed that each resident would be assessed for pneumococcal vaccination status on admission and would be offered the vaccine if they had not received it. Review of the admission Minimum Data Set (MDS, a required assessment tool) dated 12/18/19, showed that Resident #1 admitted to the facility on [DATE]. The MDS further showed that Resident #1 did not receive the influenza vaccine in the facility for the current flu season, and the reason why was not assessed. In addition, the MDS showed that Resident #1's pneumococcal vaccination was not up to date, and the reason it was not received was not assessed. Review of Resident #1's medical record on 03/18/20 showed no documentation of the influenza or pneumococcal vaccines being offered to the resident. During an interview on 03/19/20 at 1:08 PM, Staff O, Registered Nurse/Resident Care Manager (RN/RCM), stated that immunization status should have been determined upon admission, and there should have been documentation in Resident #1's medical record to show that it had been reviewed and offered upon admission. WAC Reference 388-97-1340 (2) .