

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

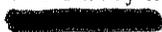
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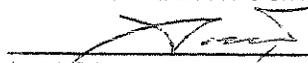
PRINTED: 12/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505453	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/22/2013
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NAME OF PROVIDER OR SUPPLIER KIN ON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4416 SOUTH BRANDON STREET SEATTLE, WA 98118
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Off-Hours Quality Indicator Survey conducted on 11/17/13, 11/18/13, 11/19/13, 11/20/13, 11/21/13 and 11/22/13 at Kin On Health Care Center. The survey included data collection on 11/17/13 from 11:00 a.m. to 4:00 p.m. A sample of 35 residents was selected from a census of 95. The sample included 30 current residents and the records of 5 former and/or discharged residents.</p> <p>The survey was conducted by:  RN, MN  MSW  MSW  a, RN, BSN  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 2, Unit D 20425 72nd Avenue South, Suite 400 Kent, Washington 98031</p> <p>Telephone: (253) 253-6000 Fax: (253) 395-5071</p> <p> 12-4-2013 Residential Care Services Date</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator/CEO	(X6) DATE 12/6/2013
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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 242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to uphold the right of Residents #50 and 93, two of three sample residents reviewed for their right to make choices, to choose the frequency of bathing. Additionally, the facility did not offer residents to choose how they were bathed (showers or a tub bath). Failure to recognize and uphold the right of residents to make basic choices about their care created the potential for a diminished quality of life.</p> <p>Findings include:</p> <p>RESIDENT #50: Resident #50 was admitted on [REDACTED]/13 with care needs related to [REDACTED] and several [REDACTED] illnesses. According to her most recent Minimum Data Set (MDS) assessment dated 11/13/13, Resident #50 was alert, oriented and able to communicate her needs and ideas without difficulty. She required assistance from staff with mobility, dressing, toileting as well as bathing.</p> <p>During an interview on 11/18/13 at 11:21 am, Resident #50 was asked if she was allowed to choose how often she was assisted with bathing</p>	F 242	<p>F242: Kin On will provide a written consent related to shower/bath frequency and caregiver according to resident's personal choices and preferences during admission and review it during the care plan conference. Resident/DPOA is encouraged to request changes any time about the cares and choices/preferences as desired. Kin On will try it's best to accommodate to such changes. Unit coordinators and social workers will ensure continual compliance. POC will be completed on 12/20/2013.</p>

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F 242	<p>Continued From page 2</p> <p>since her admission. She replied there was no choice about the frequency of bathing. She had been told she was scheduled for showers twice a week, and had not been offered the option of additional baths, even after telling staff she wanted more baths during the summer. Review of recent NAC flow sheets from October and November, 2013 revealed she was showered twice a week.</p> <p>On 11/21/13 at 9:00 am, the MDS coordinator, Staff E, was interviewed about facility policies regarding resident choices about frequency of bathing. She initially said residents were asked about preferences during an initial MDS screening, then stated they were "told the policy is 2 showers per week" for showers. She also said the facility could "try to arrange" for more showers, but the resident hadn't asked for this.</p> <p>On 11/22/13 at 10:00 am, Staff C, the Director of Nursing Services (DNS) was asked how the resident's preference/ choices were elicited regarding showers or bathing. He initially stated residents would have a choice, then explained that residents were "told" they would be scheduled for two showers per week. He elaborated, "We let them choose which days, and if they have a special party or something, we would try to give them an extra shower..." When asked to clarify if residents were really given a choice about how often they could shower, he replied, "Well, we would try to help them, but that may be something we can work on". When Staff C was asked if residents were allowed to choose a shower or a tub bath, he replied, "We basically have showers; we only have one whirlpool bath and what we have found is residents usually prefer showers". When asked if residents were</p>	F 242		

