

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

PRINTED: 07/06/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505489	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
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NAME OF PROVIDER OR SUPPLIER SEA MAR COMMUNITY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1040 SOUTH HENDERSON STREET SEATTLE, WA 98108
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Off-hours QIS Survey conducted at Sea Mar Community Care Center on 6/19/12, 6/20/12, 6/21/12, 6/22/12, 6/25/12, 6/26/12, 6/27/12 and 6/28/12. On 6/21/12, and evening survey was conducted between 7:00 pm and 9:15 pm. A sample of 37 residents was selected from a census of 94.</p> <p>The survey was conducted by:</p> <p>Susan Abrisz, MSW Jada Lynn, RN, BSN Diane Kirse, RN, BSN</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Disability Services Administration Residential Care Services, District 2E 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388 Telephone: (253) 234-6000 Fax: (253) 395-5085</p> <p><i>Bonnie Sharp</i> 7/6/12 Residential Care Services Date</p>	F 000	<p>RECEIVED</p> <p>JUL 30 2012</p> <p>DSHS/ADSA/RCS</p> <p>RECEIVED</p> <p>JUL 20 2012</p> <p>DSHS/ADSA/RCS</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Carolynn Duce</i>	TITLE <i>Admon</i>	(X6) DATE 7/27/12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1	F 000		8/9/2012	
F 248 SS=D	<p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide supplies to promote a program of appropriate leisure activities for cognitively impaired residents on one of four units, including sample Residents #14 and 89, and other residents of the Alzhiemers Living Center (ALC). This unit was separated from other units by a secured door, which resulted in the 16 residents who lived on the unit having little or no access to other units. The limited availability of structured activities, and the observed lack of supplies for leisure activities when staff were not present, placed these residents at risk for decreased stimulation and a diminished quality of life.</p> <p>Findings include:</p> <p>Resident #14 was admitted on [REDACTED] with care needs related to dementia. An initial activity assessment dated 3/22/10, identified interests such as sports, TV, cards, gardening and being outdoors. This resident's care plan, dated 4/2/12, identified a similar range of activity preferences. Review of recent flow sheets for May and June</p>	F 248	<p>F248</p> <p>§483.15 (f) (1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RESIDENT: The facility must provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and physical, mental, and psychosocial well-being of each resident.</p> <p>On 7/6/12 an in-service was given to Recreational Therapy Aides and CNA's on the ALC unit to teach skills to better engage residents during group settings to ensure staff are interacting with all residents during activities.</p> <p>RECEIVED JUL 30 2012 DSHS/ADSA/RCS</p>		

