

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/11/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50G046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/29/2013
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NAME OF PROVIDER OR SUPPLIER RAINIER SCHOOL PAT E	STREET ADDRESS, CITY, STATE, ZIP CODE RYAN ROAD BUCKLEY, WA 98321
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W 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an Annual Recertification Survey conducted at Rainier School PAT E on 3/25/13 to 3/29/13. A sample of 12 resident was selected from a census of 122. The Expanded Sample included 79 current residents.</p> <p>The survey was conducted by:</p> <p>██████████ R.N., B.S.N. ██████████ R.N., B.S.N. ██████████ A.</p> <p>The survey team is from:</p> <p>ICF/IID Survey and Certification Program Residential Care Services Division Aging and Long-Term Support Administration Department of Social and Health Services P O Box 45600 Olympia, Washington 98504-5600</p> <p>Telephone: 360-725-2405 Fax: 360-725-2642</p>	W 000		
W 104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>This STANDARD is not met as evidenced by: Based on observations and interviews the facility failed to ensure staff handled and stored food properly and failed to provide a well repaired and maintained environment which was free from</p>	W 104	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">MAY 20 2013</p> <p style="text-align: center;">DSHS/ADSA/RCS/BAAU</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Sept</i>	(X6) DATE <i>5/10/13</i>
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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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W 104	<p>Continued From page 2</p> <ol style="list-style-type: none"> 1. El Pato Salsa (2 bottles), date received label, no open date 2. Smuckers Grape Jelly, date received label, no open date 3. ½ gallon Milk (2), date received label, no open date 4. Rejuv Prune Juice, date received label, no open date 5. Spaghetti (yellow plastic container), no open date 6. Grand Parmesan, date received label, no open date 7. Spaghetti in foil covered bowl, no open date 8. Diet Mt. Dew, open, unlabeled <p>Kitchen Freezer:</p> <ol style="list-style-type: none"> 1. Pancakes, date received label, no open date 2. French Toast (5), date received label, no open date 3. 2 slices of lunchmeat in Ziploc bag, no open date 4. Waffles (24), ripped bag, date received label, no open date 5. Ben & Jerry Ice cream, no open date 6. Scandinavian Frozen Vegetables, date receive label, no open date 7. Waffles (3) in Ziploc bag, undated, unlabeled 8. Ice cream bar, unlabeled 9. 1 tall plastic glass with ice on bottom, unlabeled <p>Upright Freezer (locked):</p> <ol style="list-style-type: none"> 1. Hotdog buns bag (3), no open date 2. Hotdog buns bag (6), no open date <p>Orcas: (Exterior)</p> <ol style="list-style-type: none"> 1. Bike parts (screws, bolts, axel) on patio 	W 104			

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W 104	<p>Continued From page 3</p> <ol style="list-style-type: none"> 2. Broken office chair on patio 3. Wooden swing with broken slats, protruding rusty screws 4. Basketball pole with broken rim lying on ground 5. Missing/Broken screen from window 6. Tipped over 2 seat bike with bike chain wrapped around red wagon wheel <p>(Interior) Upright Freezer (locked):</p> <ol style="list-style-type: none"> 1. Shredded Cheddar Cheese (bag not tied shut) 2. Hot Dog Buns (1 package), open, undated <p>Dining Room Table</p> <ol style="list-style-type: none"> 1. Ketchup bottle, open, undated <p>San Juan: (Interior) Refrigerator:</p> <ol style="list-style-type: none"> 1. Ketchup (3 bottles), date received label, no open date 2. Smuckers Grape Jelly (2 bottles), date received label, no open date 3. Syrup (2 containers), date received label, no open date 4. Onion (1/2) in Ziploc bag, date received label, no open date <p>Freezer:</p> <ol style="list-style-type: none"> 1. Sausages (4), torn bag, date received label, no open date 2. Waffles (5) in Ziploc bag, date received label, no open date 3. French Toast (3), torn bag, date received label, no open date <p>Upright Freezer (locked):</p> <ol style="list-style-type: none"> 1. Corn Dogs, torn bag, no date opened 2. Brown paper sealed bag, not identified, no 	W 104		
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W 104	Continued From page 4 date frozen 3. French Fries, date received label, no date opened 4. Shredded cheese, no label, no date frozen 5. Muffins (resident ' s name), no date frozen Kitchen Cupboard: 1. Bread (3/4) loaf, date received label, no open date 2. Giant Hamburger buns (4), date received label, no open date 3. Thick-It (40oz), date received label, no open date 4. Vinegar (Best if used by date 1/22/13) 5. Fred Meyer Decaffeinated Coffee Jar, date received label, no open date 6. Krusteaz Buttermilk Biscuit Mix (not opened - box dated 3/25/13)	W 104			
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observations and interviews the facility failed to ensure that 2 of 12 expanded sample residents (Resident #13 & #18) had their own electric razors. Failure to have own electric razors prevented residents from completing tasks toward independent grooming. Findings include: Observations on 03/28/13 of Alpine cottage residents ' rooms revealed two residents did not have electric razors to complete their personal	W 137	Client #13 & #18 razors were located in their bedrooms. Person responsible: ACM Monitor: DDA2 ACM's will check and ensure that all clients that shave have a razor. When razors are broken or lost, ACM's will submit paperwork to replace razors. Tools: checklist Person responsible: ACM Monitor: DDA2	Completed 3/27/13 5/24/13 and Ongoing	