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F 242	<p>Continued From page 3</p> <p>asked about their preference, he replied, "I think mainly we do showers".</p> <p>RESIDENT #95: During an interview on 11/17/13 at 1:47 p.m., a family member of Resident #95 stated the resident was bathed twice a week. The family preferred the resident be bathed three times each week, but believed this was not an option.</p> <p>In an interview on 11/21/13 at 12:49 p.m. Staff U, the bath aide, stated each resident was bathed twice a week. The Nursing Station Coordinator (NSC) planned the schedule and discussed preferences with resident or family.</p> <p>Review of the bathing schedule confirmed each resident received a shower twice a week.</p> <p>In an interview on 11/21/13 at 2:19 pm Staff G, the Nursing Station Coordinator (NSC), acknowledged preferences about bathing were limited to morning or evening and male or female caregivers.</p> <p>Staff G also stated resident were only offered 2 showers a week. "We could not do (showers) more often on a regular basis."</p> <p>Staff G also stated the facility never used the tub because they determined the residents did not like it. When preferences were discussed with residents and family, the NSC did not ask if they wanted a tub bath instead of a shower.</p> <p>On 11/21/13 at 1:00 p.m. an observation in the shower room revealed a tub surrounded by wheelchairs and other medical equipment. Staff U stated the tub was never used.</p>	F 242		

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F 250 F 250 SS=G	<p>Continued From page 4</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, record review and observations the facility failed to address the emotional and psychosocial needs of Resident #33, one of 11 residents interviews of 35 sampled residents. Resident #33 expressed feeling of distress related to the actions and behaviors of the roommate. Although multiple staff members were aware of issues, Resident #33 remained in a distressing environment for a period of time which contributed to emotional harm for this resident.</p> <p>Findings include:</p> <p>Resident #33 was admitted to the facility on [REDACTED]/12 with multiple medical diagnoses to include [REDACTED] and [REDACTED]. The most current comprehensive assessment dated 09/28/13 determined the resident was cognitively intact and spoke some English but needed an interpreter when he communicated with the health care staff.</p> <p>In an interview on 11/19/13 at 1:30 p.m. the resident stated through an interpreter he had repeatedly requested the facility provide a room/roommate change for more than a month. The resident explained, in his primary language,</p>	F 250 F 250	<p><u>F250:</u> Kin On will ensure to provide medically-related social services to the residents to attain or maintain their optimum practicable physical, mental, and psychosocial well-being. Resident #31³³ was removed from his distressing environment and was assisted to relocate into another room on 11/28/13. We confirmed that he is adjusting well and is satisfied with his new room and new roommate.</p> <p>Social workers will assess and document resident's emotional health condition by on-going regular visitations. Social services will collaborate with other departments during daily interdisciplinary "Stand-up" meeting to address and resolve roommate related issue on a timely fashion. To strengthen documentation associated room change, social services will revise "Room Change Request Form" to include progress note to document follow-up and case resolution. Social services will partner with mental health service provider to address resident's mood and behavior to address their mental health needs. Director of social services is responsible for monitoring staff's compliance. POC is completed on 12/20/13.</p>	12/20/2013

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12/20/13

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F 250	<p>Continued From page 5</p> <p>of three separate actions and behaviors of his roommate which contributed to feeling mentally miserable in his present room assignment.</p> <p>The resident stated he was frequently woken in the middle of the night when the roommate pulled back the privacy curtain and stared steadily with "wolf-like eyes". The resident described this as torture. The interpreter confirmed the resident was very upset about the issue based on his vocal inflection and the amount of details he used to describe the situation.</p> <p>Resident #33 also stated his roommate had a habit of spitting on himself, the floor and at times on clothing laid out by staff for Resident #33. The resident stated the roommate might have dementia, nevertheless described this behavior as foul and unsanitary especially since it involved his personal belongings. Lastly Resident #33 explained his dresser was between the two beds and the roommate reached inside the top drawer and took small items such as a comb and pens. Staff moved the dresser to the other side of the bed instead of moving the resident to another room as he had requested.</p> <p>On 11/19/13 at 8:30 a.m. an observation confirmed the dresser was located between the bed of Resident #33 and the closet.</p> <p>The resident stated his DPOA was aware of his desire for a change in roommate and has spoken to the facility on his behalf, yet the facility had taken no action. The resident also said he propelled himself by wheelchair and was very distress to find empty beds the facility. The facility told Resident #33 there was no suitable room change options available.</p>	F 250		