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F 248	<p>Continued From page 2</p> <p>2012 found he attended the same activities nearly every day (Coffee, current events, music, walking). When observed on 6/21, 6/22, 6/25 and 6/27/12, he passively observed most activities, except for drinking coffee or eating snacks. During the survey, he was observed to sit in a hallway or dining room, and was not observed to be involved in sports, gardening or being outdoors.</p> <p>On 6/25/12 between 9:15 am and 9:25 am, Resident #14 was seated in the dining room. A talk show was on the TV in the dining room, which Resident #14 and two other residents did not watch. During this time, four male residents paced in the hall or stood near the nurse's station (Residents #34, 43, 88, 89). No activity, or materials for resident activities, were observed in areas where residents might use them.</p> <p>At 9:30 am, a staff member brought a cart with coffee and bananas into the dining room. Six residents were present, and were served coffee. By 9:45 am, there were eleven residents in the dining room, including Residents #14 and 89. They accepted coffee and drank it, but did not otherwise interact with staff or other residents. As residents drank coffee and ate bananas, a staff person read several brief news stories from a paper. There was little other interaction observed between staff and residents. At 10:10 am, the activity concluded, and as staff left the dining room, most residents drifted out. Residents #14 and 89 remained seated. A second observation of dining room cabinets and a TV lounge found no items for leisure activities available for residents on the unit.</p>	F 248	<p>7/13/12 The Care Plans & Activity Assessments for residents #14 and #89 were updated to reflect residents' current needs and interests based on interviews of staff and observations made by Recreation Therapy Manager (RTM) due to residents' cognitive impairments.</p> <p>On 7/17/12 an in-service of all recreational aides was conducted concerning proper documentation on Recreational Therapy Flow sheet for adequate participation of residents during activities.</p> <p>On 7/6/12 a number of activities such as big print books, picture books, dominoes, and cards were placed in the ALC dining room for residents to use at their leisure. A small basket of additional leisure items will be available to residents on 7/20/12. Items will include stress balls, blocks, cotton balls, yarn and pictures, and can vary daily.</p>	
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F 248	<p>Continued From page 3</p> <p>At 10:20 am on 6/25/12, observation of an enclosed outdoor area designated for use by ALC residents found it had a paved path and two benches. Several raised beds for planting were present in this area, and had a few random sprouts, but no flowers or other vegetation which might provide visual or sensory stimulation for residents. Residents occasionally walked in the area, but there were no items provided for games or other types of leisure activities for residents.</p> <p>On 6/27/12 at 10:30 am, a nursing assistant (Staff P) was in the ALC dining room with five residents who were eating a snack and waiting for staff to bring in coffee (Residents #14, 52, 81, 89 and 102). Staff G entered with coffee and served it to residents. At 10:45 am, residents drank coffee as a TV talk show played, which involved cooking with gourmet foods. No residents were attending to the program. There was one newspaper for residents to share; only one resident appeared to read it.</p> <p>At 10:50 am, a tray with more snacks was brought in. Staff G left with the coffee cart, and Staff P started a game of dominoes with 2 residents. Resident #14 and 89 sat holding coffee cups. At 11:05 am, Staff G and P left the dining room and six residents exited. Residents #14 and 89 were seated in the dining room, asleep.</p> <p>On 6/27/12 at 12:10 pm, eleven residents were seated in the ALC dining room, waiting for lunch. One staff member was charting, and did not interact with residents. The items available for residents earlier (set of dominoes and a newspaper) were not present. The TV was tuned</p>	F 248	<p>A music system and sensory boards are to be placed at the ALC nursing station on 8/3/12.</p> <p>The ALC TV lounge is being transformed in to a sensory stimulation room. Planning took place on 7/14/12. An outline of room set up and order of needed supplies was completed on 7/18/12.</p> <p>The RTM will randomly audit the TV station 3x/daily to ensure that residents have a channel that is of interest and appropriate for them.</p> <p>Beginning 7/18/12 additional newspapers are now available for residents interested in reading the paper.</p> <p>The activities Dept. is planning a Garden Party to take place 8/12/12. Initial calls were made to resident families on 7/16/12 & 7/17/12 to invite them to this event. Invitations to residents and their families will be sent</p>	
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F 248	<p>Continued From page 4</p> <p>to a news program, which none of the residents looked at; Resident #14 was seated, asleep.</p> <p>Activities which addressed the interests and abilities of residents with significant cognitive impairments were not provided during multiple observations throughout survey. When scheduled activities ended, supplies were removed by staff, leaving residents with minimal options for involvement in meaningful activities. Observations in resident rooms, dining room and resident lounge, found no supplies for unstructured leisure activities available (magazines or books w/ photos, basic materials for games that would be familiar to these residents, plants/ flowers), except when a scheduled activity occurred.</p> <p>On 6/27/12 at 12:25 pm, during an interview with a member of the activity staff (Staff G), the observations of a lack of materials to encourage activities for residents of the ALC was discussed. She stated staff had been told to remove a basket of activity items out of the utility room by a State fire marshal. When asked why items for resident activities were stored in a locked room where residents couldn't access them, she replied they would get lost if left out. When asked about the lack of basic supplies for resident leisure activities, she said there were no funds for activity supplies for that department.</p> <p>6/27/12 at 2:20 pm interview with the Activity Coordinator (Staff F) revealed she had started this position two weeks previously, and was reviewing needs of residents and prior activity programming. When asked about the observed lack of supplies for non-scheduled leisure</p>	F 248	<p>out 7/28/12. Supplies for the party were ordered 7/19/12 and include such items as wind chimes, pin wheels, plants and outdoor activities.</p> <p>To ensure that Residents have an ongoing program of activities that meets their interests and abilities, the Rec. Therapy Mgr. will re-assess residents and review and revise the plan of care as needed.</p> <p>Leisure activities will be made available to residents in multiple areas within the ALC unit. Rec. Therapy staff and nursing staff will be in-serviced on 8/1/2012 to ensure they are aware of leisure activity items availability and how to engage residents in meaningful interaction and activities.</p> <p>Rec. Therapy Manager will conduct weekly audits to ensure that leisure activity items are available for resident use at all times. Additionally, Rec. Therapy Manager will conduct monthly QI audit of resident activity log to ensure that residents are involved in activities which they have an interest in and are appropriate for them.</p> <p>Rec. Therapy Manager and Administrator to ensure compliance.</p>	
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F 248	<p>Continued From page 5</p> <p>activities for ALC residents, she said she was told there was "no budget for the activity department" when she asked. When observations of residents sitting with nothing for staff to engage them (books, magazines, music, simple games) before lunch, she said they do offer bingo and music, but acknowledged there weren't many supplies for residents (dominoes and a deck of cards). Observations of the TV being tuned to programs which were unlikely to hold a resident's attention (gourmet food, world news) were also discussed. When the observed lack of plants, flowers or games for residents to observe/engage in outdoors was discussed, she said she had ideas of what she would like to do for residents on the unit, but hadn't been able to start them yet.</p> <p>On 6/27/12 at 1:50 pm, a meeting with the DNS was held to discuss the above concerns regarding the lack of activities and leisure supplies for residents of the ALC. When concerns were described, she said she planned to meet with Staff F to help develop appropriate activities/ supplies for ALC residents.</p> <p>On 6/28/12 at 9:30 am, the availability of funds and leisure supplies for ALC residents was discussed with the facility's Administrator. When asked about a budget for supplies, she stated, "They don't have a fixed budget, but we will provide whatever materials they need." During a discussion of the observed lack of activity materials for resident leisure activities, she stated she believed this was a situation which the new Activity Director would resolve.</p>	F 248		
F 253	483.15(h)(2) HOUSEKEEPING &	F 253		

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F 253 SS=E	<p>Continued From page 6 MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to provide maintenance services, including repairs of damaged sinks/ equipment for residents on one of four units, and failed to ensure residents on 3 of 4 units were provided with safe storage of valuables in locked drawers. Failure to provide maintenance services placed residents at risk for loss of property and a diminished quality of life.</p> <p>Findings include:</p> <p>In an interview with Resident #54 on 6/20/12 at 9:30 am, she alleged money had been taken from her locked drawer "a few months ago". The resident stated she reported the incident to the facility. On 06/20/12, the resident's key was used and found to open her lockable drawer, as well as the drawer of her roommate.</p> <p>On 06/20/12, Resident #3 provided his key for the lockable drawer in his room. Observations revealed the key also unlocked the drawer used by his roommate. On 6/20/12 at 2:05 pm, rounds were made with a Resident Care Manager (Staff C). A random check of rooms 308, 312, 313, 318, 322 and 323 revealed the key would unlock all drawers in these rooms.</p>	F 253	<p>F253</p> <p>§483.15 (h) (2) HOUSEKEEPING & MAINTENANCE SERVICES:</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>On 6/21/12 residents #3 and #54 were given numbered nightstand keys appropriate for their nightstands and master keys were collected.</p> <p>A complete audit of all resident nightstands in the facility was conducted and completed 7/13/12 to ensure safe and secure storage of valuables.</p>	8/9/12