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W 137	Continued From page 5 hygiene care. When asked how the residents completed their grooming for the day the staff were unable to locate the electric razors and were unclear if the residents had been shaved that day.	W 137	All guardians for PAT E clients will be receiving a written consent letter related to sharp knives being secured. Additionally, HRC will receive the signed letter (when returned by guardian) for review.	Completed 3/18/13	
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews facility failed to obtain written consents prior to implementation of restrictive programs in regards to locking up sharp knives/items and food items in 4 of 8 cottages (Hyak, Orcas, Omak and San Juan). Failure to obtain written consents denied the resident/guardian the opportunity to make informed decisions about facility restrictive programs. Findings include: All observations, record reviews and interviews were between 03/25/13 and 03/29/13 unless otherwise stated. Omak, Orcas, and San Juan: Kitchen Knives Observations, record reviews, and interviews revealed all sharp knives/items were locked up and not accessible for resident use. Interviews on 03/28/13 with the Habilitation Program Administrators (HPA) 's revealed	W 263	All guardians for Hyak, Omak, Orcas, and San Juan house clients will be receiving a written consent letter related to locked freezers and/or cabinets. Additionally, HRC will receive the signed letter (when returned by guardian) for review. Person responsible: QIDP/DDA1 Monitor: DDA2 DDA1 will randomly select five clients quarterly and review their CFA/IHP/BSP and complete an environmental check of the living unit to ensure that residents/guardian are afforded the opportunity to make informed decisions about facility restrictive programs. Tools: DDA1 review form Person responsible: DDA1 Monitor: DDA2	4/24/13 5/24/13 and Ongoing	

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W 263	<p>Continued From page 6</p> <p>guardians had been notified of the restrictive practice but the facility had not yet completed the process of obtaining all consents.</p> <p>Hyak, Omak, Orcas, and San Juan: Locked kitchen cupboards and freezers</p> <p>Observation revealed the following:</p> <p>Omak: Locked kitchen cabinet</p> <ol style="list-style-type: none"> 1. Plastic container filled with creamer packets 2. Diet jelly packets in brown lunch bag 3. Maxwell House coffee packets in paper bag 4. Graham crackers 5. Sanka coffee packets in paper bag 6. Mini-wheat cereal (1.31oz) 7. Pastries (2) 8. Chocolate chips, 4 Ziploc bags 9. Tree Top Fiber Rich Apple Juice (3) 10. Marshmallows 11. Creamer packets in plastic container <p>San Juan Cottage: Locked kitchen cabinet</p> <ol style="list-style-type: none"> 1. Hershey 's Cocoa 2. Mrs. Dash Seasoning 3. Hershey 's Syrup 4. Jet Puffed Marshmallow Bits 5. Signature Creamy Peanut Butter 6. Signature Honey 7. Nesqick Chocolate Flavor <p>Hyak Cottage- 1 locked chest freezer, 1 locked upright freezer. Freezers contained various frozen food items and items were inaccessible to residents unless they asked for staff assistance.</p> <p>Omak Cottage-1 locked upright freezer. Freezers contained various frozen food items and items were inaccessible to residents unless they asked</p>	W 263		