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F 250	<p>Continued From page 6</p> <p>On 11/17/13 at 12:16 p.m. an observation revealed the roommate of Resident #33 was sitting in his wheelchair in his room. The roommate had a large amount of mucous he slowly spewed from his mouth on to his clothing and the floor.</p> <p>On 11/20/13, a record review revealed a roommate change form dated 11/04/13 was partially filled out. No documentation was found in the social services notes or nursing progress notes regarding the reason behind the request or action taken.</p> <p>In an interview on 11/20/13 at 2:08 p.m. Staff S, Social Service staff, stated she knew about the change of room/roommate request but did not document her conversations with residents. Upon review of daily Staff Stand Up meetings notes, Staff S found the roommate change request for Resident #33 had been mentioned on 10/23/13 and 10/28/13.</p> <p>In an interview on 11/21/13 at 9:20 a.m. with Staff D, director of Social Services confirmed the resident and his DPOA had requested a roommate change. Staff D stated he normally attempted to resolve the issue between roommates; however this would not be possible due to the cognitive impairment of the roommate. Staff D repeatedly stated the facility had delayed the request only because no suitable roommate had been available.</p> <p>Record review of the new admissions information the facility provided revealed 7 male residents had been admitted to the facility since [REDACTED]/13. Three of these residents were assessed to be of</p>	F 250			

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F 250	Continued From page 7 the same cognitive level as Resident #33 and were placed in rooms suitable for them. In an interview on 11/21/13 at 10:41 a.m. Staff G, the Nursing Station Coordinator, stated she did not speak the resident's primary language and did not use an interpreter. Staff G described her conversations with the resident as simple yes and no questions which she felt were adequate. She also stated she knew Resident #33 was disturbed by the roommate pulling the curtain as well as the coughing and spitting. She was unable to discern in their conversations the roommate had spit on the personal belongings of Resident #33. Staff G acknowledged she had moved the dresser because of the roommate's behavior. She was aware the resident was roommate opened the dresser drawer, but was not able to discern from their conversation this roommate removed items from the dresser of Resident #33.	F 250			
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279	F 279: Kin On will ensure the collaboration of dietitian and nursing staff to develop a comprehensive care plan according to individual resident's condition. Licensed nurses are assigned to review the care plan quarterly to ensure the information is accurate. The DNS and Unit Coordinators will ensure and continual compliance. POC is completed on 12/13/13. <i>The 2 care plans for Resident #2 and #32 were updated.</i> 	12/13/2013	

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F 279	<p>Continued From page 8</p> <p>psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to review and revise care plans to reflect the current status and care needs for Residents #2 and 32, 2 of 35 sample residents reviewed during Stage 2. Failure to accurately care plan nutritional status and needs, positioning and medication use placed residents at risk to receive less than adequate care.</p> <p>Findings include:</p> <p>RESIDENT #2: The 09/13/13 Minimum Data Set (MDS) assessment identified Resident #2 required at least extensive assistance with all Activities of Daily Living, including eating. This MDS also indicated Resident #2 recently had a significant weight loss.</p> <p>Review of the dietitian notes dated 09/12/13 and 10/21/13 identified Resident #2's IBW (Ideal Body Weight) was [redacted] to [redacted] pounds. Review of the resident's nutrition care plan, however, indicated her IBW was [redacted] pounds.</p> <p>Additionally, the resident's nutrition care plan also indicated Resident #2 should have been receiving "1800 cc/day" (1800 milliliters of fluid per day).</p>	F 279		

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F 279	<p>Continued From page 9</p> <p>Review of the intake flowsheet between October and November 2013 revealed Resident #2 consumed 1000-1200cc per day. The intake flowsheet was discontinued after 11/06/13 and read "adequate fluid intake..."</p> <p>On 11/21/13 at 10:18 a.m. Staff H confirmed the IBW recommended by the dietitian was not the same as the care plan. On 11/21/13 at 10:25 a.m. Staff E stated both the IBW and the daily fluid intake requirement should have been updated on the care plan.</p> <p>RESIDENT #32: The 11/05/13 quarterly MDS revealed Resident #32 was completely dependent on staff for care needs.</p> <p>On 11/21/13 at 8:30 a.m. Resident #32 was observed sitting in her wheelchair. The resident was leaning to the left and her head was not in the headrest. A head strap was present, but was not applied. On 11/22/13 at 8:33 a.m. Resident #32 was again observed sitting in her wheelchair. This time her head was in the headrest and a strap was applied across the forehead area. Review of the resident's care plan did not have any mention or direction to staff regarding the head strap.</p> <p>On 11/22/13 at 8:36 a.m. Staff G stated "the strap is for protection because she leans to the left side... it helps with alignment as much as possible." Staff G went on to explain the strap was used only when the resident was in her wheelchair. On 11/22/13 at 8:44 a.m. Staff E indicated the direction for use of the strap should have been identified on the mobility care plan and stated it was "missed."</p>	F 279		