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F 253	<p>Continued From page 7</p> <p>On 06/21/12 at 8:15 pm, random checks of lockable drawers were done with a CNA (Staff S), using the key of Resident #3. The key unlocked all the drawers in resident rooms 214, 215, 220, 221.</p> <p>On 06/25/12 at 2:30 pm, Staff A stated they have had this furniture for "quite some time". When it arrived, keys were given to each resident. She acknowledged Residents #3 and #54 were given master keys for the locking drawers and this should not have occurred. It was not known how many other residents or staff potentially had access to master keys for these drawers.</p> <p>LACK OF MAINTENANCE SERVICES: On 6/26/12 at 8:55 am in room 339, the laminated counter top around the sink was found to be torn and damaged. On 6/26/12, similar findings were noted for the counter top around the sink in room 345.</p> <p>On 06/25/12 at 9:00 am, the left armrest of a reclining wheelchair used by Resident #47 was torn and partially missing. The wall behind the Resident's bed was observed to have multiple areas of vertical scrapes and gouges in the wall.</p> <p>On 6/19/12 at 2:30 pm, observation of Resident #103's wheelchair revealed the left armrest of his wheelchair was scraped and torn.</p> <p>On 6/27/2012 at 2:00 pm, rounds were made throughout the facility. Loose handrails were found in the halls outside rooms # 216, 344 and 350. A handrail was missing from the wall outside the elevator on the 3rd floor.</p>	F 253	<p>On 7/17/12 all management team members were in-serviced as to resident secure belongings key policy form and that each nightstand has a numbered key and master key. No master keys will be assigned to residents. Master keys will be used for administrative use only in the event the resident misplaces numbered nightstand key.</p> <p>Laminate counter tops around sinks in rooms 339 & 345 will be replaced no later than 8/12/12.</p> <p>Temporary wheelchairs were provided to residents # 47 and # 103. Resident # 103's previously ordered chair will be delivered 7/26/12. The VA will provide a new chair for resident # 47.</p> <p>The loose handrails in the hallway outside rooms 216, 344 & 350 were repaired 6/29/12.</p> <p>Weekly audits of all facility handrails will be conducted for the next 90 days to ensure compliance and monthly thereafter.</p>	
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F 253	Continued From page 8	F 253	Facility Manager and Administrator to ensure compliance	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The following citation refers to paragraph #2 in the above regulation, 42 CFR 483.10m(k): Based on observations, interviews and record reviews, the facility failed to revise the care plans for Residents # 73, 71 and 9, three of 37 sample residents, to ensure care plans accurately reflected current care needs and interventions for these residents. Failure to meet this requirement placed residents at risk for unmet care needs.	F 280	F280 §483.20 (d) (3), 483.10 (k) (2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP: The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other	8/9/12

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F 280	Continued From page 9 Findings include: RESIDENT #73: Resident #73 was admitted in [REDACTED] with care needs related to [REDACTED]. A bladder assessment dated 4/21/12 included information that Resident #73 had a history of urinary incontinence prior to 2011, and identified risk factors which increased the likelihood of incontinence. This assessment also stated the resident needed physical assistance from staff with toileting. His Minimum Data Set (MDS) assessment, dated 5/22/12 identified this resident as needing extensive assistance from one staff person with toileting. He was also assessed as always incontinent of urine. His current care plan, dated 5/2/12 included directives to staff such as "Check res every 2 hours and assist w/ toileting as needed" and "Provide pericare if incontinent". On 6/22/12 at 12:20 pm, Resident #73 walked past the nurses' station. An area of wetness was present on the back of his pants. A nurse who also observed this asked an NAC to change the resident. When observed on 6/25/12 and 6/27/12, Resident #73 was not taken into the bathroom to be toileted. On 6/27/12, the resident's assigned caregiver, (Staff P) was asked how often Resident #73 was toileted. She replied, "Oh, we can't...he fights if I try to take him. It takes two staff to change him." Review of the current care plan did not reflect this change in the resident's care needs. RESIDENT #71:	F 280	appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Resident #73 On [REDACTED] resident had a full Bowel and Bladder assessment completed, the Care Plan updated, and the CNA flow sheets updated to his physical assistance needs with toileting. In addition, the Bedside Care Plan/ CNAs Kardex will have current individualized toileting/eliminating plan and when indicated documentation of how he may have refusal of his care needs.	

