

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

PRINTED: 09/09/2013
FORM APPROVED
OMB NO. 0938-0391

1244

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505329	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2013
NAME OF PROVIDER OR SUPPLIER BUENA VISTA			STREET ADDRESS, CITY, STATE, ZIP CODE 151 BUENA VISTA DRIVE COLVILLE, WA 99114		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Buena Vista on 08/19/13, 08/20/13, 08/21/13, and 08/22/13. A sample of 28 residents was selected from a census of 38. The sample included 27 current residents and the records of 1 former and/or discharged resident.</p> <p>The survey was conducted by:</p> <p>██████████ R.N., B.S.N ██████████ R.N., B.S.N ██████████ R.N., B.S.N ██████████ M.S.W ██████████ R.N., B.S.N., M.S.</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Long-Term Support Administration Division of Residential Care Services, District 1, Unit A Rock Pointe Tower 316 West Boone Avenue, Suite 170 Spokane, Washington 99201-2351 Telephone: (509) 323-7302 Fax: (509) 329-3993</p> <p><i>[Signature]</i> Residential Care Services Date <u>9/9/13</u></p>	F 000			

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SPOKANE WA

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

[Signature] NH Administrator 9/18/2013

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 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to promote care in a manner that maintained dignity during dining for 2 of 28 sample residents (#30, 32). Findings include:</p> <p>1. Resident #32 had [REDACTED]. Per record review, he required extensive assistance for eating. Per observation on 8/19/13 at 12:15p.m., Staff #G assisted the resident with lunch. Staff #G placed the fork with food on it up to the resident's mouth. The resident would not open his mouth and Staff #G kept saying, "you need to eat, open your mouth." The resident said "no." Staff #G then stated the resident had an order to eat and she was going to tell the doctor he wasn't eating. The resident stated "you are going to tattle on me?" and the staff member stated "yes, and I wonder what he will have to say." The resident continued to refuse to eat. Per observation on 8/21/13 at 12:30p.m., Staff #G assisted the resident with lunch. A resident at the table asked the aide why he wasn't eating. The aide then turned to the Resident #32 and stated "she wants to know why you aren't eating and starving yourself?" The facility failed to ensure the resident had a</p>	F 241	<p>F 241 This will be corrected.</p> <p>1) Staff G has been counseled on appropriate verbal interventions for encouraging intake for resident #32.</p> <p>2) Staff interventions for dealing with nasal discharge of #30 have been clarified.</p> <p>3) All staff will receive additional in-service education on enhancing dignity and respect in full recognition of residents' individuality. Staff will also receive education on Quality Assurance Performance Improvement methods of problems solving.</p> <p>4) Director of nursing will monitor for ongoing compliance.</p>	10/1/13

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F 241	<p>Continued From page 2 dignified dining experience.</p> <p>2. Resident #30 had diagnoses including [REDACTED]. Per record review, the resident had problems with [REDACTED], [REDACTED] inattention, required extensive assistance and cueing with most activities of daily living, and had a history of having "no tolerance" of others.</p> <p>Review of the resident's care plan revealed an identified problem of constant nasal drainage at meal time. The care plan goal was for the resident not to be offensive to others. Interventions included sitting away from others in the dining room and offering and keeping Kleenex with the resident. There were no care plan directives about assisting the resident with the nasal drainage at meal times and providing personal care at other times during the day to assist the resident to have a clean face and hands.</p> <p>Review of the physician visit dated 5/10/13 noted the resident seemed unaware of the nasal drainage.</p> <p>During observation of dining in the assisted dining room on 8/20/13 at 12:15 p.m., the resident had continuous clear watery nasal drainage dripping into his food while he ate. Staff did not offer to assist him with the drainage.</p> <p>On 8/20/13 at 3:30 p.m., the resident was in the hallway near the nurse's in full view of staff, other residents, and visitors. He was eating chips with clear nasal discharge dripping from his nose to his shirt. The front of his shirt and pants were visibly stained with nasal drainage. The resident had no Kleenex and staff passing by did not stop and offer Kleenex and assistance with cleaning his face and hands.</p>	F 241	F 241 See correction on pg 2 of 13	

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F 241	Continued From page 3 At 3:45 p.m., at the request of the surveyor, Staff #H observed the resident, gave him Kleenex, and cleaned his face and hands. On 8/21/13 at 1:40 p.m., Staff #D and the surveyor observed the resident with nasal drainage. Staff #D confirmed that staff did pass by the resident without assisting him. The facility's interventions focused on the resident having Kleenex at mealtimes. The lack of evaluation about the effectiveness of the resident using Kleenex and the lack of new interventions to address the resident's need for care if he was not aware of the nose drainage placed him at risk for loss of dignity.	F 241	F 241 See correction pg 2 of 13		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide an ongoing program of activities designed to meet the individual needs for 1 of 1 (#2) residents in a sample of 28. Findings include: Resident #2 was alert with periods of confusion. Per record review, the resident required extensive to total assistance with activities of daily living. Per record review, the resident's current plan of care had the resident goals as attending group	F 248	F 248 This will be corrected. 1) Resident #2's activity plan has been revised as part of previously scheduled review and quarterly MDS due 8/30/2013. 2) All residents' activity plans are being reviewed for accuracy with changes as needed. 3) The process for updating activity plans has been reviewed and revised to ensure activities meet the current needs and interests of the resident. 4) Activity Director will monitor for ongoing compliance.	10/1/13	