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F 334 SS=D	<p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has</p>	F 334	<p>F334: Kin On will provide education to the resident about the advantages and risks of receiving vaccines injections. An annual education will be incorporated in the monthly Review Quality of Life Issues meeting and individual counseling will be provided as needed. The vaccines will only be given to a resident when a written informed consent is signed by resident/DPOA. The DNS and Unit Coordinators will ensure continual compliance. POC is completed on 12/13/2013.</p>	12/13/2013
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NAME OF PROVIDER OR SUPPLIER KIN ON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4416 SOUTH BRANDON STREET SEATTLE, WA 98118
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F 334	<p>Continued From page 11 already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure Resident #16, one of five residents reviewed for immunizations, was provided education on the benefits and risks of an influenza vaccine prior to receiving it. This failure placed her at risk for potential adverse side effects from the vaccine.</p> <p>Findings include: Review of Resident #16's immunization record</p>	F 334		
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F 334	Continued From page 12 revealed she had received the influenza vaccine on 10/01/13. There was no evidence in the record Resident #16, or her representative, had been provided with education about the influenza vaccine or the opportunity to accept or decline the vaccine. Review of the facility's Influenza Immunization Policy revealed residents were to be educated on the benefits and risks of the influenza vaccine and also given an opportunity to accept or decline the vaccine before the vaccine was administered. On 11/21/13 at 2:50 p.m. in an interview, Staff C acknowledged Resident #16's record did not indicate the resident or her representative received education on the risks and benefits of influenza vaccine before the vaccine was given. There was also no consent form, or other indication Resident #16 was given an opportunity to accept or decline the vaccine.	F 334		
F 371 SS=F	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:	F 371	F371: 1. Dietary Manager conducted an in-service on December 11, 2013 to remind all kitchen staff: Scoops that are used to scoop dry goods need to be stored outside the containers. The production coordinator will monitor and ensure compliance. POC is completed on 12/11/2013	12/17/2013 12/11/2013

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F 371	<p>Continued From page 13</p> <p>Based on observation, interview and record review, the facility failed to properly store and label food, to prepare raw food according to sanitation guidelines, and to hold hot food at the proper temperature during meal service. Failure to store, properly label, prepare and serve food according to food sanitation regulations placed residents at risk for food-borne illness.</p> <p>Findings include:</p> <p>IMPROPER STORAGE OF DRY GOODS: On 11/17/13, initial observations of the facility's dietary department were conducted between 11:35 am and noon. At 11:51 am, a plastic bin containing uncooked rice was observed with a plastic bowl in with the rice, used to scoop the rice. Scoops used for dry goods are to be stored outside the container, since portions of the scoop handled by staff could potentially contaminate the contents of the bin.</p> <p>At 11:53 am, Staff V, the manager on duty, was asked whether scoops were to be stored inside or outside of bins of food such as the rice. She said it should be stored "outside". When asked why this was so, she replied "Because my manager says so".</p> <p>FAILURE TO LABEL STORED FOOD: During initial rounds on 11/17/13 at 11:48 am, in the main freezer, twelve to fifteen large bins of containing packages of frozen meat were stored there. The meat was portioned into approximately 2 pound packages wrapped in clear plastic. None of the packages of frozen meat were labeled to identify what type of meat the package contained, when or where the meat had been processed, or who was the vendor. There was no information</p>	F 371	<p>2. Meat packing label with shipment and/or lot number will be cut off from the original box, and retained in the Kin On meat container. A different color code will be assigned to a specific shipment and will be added to the original meat packing label and the final processed meat packages in the meat containers accordingly to ensure correctly identifying the type of meat and source. Effective immediately, descriptions such as "processed by", "used by", etc. will be added to all date labels to clearly explain what the date refers to.</p> <p>An in-service training will be conducted on December 17, 2013 to ensure all kitchen staff is informed of this change. Dietary Manager is responsible to set up the system and production coordinator will ensure compliance. POC will be completed on 12/17/2013</p>	12/17/2013