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W 322	Continued From page 8 having falls on 02/11/13 through 03/26/13 (at time of review). Review of resident ' s file noted that resident had one fall in December, one fall in January, two falls in February, and eight falls in March with the two falls in February and the eight in March coming after the start of the new medication. No physician assessment had been done to determine if the medication was or was not helping the resident ' s mobility. Resident #10 ' s file revealed last Annual Health Care Assessment was completed on 10/16/2011. Resident #12 ' s file revealed last Annual Health Care Assessment was completed on 07/18/2011.	W 322	Resident #1, #6, 7, 8, 9, & 11 based on assessed-need will be referred to an Audiologist. Person responsible: Clinical Director Monitor: Asst. Superintendent/DDA2	5/24/13 And ongoing	
W 323	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. This STANDARD is not met as evidenced by: Based on record reviews and interviews 7 of 12 sampled residents (Resident #1, 6, 7, 8, 9, 11 and 12) had not received annual/or as recommended audiology exams. Failure to provide a timely audiology exam placed residents at risk of unidentified changes in hearing and/or other medical issues which could lead to deterioration in their overall health. Findings include: All document reviews and interviews were conducted between 03/25/13 and 03/29/13 unless otherwise stated. Record review revealed that Resident #1 ' s last hearing evaluation was completed in 2008 with a recommended follow-up in three years.	W 323	All PAT E clients have been reviewed/ assessed by a physician related to their hearing during 90 day review. Any client with an assessed need will be referred to an Audiologist. Person responsible: Primary Care Physician Monitor: Clinical Director/DDA1	5/24/13 And ongoing	

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W 323	Continued From page 9 Record review revealed that Resident #6 ' s last hearing evaluation was completed in 2009 with a recommended follow-up in three years. Record review revealed that Resident #7 ' s last hearing evaluation was completed in 2009 with a recommended follow-up in three years. Record review revealed that Resident #8 ' s last hearing evaluation was completed in 2009 with a recommended follow-up in three years. Record review revealed that Resident #9 ' s last hearing evaluation was completed in 2011 with a recommended follow up in six months due to significant changes with his hearing ability. Record review revealed that Resident #11 ' s last hearing evaluation was completed in 2008 with a recommended follow-up in three years. Record review revealed that Resident #12 ' s last hearing evaluation was completed in 2009 with a recommended follow-up in three years. Interview with the RN4 revealed the facility does not have an audiologist at this time.	W 323			
W 336	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This STANDARD is not met as evidenced by: Based on interviews and record reviews facility	W 336			

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W 336	<p>Continued From page 10</p> <p>failed to complete Quarterly Nursing Assessments for 1 of 1 sampled residents (Resident #9) and 14 of 15 expanded sample residents (Resident #34, 35, 36, 37, 38, 39, 40, 42, 43, 44, 45, 46, 47, 48). Failure to complete Quarterly Nursing Assessments placed residents at risk for unmet nursing care needs.</p> <p>Findings include:</p> <p>All interviews and record reviews were completed between 03/25/13 and 03/29/13.</p> <p>Record reviews revealed Quarterly Nursing Assessments had not been done.</p> <p>Resident #9 had a quarterly nursing assessment completed in 02/2013, however he had not had quarterly nursing assessment performed in 2012.</p> <p>Resident #34, 35, 36, 37, 38, 39, 40, 42, 43, 44, 45, 46, 47, 48 had quarterly nursing assessments completed in 02/2013, however had not had a Quarterly Nursing Assessments performed in 2012.</p> <p>Resident #34 had a Quarterly Nursing Assessment completed in 01/2013, however had not had a Quarterly Nursing Assessments performed in 2012.</p> <p>Interviews with nursing staff revealed the facility had failed to provide Quarterly Nursing Assessments for residents of San Juan cottage during 2012.</p>	W 336	<p>Involved nursing staff received corrective action and retrained in the following:</p> <p>Review of the Nursing Process Quarterly Review section with emphasis on completion, documentation and filing a direct physical exam in conjunction with the Nursing Quarterly Review.</p> <p>Clients/Residents # 9, 34, 35, 36, 37, 38, 39, 40, 42, 43, 44, 45, 46, 47, and 48 will have direct physical exams completed, documented and filed.</p> <p>All RN staff with Primary Care Nurse duties trained to complete, document and file a direct physical exam in conjunction with the Nursing Quarterly Review. This training will be reviewed/retaught annually. Training for new PCNs will be completed during the Nursing Orientation process.</p> <p>Nurse Managers will review/monitor for timely completion on a regular basis.</p> <p>Responsible: RN 4</p> <p>Monitor: DON</p> <p>Tools: Checklist</p>	<p>Completed 2-15-13</p> <p>Completed 2-15-13</p> <p>Completed 2-25-2013</p> <p>Within 30 days of hire</p> <p>Completed 2/28/2013 and ongoing</p>	
W 337	<p>483.460(c)(3)(iv) NURSING SERVICES</p> <p>Nursing services must include, for those clients</p>	W 337			