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F 280	<p>Continued From page 10</p> <p>Resident #71 was admitted [REDACTED] with care needs related to impaired mobility and other complex medical conditions. His most recent MDS assessment, dated 5/8/11, identified the resident's vision as impaired. It noted he needed large print in order to read, and did not have glasses. Review of his 5/4/12 care plan found this problem with his vision had not been addressed.</p> <p>On 6/27/12 at 4:30 pm, interview with the MDS coordinator (Staff H) revealed the option of having the resident seen by the optometrist for glasses had been discussed with his family in the past, but was declined. She stated staff had been working with a new legal representative to address this need. After reviewing the care plan, Staff H acknowledged the resident's impaired vision was not addressed in his care plan and needed to be added.</p> <p>RESIDENT #9: This resident was last admitted on [REDACTED] with diagnoses of [REDACTED] among other conditions.</p> <p>This resident was initially observed on 6/20/12, and during the course of the survey, to self-propel herself in a wheel chair around the nursing unit. She was observed to need extensive assistance of one person for transfers, being able to stand only with knees bent. While in bed, she was not able to extend her legs out straight.</p> <p>Her hands were essentially non-functional bilaterally due to having her fingers clutched tightly to her palms. Her nails were long and sharp, but had not broken the skin. The palms and fingers of her hands were soiled with matter</p>	F 280	<p>Resident #71</p> <p>On June 27, 2012, a Care Plan was implemented on his vision impairment. A referral was submitted for evaluation by the optometrist to enhance his vision and place current interventions on the care plan. Resident is scheduled to see the optometrist on July 31, 2012. All plan of care will be updated to all nursing disciplines related to his vision deficits.</p> <p>Resident #9</p> <p>On June 27th, 2012, a referral was submitted to the Occupational Therapy (OT) to evaluate for both upper extremities (hands), recommendations for contractures preventive care and initiate therapy.</p>		

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F 280	<p>Continued From page 11 and malodorous. Nail care was to be done by Licensed Nurses, but was repeatedly documented on the Medication Administration Record (MAR) as refused.</p> <p>On several occasions, the surveyor attempted to evaluate whether the resident could extend her fingers. The resident would grimace, pull back her hand and state that it hurt her. Both her nursing caregiver and the Restorative Aide, Staff M, stated the resident was very resistive to allowing anything to be done with her hands, that she would state it hurt, and start crying and screaming.</p> <p>The most recent Minimum Data Set (MDS) of 5/14/12 documented the resident's functional abilities for mobility as needing extensive assistance of one person, but bathing and personal hygiene/grooming as total assistance of one person. Range of motion was scored as being impaired for her upper extremities, but unimpaired in the lower extremities. She was not receiving any skilled therapy at this time, but was involved with the Restorative Program for lower extremity passive range of motion (PROM), transfers, and walking.</p> <p>The most current Care Plan for Impaired Physical Mobility, dated 3/19/12, described the resident as having limited lower extremity/knee range of motion, with an intervention of needing limited assistance of one person.</p> <p>The most recent Care Plan for Self Care Deficit, dated 5/15/12 did not accurately reflect her need for extensive assistance with grooming/hygiene, nor identify any specific interventions related to</p>	F 280	<p>PT and ST also screened the resident for further therapy needs. On June 28, 2012, the physician assessed the resident hand contractures. The physician was able flex her fingers bilaterally without pain and documented the status of the contractures. On June 28, 2012, the medication [REDACTED] was ordered to be administrated prior to OT therapy to alleviate any discomfort. In addition, Tylenol was ordered to decrease pain, if she complains of pain prior to therapy treatment. A hand cream was ordered to place on hand, prior to OT working with her to decrease pain and joint discomfort. The resident care plan was updated and CNAs flow sheet interventions were to wash her hands BID and after meals. Resident remains on nail care and skin checks.</p>	

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F 280	Continued From page 12 the hands for grooming, dressing or hygiene. One intervention stated to refer to the Restorative care plan, which only focused on the need for lower extremity goals and interventions. During an interview on 6/26/12 at 1:00pm with Staff D, Resident Care Manager of 2nd floor, the resident's functional status and care plan interventions were discussed. Staff D acknowledged the lack of care plan revision to reflect current functional status, as well as lack of interventions to address bilateral hand impairment. She stated that better interdisciplinary communication in assessment and goal setting was needed, and would be sought. After the 5/14/12 comprehensive assessment, the facility failed to accurately update and revise the plan of care to reflect the resident's most current functional status, nor did the facility identify the need for intervention of care related to the impairment of bilateral hands.	F 280	Care plan will indicate her skin care and nail care to be evaluated at the time that she receives the PRN meds to prevent overmedicating the resident. More effective communication among the interdisciplinary team will provide consistency to the assessment and care planning of the resident. The Care Plan for Self Care Deficit will address the hands for grooming, dressing and hygiene. Upon completion of OT services, a Restorative program will be implemented to reflect resident care needs. The 5/14/2012, MDS indicates functional impairment of upper and lower bilateral extremities.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309	On July 3, 2012, an in-service was conducted with CNAs to report to licensed nurses (LNs) any changes regarding residents care needs.	8/9/12

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On 7/27/2012 and 7/31/2012, all staff will be in-serviced on proper reporting to LNs any changes in resident care needs specifically on vision deficits, and individualized toileting/eliminating plan with how residents may refuse their care needs.

In order to maintain compliance, the Nursing department will perform monthly audit of Resident Bowel and Bladder Assessments and Care Plans to

ensure comprehensive care plan, interventions that meets resident's current care needs.

Audits results will be reported at the monthly QI meeting. The Administrator, RCMs and DNS are to ensure compliance.

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F 309	Continued From page 13 by: Based on observation, interview and record review, the facility failed to recognize and assess symptoms of pain for Residents #47, 9 and 54, three of three residents reviewed for pain management. The facility failed to consistently recognize verbal and non-verbal indicators of pain, or to evaluate the resident's level of pain and the efficacy of current pain management approaches. Failure to identify and effectively manage symptoms of pain for these residents resulted in a potential decrease in their physical and emotional well-being and diminished quality of life. Findings include: RESIDENT #47: On 6/20/12 at 9:05 am, Resident #47 was observed as a female staff member placed a splint on the resident's left arm. He was moaning or saying "Ohh--Oww..." several times as she applied the splint. Approximately 10 to 20 seconds after the splint was in place, the resident stopped moaning. On 6/26/12 at 6:45 am, Resident #47 was observed as a nursing assistant (Staff Q) dressed the resident in a t-shirt. He moaned and grunted as she moved his arms. At 9:10 am, a Restorative Aide (Staff M) approached the resident and told him she was going to help him with his Range of Motion (ROM) exercises, and put splints on his arms. Staff M used a warm, wet towel to wash Resident #47's right hand. As she did this, he began to shake his head "No". As Staff M extended his fingers to wash them, he began to call out with increased frequency and volume,	F 309	F309 \$483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING: Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Resident #47 On 6/27/2012, this resident's pain assessment was updated to reflect current pain status. Staff M was directly educated on 6/27/2012 relating to interventions when pain is observed.	