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F 371	<p>Continued From page 15</p> <p>for food to be labeled as well as dated was reviewed, she then said it wasn't necessary because all of her staff could recognize the food stored there.</p> <p>On 11/21/13 at 12:20 pm, a follow up interview was conducted with Staff Q about the the facility's policy regarding labeling of stored food. She provided a policy written in Chinese, which she said did direct staff to date and label food for proper storage.</p> <p>On 11/22/13 at 10:15 am, during an interview with Staff A, the facility's Administrator, he stated he did not have a direct supervisory role for the dietary department. When data was discussed about the lack of labeling of stored food, especially large quantities of frozen meat, he said he would talk further with management staff about this.</p> <p>FAILURE TO WASH VEGETABLES WHEN REQUIRED:</p> <p>On 11/21/13 at 12:15 pm, a dietary staff member, Staff R, was observed peeling raw cucumber-shaped green vegetables. A box next to her contained more unpeeled vegetables, wrapped individually in paper. When Staff R was asked if she had washed them before peeling them, she responded "No".</p> <p>Follow up interview with Staff Q at 12:16 pm revealed the vegetables being peeled were a type of squash. She was asked about the facility's policy for washing vegetables prior to peeling them. She replied the squash would be cooked, so they didn't need to be washed before they were peeled. When the requirement for all raw fruits and vegetables to be washed before cutting,</p>	F 371	5. Production coordinator will ensure food continue maintaining at proper temperature by periodically measuring the food temperature throughout the entire serving period. Instruction was given on 11/28/13 in the monthly kitchen operations meeting. Production coordinator will monitor and ensure compliance. POC was completed on 11/28/2013	11/28/2013

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F 371	Continued From page 16 peeling or cooking was reviewed with her, Staff Q again said the squash did not need to be washed because "it would be cooked". FAILURE TO MAINTAIN FOOD AT PROPER HOLDING TEMPERATURES: During observations of the noon meal service on 11/20/13, at 12:20 pm, temperatures for several food items served from the steam table were obtained to determine if they were being maintained at the required holding temperature of 135 degrees Fahrenheit (dF). A pan of pureed vegetables registered 113 dF and a pan of pureed meat was 107 dF. A second pureed entree was 120 dF. These temperatures, below the holding temperature of 135 dF were discussed with dietary staff, who also verified the temperatures with their thermometer.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the	F 431	F431: The Unit Coordinators will work with pharmacist and review the medication storage according the manufacturer's recommendations. Licensed nurses are notified the proper ways of medication storage and all medication storage requirements will be reviewed and ensure it is stored properly. The DNS will ensure implementation and continue in compliance. POC is completed on 11/29/2013.	11/29/2013

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F 431	<p>Continued From page 17</p> <p>facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</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 medications were stored at proper temperatures and biologicals were discarded once expired. Failure to store medications properly and discard expired biologicals in two of two medication storage rooms placed residents at risk for receiving medications/biologicals that were expired and or had compromised integrity.</p> <p>Findings include:</p> <p>STATION 1 MEDICATION STORAGE ROOM: Observation of the Station 1 medication storage room on 11/20/13 at 11:54 a.m. revealed three dozen (36 total) [REDACTED] suppositories stored in the refrigerator. The refrigerator temperature was 35 degrees Fahrenheit (F). Review of the manufacturer's storage instructions indicated the suppositories were to be stored at</p>	F 431			

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F 431	Continued From page 18 room temperature (between 66 degrees F and 77 degrees F). Additionally, 15 intravenous stat kits were found with an expiration date of 04/2011. On 11/20/13 at 12:10 p.m., Staff L and Staff M acknowledged the suppositories were not stored at the appropriate temperature as recommended by the manufacturer and the intravenous stat kits had an expiration date of 04/11. Staff L further stated "the IV kits are expired and are supposed to be discarded." STATION 2 MEDICATION ROOM: On 11/20/13 at 12:15 p.m. 20 [REDACTED] 25 mg suppositories were found to be stored in a refrigerator with a temperature that registered on the facility's thermometer below 40 degrees F. The manufacturer's directions read to store the medication between 68 and 77 degrees F. Staff I confirmed the medication was not stored at the proper temperatures according to manufacturer's recommendation.	F 431			
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any	F 514	F514: Social services will update resident #22, #35, #63's PASRR to provide accurate information. King County PASRR contractor will conduct an in-service training on 12/23/13. Social worker will be educated on how to ensure PASRR accuracy and develop procedure to review and update PASRR as needed. Nursing will conduct an in-service training to all licensed	12/23/2013	