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W 337	<p>Continued From page 11</p> <p>certified as not needing a medical care plan, a review of their health status which must be recorded in the client's record.</p> <p>This STANDARD is not met as evidenced by: Based on record review 3 of 12 sample residents (Resident #1, 10, and 11) revealed documentation ordered by a physician was not completed on resident treatment sheets. Failure to document provided an inaccurate account of residents' medical condition. Findings include: Resident #1 has an order for "BM (Bowel Movement) monitoring, every shift, if no BM for 3 days, give prn _____ as ordered on MAR (Medication Administration Record)." Resident #1's IHP (Individual Habilitation Plan) states that resident continues to have multiple instances of abdominal distention, constipation and is on an extensive bowel program including: _____ sodium, _____ glycol, _____ and _____ or gas. He also receives a _____ suppository as needed. Resident has several days with little or no bowel movements followed by episodes of diarrhea. He had an increase in agitation and threats of aggression towards staff. Documentation was missing on the following dates: February 2013 - Day shift: Feb. 16 & 28 Night shift: all month January 2013 - Day shift: Jan. 17, 18, & 25 Evening shift: Jan. 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 21, & 23 Night shift: all month December 2012 - Day shift: Dec. 1, 2, 3, 5, 9, 10, 16, 20, 21, 22, 25, 27, & 29</p>	W 337	<p>For clients # 1, 10 and 11 PAT E Nurses trained to review/check BM monitoring flow sheet/nursing order AM and PM shift daily. AC staff will be trained in completing Nursing Orders thoroughly to ensure proper medical care is provided.</p> <p>All nursing staff trained to review/check BM monitoring flow sheet/nursing order AM and PM shift daily. All new nurses will be trained within 30 days of hire. All nurses will be re-trained/annually Responsible: RN 4 Monitor: DON</p> <p>For client # 10, identified nurse counseled regarding scheduled BP monitoring nursing orders.</p> <p>All nursing staff trained to follow scheduled monitoring of BPs/Nursing Orders.</p> <p>All RNs will be trained in the following: 1. Monitor nursing orders twice monthly for completion/documentation of specified data. 2. PCNs are to review/monitor all nursing orders two times each month, initialing in the appropriate box at the bottom of the page, indicating the date that they reviewed/monitored the nursing orders for completion/ data input.</p>	<p>5/29/2013</p> <p>5/29/2013</p> <p>5/29/2013</p> <p>Completed 4/18/2013</p> <p>5/29/2013 and ongoing</p> <p>5/29/2013 and ongoing</p>	