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F 309	<p>Continued From page 14</p> <p>and shook his head "No" repeatedly. As this occurred, Staff M continued to wash the resident's hand and arm. When she stopped to get a second towel, the calling out decreased after approximately 30 seconds.</p> <p>As Staff M began to wash Resident #47's left hand with a warm towel, he began to grimace and shake his head "No" after 15 to 20 seconds. When she extended the fingers of his left hand, he again called out "Ohh.... Oww..." several times. When Staff M was asked about the calling out, she replied "Well, he usually does that". When asked if she had told the nurse about this behavior, she said she had. When asked if she thought the resident was in pain, she did not reply. When asked why she thought Resident #47 was moaning and saying "Oww", she replied, "Because he doesn't like it" (ROM). When asked why she thought he didn't like it, she replied, "Because it hurts..."</p> <p>At 9:25 am on 6/26/12, an RN (Staff I) was asked to observe the conclusion of Resident #47's ROM treatment with the surveyor. As Staff M continued with splinting his left arm, Resident #47 grimaced, shook his head "No" and said "Oww" several times over 2 to 3 minutes. Once the splint was in place, Staff I was asked what she thought about the behavior. She said, "It looks like he's in pain."</p> <p>She looked at the resident's Medication Administration Record (MAR) and found the resident had a physician's order for Tylenol 500 mg to be given "as needed" (prn) for pain. Review of pain assessments for Resident #47 recorded by each shift in the MAR during May and June</p>	F 309	<p>On 6/27/12 the Rehab department was in-serviced on recognizing verbal and non-verbal indicators of pain and to report to licensed nurses so that they can assess and evaluate the resident's level of pain and provide pain management.</p> <p>Staff Q was in-serviced on 7/19/12 related to interventions concerning pain management.</p> <p>On 7/27/12, and 7/31/12 further in-servicing will be provided concerning pain management for all direct care staff.</p> <p>Resident #9</p> <p>6/27/12, the Treatment nurse observed and assessed her hand and found no signs and symptoms of skin breakdown.</p> <p>On June 27, 2012, the LN administered Tylenol for pain related to Restorative program prior to treatment to the extremities.</p>	

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F 309	<p>Continued From page 15</p> <p>2012, found all nursing staff documented the resident was not having pain. Further review of the MAR found he had received only one dose of prn Tylenol in mid May, despite Staff M's report the resident "usually" presented with similar reactions to ROM/splint application.</p> <p>Review of this resident's care plan, dated 4/25/12, revealed it addressed problems of chronic neck pain, and directed staff to "monitor for verbal and non-verbal pain sx". Review of quarterly Restorative Therapy evaluations dated 2/2/12 and 4/5/12 did not identify any problems with symptoms of calling out or other non-verbal signs of pain for this resident. Review of Restorative Aide flow sheets for April, May and June 2012, revealed no documentation by Restorative staff identifying verbal or non-verbal signs of pain symptoms for Resident #47 until after his treatment on 6/26/12.</p> <p>On 6/26/12, Staff C was interviewed. She stated she was responsible for supervising the restorative services for the floor on which Resident #47 resided. When asked how often she observed Restorative Aides as they provided ROM care for residents, she stated she did this "every day". When asked if she had recently observed Staff M providing ROM/ splinting for Resident #47, she replied, "No". The observations from earlier in the morning, and concern that staff had not recognized or reported symptoms of pain to the nurse were reviewed. The failure to request medication for this resident once he began grimacing / showing non-verbal signs of pain was also discussed.</p> <p>The above findings, including a lack of</p>	F 309	<p>On 6/27/12 the Rehab department was in-serviced on recognizing verbal and non-verbal indicators of pain and report to licensed nurses to assess and evaluate the resident's level of pain and provide pain management.</p> <p>On 6/30/12 resident received full hand and nail care.</p> <p>The Quarterly Pain assessment and MARS flow sheets will indicate resident need of pain medication and be updated by nursing staff.</p> <p>On 7/27/12, and 7/31/12 further in-servicing will be provided concerning pain management for all direct care staff.</p> <p>Resident #54</p> <p>On 6/27/12 the resident's pain assessment was done to reflect her current pain status.</p>		