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F 514	<p>Continued From page 19 preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure clinical records maintained for each resident were complete and accurate. The facility failed to ensure required screenings were accurate and updated and staff accurately documented care and services provided for Residents #22, 35, 63, 5 and 24, five of the 35 sample residents. Failure to ensure clinical records were accurate and complete placed residents at risk for unmet needs.</p> <p>Findings include:</p> <p>PASRR ACCURACY/UPDATING RESIDENTS #22, 35 and 63: Resident #22 was admitted to the facility on [REDACTED]/13 with care needs related to [REDACTED] and [REDACTED].</p> <p>Resident #22 was admitted with a Preadmission Screening and Resident Review (PASRR) completed by the hospital from which the resident was admitted. Review of Section I of the form revealed the resident's diagnosis of [REDACTED] was not identified. Furthermore, Section II indicated the resident's care needs at the facility would not exceed 30 days, which the resident clearly surpassed.</p> <p>Similar findings were found for Residents #35 and 63. Resident #35's PASRR was dated 10/12/11 and indicated the resident would not be in the facility for more than 30 days. This form did not</p>	F 514	<p>nurses related to care plan, nursing procedures and documentation on 12/19/2013. Director of social service and Director of nursing will ensure staff's continual compliance. POC is completed on 12/23/13.</p>

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F 514	<p>Continued From page 20</p> <p>have the required physician's signature. Resident #35 was also not coded to have [REDACTED] or [REDACTED], which she was identified to have on a Minimum Data Set (MDS) assessment dated 11/1/13.</p> <p>Resident #63 had a PASRR completed 09/24/10. The resident was marked as having no mental illness. Review of the 10/23/13 MDS revealed the resident had diagnoses of [REDACTED] and [REDACTED] (to be coded in Section II). The PASRR did not reflect this.</p> <p>On 11/21/13 at 10:55 a.m., Staff D stated the PASRRs for Residents #22, 35 and 63 should have been updated to reflect accurate information.</p> <p>DOCUMENTING CARE AND SERVICES RESIDENT #22: Record review revealed upon admission Resident #22 had a consent signed [REDACTED]/13 for the administration of the flu vaccine. Review of the Medication Administration Record (MAR) indicated the resident had not received the vaccination.</p> <p>On 11/20/13 at 11:40 a.m. Staff I stated the facility started administering the flu vaccine in September. Staff I was not able to explain why Resident #22 had not received her flu vaccine despite her signed consent.</p> <p>On 11/21/13 at 9:21 a.m. Staff C explained Resident #22 had not gotten her flu vaccine due to an illness that contraindicated the administration at that time. When asked if this explanation was documented, Staff C stated that it was not, and added "In the future we need to</p>	F 514		

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F 514	<p>Continued From page 21 have better documentation."</p> <p>RESIDENT #5: Resident #5 was admitted [REDACTED]/09 with care needs related to multiple diagnoses including dementia. The 09/26/13 MDS revealed the resident had no speech and was rarely/never understood by others. Due to this, the resident's son made decisions to about her care.</p> <p>A dental screening done on 06/26/13 read, "upper teeth need to be extracted." A nurse's note dated 06/27/13 read "Message regarding dentist's recommendation extraction to upper teeth was related to her son... He agreed with the extraction. Will arrange the dental appointment for him." No other notes related to this situation could be found in the documentation for this resident.</p> <p>On 11/21/13 at 1:34 p.m., Staff H was not able to locate additional information about this dental situation for Resident #5. On 11/21/13 at 2:00 p.m., Staff E explained the resident's son was contacted about getting her teeth extracted and had changed his mind. Staff E said one of the secretaries told a nurse about the situation, but the nurse did not document it.</p> <p>RESIDENT #24: On 11/22/13 at 9:30 am, Staff N, an RN, was asked to help check Resident #24's fingernails. She said she had attempted to provide nail care the previous day, but the resident had resisted trimming the nails of his left hand. This refusal was not noted in his record. When asked if she documented this refusal, she acknowledged she had not, and that she "probably should have".</p>	F 514		
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F 514	Continued From page 22 Additional review of the Medication Administration Record (MAR) where staff were directed to document assessments of symptoms of pain every shift for this resident, found staff had documented pain one time during the month of November 2013. On 11/22/13 at 11:30 am , during an interview with Staff P, a Restorative Aide, he reported the resident called out during range of motion exercise on each of the five days per week he provided care for this resident. This information was not documented in the resident's record.	F 514			

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