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W 337	<p>Continued From page 12</p> <p>Evening shift: Dec. 5, 9, 17, 18, & 27</p> <p>Night shift: all month</p> <p>Resident #1 has an order for " Bag balm to peri area EVERY AM AND PM to prevent skin breakdown. Wash with warm soapy water prior to applying. " documentation was missing on the following dates:</p> <ul style="list-style-type: none"> February 2013 - Day shift: Feb. 16 & 28 January 2013 - Day shift: Jan. 1, 2, 5, 6, 7, 9, 13, 24, 25, & 31 <p>Evening shift: Jan. 1, 2, 3, 4, 5, 6, & 7</p> <ul style="list-style-type: none"> December 2012 - Day shift: Dec. 1, 2, 4, 5, 7, 9, 12, 13, 14, 16, 22, 25, 27, 29, & 31 <p>Evening shift: Dec. 5 & 27</p> <p>Resident #10 has an order to " Obtain BP (blood pressure, P (pulse) weekly on Saturday AM. Report Systolic BP >60 or <90, Diastolic BP >100 or <50. Pulse >100 or <60 to RN/MD (Registered Nurse or Medical Doctor). " documentation was missing on the following dates:</p> <ul style="list-style-type: none"> February 2013 - Day shift: Feb. 16th <p>Resident #10 has an order to " Inspect and perform fingernail hygiene, as needed, every Saturday AM. Inspect and perform toenail care, as needed, every Saturday PM. " Documentation was missing on the following dates:</p> <ul style="list-style-type: none"> February 2013 - Day shift: Feb. 2, 16, & 23 <p>Evening Shift: Feb. 2, 16, & 23</p> <ul style="list-style-type: none"> January 2013 - Day shift: Jan. 5, 12, 19, & 26 <p>Evening shift: Jan. 5, 12, 19, & 26.</p> <ul style="list-style-type: none"> December 2012 - Day shift: Dec. 1, 8, 15, 22, & 26 <p>Evening shift: Dec. 1, 8, 15, 22, & 26</p>	W 337	<p>3. PCNs will complete a QA monitoring sheet for ALL discrepancies regarding completion/documentation of lack of specified data and sent to the nurse manager for that area. For all AC nursing orders with discrepancies, send an email to the ACM, noting that date on the QA monitoring form and submit to the nurse manager for that area.</p> <p>All new nursing staff will be trained within 45 days of hire. All nursing staff will be re-trained annually. Monitoring/reviewing for completion will be done on a regular basis.</p> <p>Tools: Checklist Responsible: RN 4 Monitor: DON</p> <p>All ACMs will be instructed to monitor nursing orders twice monthly for completion/documentation of specified data.</p> <p>Tools: checklist Responsible: ACM Monitor: DDA2</p>	<p>5/29/13 and ongoing</p> <p>5/29/13 and ongoing</p>
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NAME OF PROVIDER OR SUPPLIER RAINIER SCHOOL PAT E		STREET ADDRESS, CITY, STATE, ZIP CODE RYAN ROAD BUCKLEY, WA 98321		
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W 337	<p>Continued From page 13</p> <p>Resident #11 has an order to " Inspect and perform fingernail hygiene, as needed, every other Saturday AM. Inspect and perform toenail hygiene as needed, every other Saturday PM. " Documentation was missing on the following dates:</p> <ul style="list-style-type: none"> February 2013 - Feb. 2 (fingernail and toenail) Feb. 9 (toenail) Feb. 16 (fingernail and toenail) Feb. 23 (fingernail and toenail) January 2013 - Jan. 5; 12; 19; & 26 (fingernail and toenail) December 2012 - Dec. 1; 8; 15; & 22 (fingernail and toenail) <p>Resident #11 has an order to " Monitor for BM 's (bowel movements), if no BM in three days notifies nurse. " Documentation was missing on the following dates:</p> <ul style="list-style-type: none"> February 2013 - Day shift: Feb. 9, 10, & 28 Evening shift: Feb 1, 2, 4, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23, 26, 27, & 28 January 2013 - Day shift: Jan. 2, 30, & 31 December 2012 - Dayshift: Dec. 1, 2, 3, 6, 8, 9, 10, 13, 15, 16, 19, & 20 Evening shift: Dec. 3, 4, 5, 6, 7, 8, 9, 11, 15, 22, 23, 24, 25, 28, 29, 29, & 31 Night shift: Dec. 31 	W 337	<p>Toilet paper was replaced/stocked.</p> <p>Person responsible: ACM Monitor: DDA2</p> <p>All PAT E houses will have toilet paper available in all bathrooms. Bathrooms will be checked 2 x 's per shift and at change of shift for toilet paper and if there is no toilet paper in the dispenser, staff will restock it.</p> <p>Person responsible: ACM Monitor: DDA2</p> <p>ACM's will randomly check toilet paper dispensers five times quarterly. If no toilet paper is in the dispenser, ACM will notify staff to restock it.</p>	<p>Completed 4/24/13</p> <p>Completed 4/24/13</p>
W 424	<p>483.470(d)(1) CLIENT BATHROOMS</p> <p>The facility must provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the clients.</p> <p>This STANDARD is not met as evidenced by:</p>	W 424	<p>Tools: checklist</p> <p>Person responsible: ACM Monitor: DDA2</p>	<p>5/24/13 And ongoing</p>