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F 309	<p>Continued From page 16</p> <p>documented information reflecting this resident's pain was also discussed with the facility's DNS at 1:30 pm on 6/26/12. She stated she would be reviewing care of Resident #47 and other residents with contractures.</p> <p>RESIDENT #9: On June 20, 2012, Resident #9 was laying in bed, awake and alert, with her legs drawn up and bilateral hands positioned into fists. When asked if she could uncurl her hands she stated "No, not much". She was able to partially open the index and thumb to make a pincer movement. She said it 'hurt' if she tried to open further. It was also noted the palms and fingers were heavily soiled with matter, and malodorous. Her fingernails were sharp and long, and pressed into the palms of her hands. No open areas could be observed.</p> <p>She was not able to fully extend her legs, as they were bent at the knee at approximately a 90 degree angle. She was otherwise able to move her arms and legs freely. She was observed throughout the survey to self-propel herself in a wheelchair.</p> <p>The clinical record shows she received Occupational Therapy until February, 2011, when she was referred to the Restorative Nursing Program (RNP). Stated goals for this resident included the use of 'carrots' or hand rolls for 1-2 hours as tolerated, and Active Range of Motion (AROM) to open hands for hygiene, as well as for four wheel walker safety. The use of the hand splints was discontinued due to refusal by the resident. Nursing staff was responsible for monitoring and cutting her nails every two weeks, but the MAR flow sheets documented refusal.</p>	F 309	<p>Resident was started on [REDACTED] to address her depression and neuropathic pain.</p> <p>On 7/17/12, the providers were notified to identify pain on their Bimonthly Evaluation/Progress notes for those residents whom they visit and assess.</p> <p>On 7/27/12 and 7/31/12, RCMs will conduct an in-service to all direct care staff on effective communication among the interdisciplinary team in order to provide consistent care and follow resident plan of care.</p> <p>The resident's individualized plan of care will be reviewed quarterly and as needed by the RCM/LN.</p> <p>The Nursing department will audit residents pain management.</p>	

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F 309	<p>Continued From page 17</p> <p>The Restorative record showed that the resident had a long history of refusing treatment for her hands and legs, to the point the resident only accepted passive ROM on her legs. Quarterly Restorative Notes repeatedly showed during treatment the resident would "scream and c/o [complain of] pain" (4/14/11). On 7/1/11, Staff V, Restorative Aide, charted "even know [though] i always ask the nurse to pre-medicate before her exs., i been doing PROM [passive range of motion] for her lower extremities, is hard to do her upper exts". Quarterly Restorative Progress Notes from 4/14/11 to the last notation on 2/28/12, all documented the resident exhibited and verbalized pain during attempts at treatment.</p> <p>The Care Plan for High Risk for Pain, initiated on 1/11, revised on 1/7/12, and lastly on 5/15/12, stated to "to assess pain, give pain medication as ordered, observe for nonverbal sign of pain, among other interventions.</p> <p>Pain management for this resident consisted of an order for Tylenol 650mg as needed for arthritis, but was changed on 4/28/11 to Ibuprofen 400mg every 4-6 hours as needed for DJD (degenerative joint disease), pain and fever. The resident had no record of receiving any pain medication, and the Ibuprofen was discontinued for "non-use" on 12/6/11. Quarterly Pain Assessments by nursing were all scored as negative for pain, and the MAR flow sheets to monitor for daily pain were all negative.</p> <p>On 6/28/12, the resident's attending physician, Staff U, visited the resident to assess the resident for "possible hand contractures and related pain".</p>	F 309	<p>Audit results will be reported at the monthly QI meeting. DNS, RCMs, Physical Therapist, and Administration will ensure compliance.</p>	
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F 309	<p>Continued From page 18</p> <p>The attending Progress note stated that he "was able to easily extend each and all fingers without difficulty or pain", and stated the problem was "postural hyperflexion of fingers/hand bilaterally" rather than 'true contractures'. During an interview on 6/26/12 with the Resident Care Manager, Staff D, she stated the resident's screaming and refusal of care could be from behaviors related to anxiety.</p> <p>Failure to recognize and provide pain medication when the resident stated she was in pain, and the lack of communication between Restorative and Nursing staff regarding the origin for her refusal of treatment, contributed to a decline in the physical functioning and untreated pain for the resident.</p> <p>RESIDENT #54: Resident #54 suffered from [REDACTED] among other conditions. On 06/20/12 at 9:40 AM, Resident #54 stated she was having pain from the waist down and the pain was severe with movement. She stated she could not tolerate narcotics and she only took Tylenol for pain. She stated she was depressed and preferred to stay in her room. She was tearful and had a sad affect. She acknowledged that her mood might improve if her pain was controlled. During the survey period the Resident was observed to be self-isolating. She ate very little and was tearful at times.</p> <p>A review of the 02/06/12 MDS (Minimum Data Set) revealed the patient was feeling depressed and was having trouble concentrating. The Resident required extensive assistance for ADL's</p>	F 309		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505489	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2012
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NAME OF PROVIDER OR SUPPLIER SEA MAR COMMUNITY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1040 SOUTH HENDERSON STREET SEATTLE, WA 98108
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F 309	<p>Continued From page 19</p> <p>(activities of daily living) and was scored as having no pain. A review of the 04/25/12 MDS revealed the resident had a decrease in her mental status. She was scored as having pain at a level of 10/10 and her activities were limited due to pain. She was not on a scheduled regimen of pain medications.</p> <p>A review of the MAR from 05/01/12- 05/30/12 revealed the resident complained of pain 33 times, and 22 times from 06/01/12- 06/26/12 and received only Tylenol for pain. On 6/26/12 at 2:50 PM in an interview with Staff R, LN, she stated the resident only had Tylenol for pain and was not on a scheduled pain regimen.</p> <p>On 6/28/12 at 9:45 am, in an interview with Staff C, the RCM, she stated Resident #54 had received a psychiatric evaluation in July 2011, February 2012, April 2012. On 06/11/2012 was seen by the facility physician. She acknowledged the Resident's pain had not been assessed during those visits. She stated a formal pain assessment was done on 5/10/12 by the nursing staff and the Resident had no complaints of pain. There was no evidence that medications specific for the treatment of neuropathic pain had been considered or attempted.</p>	F 309		
F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p>	F 312	<p>F312</p> <p>§483.25 (a) (3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS: A resident who is</p>	<p>8/9/12</p>

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F 312	<p>Continued From page 20</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure residents who were unable to carry out the activities of daily living (ADLs) received the necessary assistance to maintain good grooming, and personal and/or oral hygiene for four of 32 sample Residents (#23, 52, 47 and 9) who were dependent on staff for assistance with ADLs. This failure placed residents at risk for unmet care needs and a diminished quality of life.</p> <p>Findings include:</p> <p>RESIDENT#23: Resident #23 was a long-term resident of the facility, with care needs related to dementia and impaired mobility. Her most recent Minimum Data Set (MDS) assessment, dated 6/4/12, identified this resident as needing total assistance from staff with personal hygiene, which included oral care. Her care plan, dated 6/12/12, identified the resident as being dependent on staff for oral care. An interview with a family member on 6/21/12 revealed a concern about whether Resident #23 was assisted with oral care on a regular basis.</p> <p>On 6/26/12 between 6:10 and 6:40 am, Resident #23 was showered by a bath aide. After she was showered and dressed, she walked up and down the hall in a special walker. She was not provided oral care while in the shower room and was not taken to her room for oral care. At 11:05 am on 6/26/12, Resident #23's mouth and teeth were observed. A significant amount of orange debris</p>	F 312	<p>unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Resident #23</p> <p>On 7/3/12 oral care plan and flow sheet was updated to reflect daily oral hygiene.</p> <p>Resident #52</p> <p>On 6/26/12 all residents were assessed to have appropriate oral care supplies labeled with their names.</p> <p>On 7/3/12 oral care plan and flow sheet was updated to reflect daily oral hygiene.</p> <p>On 7/3/12 direct care staff was in-serviced on resident ADLs.</p> <p>Resident #47</p> <p>On 7/27/12 staff W was in-serviced to provide ADL care on a daily basis. Resident was shaved on 6/27/12.</p>	
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F 312	<p>Continued From page 21</p> <p>was visible on her upper teeth, as well as debris along her lower gums. The observed lack of oral care for this resident was discussed with Staff C at 11:15 am.</p> <p>RESIDENT #52: Resident #52 was admitted [REDACTED] with care needs related to [REDACTED]. His most recent MDS of 5/2/12 assessed this resident as needing extensive assistance from staff with Activities of Daily Living (ADLs), including oral care. Current care directives for staff posted in the resident's room also identified his need for assistance with ADLs.</p> <p>When observed on 6/26/12 at 5:45 am, a nursing assistant (Staff N) helped Resident #52 with morning ADLs. The resident was toileted, then escorted to a sink. At 5:58 am, Staff N looked through several drawers by the sink, then exited the room and returned with several washcloths. Staff N washed Resident #52's face, but not his hands, even though the resident had just used the toilet. Staff N then searched through cabinets, and again left the room. He spoke briefly to a nurse (Staff O), who left the unit and returned a few minutes later with several toothbrushes.</p> <p>When Resident #52 was handed the toothbrush, he brushed his teeth. While rinsing his mouth, the water he spit out was pink/ bloody. When Staff N was asked about the lack of supplies for oral care, he said this was because other residents took them. (The supplies for the roommate were present in the cabinet). When Staff N was asked how often Resident #52 received oral care, he responded he didn't know because he worked on call. Review of this resident's Nursing Assistant</p>	F 312	<p>Resident #9</p> <p>On 6/28/12, resident had flow sheet and care plans updated indicating hand washing twice daily and after meals.</p> <p>On 7/27/12 a referral was submitted to the Occupational Therapy (OT) to evaluate for both upper extremities (hands), recommendations for contractures preventive care and initiate therapy.</p> <p>On 7/29/12 PT and ST also screened the resident for further therapy needs. There were no additional skilled needs indicated at this time.</p> <p>On 7/27/12 and 7/31/12, all direct care staff will be in-serviced on ADLs, such as, resident handwashing hygiene, oral care, care plan for oral care, and shaving for all residents, specifically dependent residents.</p>	
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F 312	<p>Continued From page 22 flow sheets found no recent refusals of care.</p> <p>RESIDENT #47: Resident #47 was admitted on [REDACTED] with care needs related to [REDACTED]. He also had [REDACTED]. His most recent MDS assessment, dated 4/4/12, identified Resident #47 as needing total assistance from staff with all ADL's including shaving. His care plan, dated 4/25/12, also identified his need for total assistance with all ADL'S.</p> <p>On 6/27/12 at 10:45 am, Resident #47 was seated in a reclining wheelchair in his room. He was dressed but was not shaved and had approximately a day's growth of beard present. At 12:40 pm, Resident #47 was in the third floor dining room, waiting for lunch. He was unshaved.</p> <p>Interview with staff revealed Resident #47's assigned nursing assistasnt on that day was Staff W. When asked if Resident #47 had received all morning care that day, Staff W replied "Yes". When asked if there was a reason he wasn't shaved, Staff W replied, "I got busy, so there wasn't enough time to do it". During an interview with the RCM (Staff C) at 12:44 pm, she was asked about staff shaving dependent residents. She stated "They should try to do it... but they can do it on evenings too." When asked if shaving male residents was a routine part of morning care, she acknowledged it was.</p> <p>RESIDENT #9: This resident was a long term resident with care needs related to impaired mobility, arthritis, and</p>	F 312	<p>CNAs/RAs will communicate and report to PT/OT/LN any changes in resident care needs in order to promote that all disciplines are providing continuity of care to residents.</p> <p>A monthly QI audit will be initiated to monitor oral care and shaving.</p> <p>RCMs, DNS and Administrator are to ensure compliance.</p>	
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F 312	<p>Continued From page 23</p> <p>Degenerative Joint Disease, among other conditions.</p> <p>Initially, on 6/20/12, and throughout the survey, the Resident was observed to have her hands tightly clenched into the palms of her hands. Her fingernails were long and sharp, with soiled matter around the cuticles and palms of her hands, and malodorous. When she was asked if she could open her hands, she would pull back her hand and state that it hurt. She could self-propel herself in a wheel chair by using her feet.</p> <p>The Quarterly MDS, dated 5/14/12, scored the resident as having impaired functional status. She needed extensive assistance of one person for mobility, transfers, and eating. She needed total assistance of one person for personal grooming, dressing and bathing. She had limited range of motion in both upper and lower extremities, and received Restorative therapy six times a week.</p> <p>The Care Plan for Self Care Deficit, last updated 5/15/12, did not accurately reflect the residents current functional level of total assistance. Interventions were directed toward tasks that needed limited assistance from the caregiver. Her therapy with the Restorative Program was directed toward providing Passive Range of Motion (PROM) to her lower extremities, and assistance transferring from bed to chair. Staff M, Restorative Aide, stated that she always attempted to wash her hands and do some massage as well, but this was not formally part of the Restorative orders. Staff M stated the resident was often resistive to any interventions with her hands.</p>	F 312		