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W 424	Continued From page 14 Based on observations facility failed to provide toilet paper in 2 of 8 cottages (Omak and San Juan). Failure to provide toilet paper prevented residents from maintaining good hygiene following toileting. The findings include: Omak: Bathroom 1. 03/28/13 09:00 AM -No toilet paper in bathroom(B15) 2. 03/29/13 10:00 AM -No toilet paper in bathroom(B13) San Juan: Bathroom 1. 03/26/13 08:20 AM -No toilet paper in bathroom (A13) 2. 03/26/13 08:20 AM -No toilet paper in bathroom (A15) 3. 03/28/13 2:00 PM -No toilet paper in bathroom (B15)	W 424	Bathrooms have been deep cleaned.	Completed 4/24/13
W 454	483.470(I)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations facility failed to provide sanitary bathrooms in 2 of 8 cottages (Omak and Orcas). Failure placed residents at risk of being exposed to unsanitary conditions which could cause health risks. Findings include: Observations at Omak Cottage on 03/25/13, 03/28/13 and 03/29/13 revealed bathroom B13 and B15 having an extremely strong smell of urine. Observations at Orcas Cottage on 03/25/13 and 03/27/2013, revealed bathroom B15 had an	W 454	A service request and referral to CMO for assessment for Orcas House B15, Omak House B13 & B15 has been made. Person responsible: Maintenance Monitor: Asst. Superintendent/DDA2 Necessary repairs/corrections will be made per assessment. Person responsible: Maintenance Monitor: Asst. Superintendent/DDA2	Completed 4/24/13 5/24/13 and ongoing

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W 454	Continued From page 15	W 454			
W 455	extremely strong smell of urine. 483.470(I)(1) INFECTION CONTROL	W 455			
	<p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>This STANDARD is not met as evidenced by: Based on observations and interviews facility failed to ensure an active program to store, clean, label and separate personal electric razors in 3 of 8 cottages: Omak 1 of 2 sampled residents (Resident #12) and 6 of 7 expanded sampled residents (Resident # 28, 29, 30, 31, 32, 33); San Juan (resident unknown); and Aspen 2 of 2 expanded sample residents (Resident #20 & 78). This failure placed residents at risk of being exposed to a communicable disease.</p> <p>Findings include:</p> <p>Observation of laundry room in Omak cottage on 03/27/13 revealed electric razors were being recharged and either laying on top of each other or laying on the counter next to the sink. Two of the electric razors were recharging and laying on top of a used, wet coffee filter that still contained coffee grounds. One electric razor was recharging and laying in a puddle of water next to the coffee maker. One electric razor was recharging and laying in spilled coffee on the counter. The electric razors were not labeled with resident names.</p> <p>Interview with staff in Omak on 03/27/2013 confirmed staff would be unable to identify the correct electric razor for the correct resident when</p>		<p>Residents #12, 28, 29, 30, 31, 32, 33, 20, & 78 razors will be individually labeled and stored. New items purchased will be labeled prior to use.</p> <p>Person responsible: ACM Monitor: DDA2</p> <p>ACM's will train all Pat E staff in proper use (label, clean) and storage of razors to minimize risk of being exposed to communicable disease.</p> <p>Tools: Inservice record form Person responsible: ACM Monitor: DDA2</p> <p>ACM's will randomly select five client razors quarterly and ensure the razors are labeled, clean, and stored away from water/ separated to minimize risk of clients being exposed to a communicable disease.</p> <p>Tools: checklist Person responsible: DDA1 Monitor: DDA2</p>	<p>Completed 4/24/13</p> <p>5/24/13 and ongoing as needed</p> <p>5/24/13 and Ongoing</p>	

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W 455	Continued From page 16 electric razors are unlabeled. Upon removing the electric razor heads it was determined that all unlabeled electric razors had been used on residents. Observation of laundry room in San Juan cottage on 03/27/13 revealed one electric razor laying at the back of the sink. The electric razor was not labeled with a resident ' s name and staff could not identify which resident owned the electric razor. Observation at Aspen Cottage on 03/27/13 revealed that Resident #21 and 78 ' s electric razors were in the bathroom, in a drawer together. Electric razors were labeled with resident names; however electric razors were stored in the same drawer, allowing cross contamination.	W 455			
W 473	483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observation and interviews the facility failed to serve food within 15 minutes of removal from a temperature control device or failed to maintain the appropriate food temperature on Orcas cottage, 2 of 2 sampled residents (Resident #7 and 8) and 14 of 14 expanded sampled residents (Resident #64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, and 77) and San Juan cottage, 1 of 1 sampled resident (Resident #9) and 15 of 15 expanded sample residents (#34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, and 48). Failure to serve food promptly resulted in residents being served food that had	W 473			