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F 312	Continued From page 24 Interventions for the provision of care did not recognize the severe impairment of her hands and the effect of that impairment on her ability to dress, groom or feed herself. There were no care directives with a focus on her hands, with the exception of the Licensed Nurse to cut nails every two weeks. This was documented as repeatedly refused. Nursing did not provide interventions to ensure hand hygiene, or prevention of further decline in ADL function of hands.	F 312			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure dry goods were stored in a sanitary manner. Additionally, the facility failed to provide proper food handling for one resident during meal service. Failure to properly store and serve food under sanitary conditions created the potential for food-borne illness. Findings include:	F 371	RECEIVED JUL 30 2012 DSHS/ADSA/RCS F371 §483.35 (i) FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY: The facility must- (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions.	8/9/12	

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F 371	Continued From page 25 IMPROPER STORAGE OF DRY GOODS: On 6/19/12 at 12:10 pm, during an initial tour of the dietary department, observation of the dry storage area revealed an opened bag of croutons, an open bag of cereal and a partially used box of cake mix which had not been resealed after opening. On 6/26/12 at 11:33 am, during a return visit to the kitchen, several items which had not been securely resealed after opening were again observed. These items included a bag of dry cereal, a large bag of corn meal and two bags of dried beans had not been resealed after opening. Interview with the Dietary Manager (Staff E) at 11:35 am revealed he had discussed the need to properly seal and store dry goods after the visit on 6/19/12. He acknowledged the items observed on 6/26/12 were not resealed in a manner that would prevent access by insects or vermin. IMPROPER FOOD HANDLING: On 6/16/12 at 12:30 PM, during observations of the noon meal service in the third floor main dining room, Staff J served lunch to Resident #28. He was observed to touch the bun, lettuce and sliced tomato with his bare hands as he served the resident's meal.	F 371	On 6/26/12 and 7/16/12 all kitchen staff were in-serviced on proper storage, preparation, distribution and service of food using sanitary conditions per Sea Mar policy and procedure. 7/17/12 Staff J was in-services to proper handling and service of resident food using sanitary procedures. 8/10/12 all nursing, recreational therapist and restorative staff were in-serviced to proper handling & service of resident food using sanitary procedures To ensure continued compliance with food storage and serving requirements, a monthly audit will be conducted in food services to ensure all food is stored properly and in dining room, to ensure all staff are following policies and procedures in serving/handling resident food items/infection control processes. Audit results will be reported as part of QI process. Food Services Director, DNS, RCMs and Administrator to ensure compliance.		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441			

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F 441	Continued From page 26 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to properly sanitize combs used by	F 441	F441 §483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS: The facility must establish and maintain an Infection Control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program: The facility must establish an Infection Control Program under which it- (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an	8/9/12	

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F 441	<p>Continued From page 26 to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to properly sanitize combs used by</p>	F 441	<p>F441</p> <p>§483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS: The facility must establish and maintain an Infection Control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program: The facility must establish an Infection Control Program under which it- (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an</p>	
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F 441	<p>Continued From page 27 .</p> <p>residents in a shower room after each use. Failure to sanitize items such as combs created the potential for transmission of infectious conditions among residents.</p> <p>Findings include:</p> <p>On 6/26/12 between at 6:10 am and 6:40 am, a bath aide (Staff J) was observed as he showered Resident #23. When the resident's shower was completed at 6:30 am, Staff J combed Resident #23's hair with a plastic comb. After combing her hair, Staff J briefly rinsed off the comb under the shower head, and placed it back on a shelf. The comb was not sanitized after use. Further observation of the shower room after the resident exited revealed there was no name on the comb, and no container of a sanitizer in this area to provide for sanitizing of combs between resident use.</p> <p>On 6/26/12 at 10:35 am, the above observations were shared with the DNS (Staff B) during a brief interview. She was not aware of the lack of sanitizer for combs used in the shower room for multiple residents.</p>	F 441	<p>individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection: (1) When the infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>On 6/26/12 sanitation solution and containers were placed in each shower room.</p>	

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On 6/26/12 Shower staff was in-serviced on policy and procedures developed, cleaning schedule for changing of solution on a bi-monthly schedule and documentation of completion.

An additional in-service was provided on 7/20/12 to ensure compliance.

The MSDS books were updated with the appropriate paperwork on 6/26/12.

The infection Control nurse will audit the compliance bi-monthly and report in Monthly QI.

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