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W 473	<p>Continued From page 17 not been held at the appropriate temperature creating a potential for foodborne illness.</p> <p>Findings include:</p> <p>Observation at Orcas cottage on 03/25/13 revealed luncheon food items had been removed from the kitchen insulated food cart and placed in food warming bowls. The temperature of the food was taken 20 minutes into the serving time and revealed the following: Chicken nuggets 130°, chopped French dip meat item 100°, ground French dip meat item 137°, green beans 121°, and cooled dairy dressing for salad 60°. Two special diets, covered in foil, had been removed from a temperature controlled device and left in the dining area for over 45 minutes before being served to residents.</p> <p>Observation at San Juan cottage on 03/26/13 revealed luncheon food items had been removed from the kitchen insulated food cart and placed in the dining area. The temperature of the food was taken 20 minutes into the serving time and revealed the following: Chicken Fried Steak 120°, corn 115° and the tapioca orange dessert 55°. When these temperatures were pointed out to the AC3 he asked staff to reheat one of the luncheon plates that had just been served to a resident.</p> <p>USDA guidelines recommend food must be reheated to 165 degrees Fahrenheit or above and held above 140 degrees Fahrenheit until served, in order to destroy the bacteria that can cause food borne illness. Cold food items should be held and served at 45 degrees Fahrenheit or cooler.</p>	W 473	<p>All PAT E staff will be instructed/trained to serve food within 15 minutes of removal from food cart, serving hot food at 140 degrees. Any food that drops below 140 degrees will be reheated in the microwave or oven. Staff will use a thermometer when needed.</p> <p>Tools: Inservice record form Person Responsible ACM Monitor DDA2</p> <p>ACM will randomly select five meals quarterly and ensure food is served within 15 minutes of removal from food cart, and/or food is served at 140 to 115 degrees.</p> <p>Tools: checklist Person Responsible: ACM Monitor: DDA2</p>	<p>5/24/13 And ongoing</p> <p>5/24/13 and Ongoing</p>

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W 478	<p>483.480(c)(1)(ii) MENUS</p> <p>Menus must provide a variety of foods at each meal.</p> <p>This STANDARD is not met as evidenced by: Based on observations and record reviews the facility failed to provide a variety of foods at each meal for 1 of 1 sampled residents (Resident #1) and 7 of 7 expanded sample residents (Resident #48, 66, 67, 69, 72, 76, 78) who receive specialized diets. Failure to provide alternatives did not give residents a choice of foods. Findings include: All observations of meal service were on 03/25/13 through 03/28/13 unless otherwise specified. During the meal service Resident #1, 48, 66, 67, 69, 72, 76 and 78 received their specialized meals from the kitchen. Residents were not offered an alternative to the meal that was being served.</p>	W 478	<p>PAT E staff will be instructed/trained to offer meal alternatives to residents who receive specialized diets.</p> <p>Tools: inservice record form Person Responsible ACM Monitor DDA2</p> <p>ACM will randomly select five meals quarterly and ensure residents who receive specialized diets receive alternate meal choices.</p> <p>Tools: Checklist Person Responsible: ACM Monitor: DDA2</p>	5/24/13	
W 488	<p>483.480(d)(4) DINING AREAS AND SERVICE</p> <p>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>This STANDARD is not met as evidenced by: Based on observations facility failed to allow residents the opportunity to serve independently at Tyee/Shasta during meal time. Failure placed residents at risk for diminished ability in skill development and potential loss of independence. Findings include: Observation on Tyee/Shasta on 03/25/13 revealed that staff served the food not allowing residents the opportunity to serve self</p>	W 488		5/24/13 and Ongoing	

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W 488	Continued From page 19 independently.	W 488	<p>Tyce/Shasta staff will be instructed/trained to assure that each resident eats in a manner consistent with his or her developmental level.</p> <p>Tools: Inservice record form Person Responsible ACM Monitor DDA2</p> <p>Pat E staff will be instructed/trained to assure that each resident eats in a manner consistent with his or her developmental level.</p> <p>Tools: Inservice record form Person Responsible ACM Monitor DDA2</p> <p>ACM's will randomly select five meals quarterly and ensure residents eat in a manner consistent with his or her developmental level.</p> <p>Tools: checklist Person Responsible: ACM Monitor: DDA2</p>	5/24/13 And ongoing	5/24/13 And ongoing