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F 248	<p>Continued From page 4</p> <p>activities 1 or 2 times per week and to continue to enjoy visits from her husband. Interventions were watching tv shows and visits from her husband. She enjoyed reading, listening to music and games.</p> <p>Per review of the activity flow sheet for July 2013, the resident had 3 documented activities for the month (2 pet visits and 1 Bingo). August 2013 also had 3 activities the resident participated in (3 pet visits).</p> <p>Per observation throughout the survey, the resident was in her room in bed with the tv on. On two occasions the resident was up in her wheelchair at the bedside. The resident was not out of her room or engaged in any other activity other than having the tv on.</p> <p>During an interview on 8/20/13 at 9:50 a.m., a family member stated the resident loved to play Bingo and had asked the facility to have her go to Bingo when she was up in her wheelchair.</p> <p>On 8/21/13 at 2:00 p.m., Bingo was being played in the dining room. Resident #2 was observed up in her wheelchair in her room. No staff offered to take the resident to the Bingo activity.</p> <p>During an interview on 8/23/13 at 11:00 a.m., Staff #I stated the resident used to like to come to music and Bingo. She thought the resident was participating in some in room activities but was not consistently monitoring her participation.</p> <p>On 8/23/13 at 11:25 a.m., Staff #J stated the staff would offer the resident activities if she was up. She stated she used to do crossword puzzles but she doesn't do them much anymore.</p> <p>The facility failed to provide an ongoing program of activities to meet the resident's individual needs. This failure placed the resident at risk for diminished quality of life.</p>	F 248	F248 See correction pg 4 of 13		

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F 280 F 280 SS=D	<p>Continued From page 5</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to review and revise the plan of care for 1 of 14 residents (#2) in a sample of 28 related to positioning and activities of daily living (adl's). Findings include:</p> <p>Positioning Resident #2 was alert with periods of confusion. Per record review, the resident required extensive to total assistance on all activities of daily living (adl's).</p>	F 280 F 280	<p>F 280 This will be corrected.</p> <p>1) Resident #2 and spouse participated in revision of care plan as part of previously scheduled review and quarterly MDS due 8/30/2013.</p> <p>2) The procedure for updating care plans has been reviewed and revised to ensure increased resident and/or resident representative as well as interdisciplinary team participation.</p> <p>3) Staff will receive in-service education on the new procedure for updating care plans.</p> <p>4) Director of nursing will monitor for ongoing compliance.</p>	10/1/13

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F 280	<p>Continued From page 6</p> <p>On 8/20/13 and 8/21/13, the resident was observed up in her wheelchair for approximately 1 1/2 hours each time, her right arm was sliding off the arm rest and her upper body leaned to the right side without support. There were no positioning aides observed to assist the resident to keep her body upright while up in the wheel chair.</p> <p>Per review of the resident's most recent plan of care, the care plan did not identify the resident had any problems with positioning.</p> <p>On 8/21/13 at 3:15 p.m., Staff #K stated she always leaned over to her right side in her wheelchair. She stated they tried to use pillows to position her but she pulled them out.</p> <p>On 8/22/13 at 10:10 a.m., Staff #F stated the staff probably positions her correctly when they get her up into the wheel chair but she only stays up for about an hour and a half so they probably don't go back and check on her positioning. She confirmed the careplan had not been updated since her most recent decline.</p> <p>The facility's lack of re-evaluation with positioning placed her at risk for poor positioning when up in her wheelchair.</p> <p>ADL's Resident #2 was alert with periods of confusion. Per record review, the resident required extensive to total assistance on all activities of daily living (adl's).</p> <p>Per review of the resident's most recent plan of care, it was documented that the resident was able to participate in upper body care. She required set up for oral care, hair care and washing her face.</p> <p>Per interview on 8/22/13 at 9:15 a.m., Staff #J stated she was totally dependent on staff to help her with her cares such as washing her face and</p>	F 280	F280 See correction pg 6 of 13	

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<p>F 280</p> <p>F 309 SS=D</p>	<p>Continued From page 7 combing her hair. On 8/22/13 at 9:30 a.m., Staff #M stated the resident couldn't assist and was totally dependent on all her cares. On 8/22/13 at 10:10 a.m., Staff #F confirmed the careplan needed updated due to her more recent decline. The facility was aware of the resident's decline in abilities and failed to revise her plan of care which placed her at risk for not receiving proper care.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide necessary care and services related to proper positioning for 1 of 1 residents (#2) in a sample of 28. Findings include: Resident #2 had diagnoses that included a disease of the [REDACTED]. She was alert with periods of confusion. Per record review, the resident required extensive to total assistance with all activities of daily living. On 8/20/13 and 8/21/13, the resident was up in her wheelchair for approximately 1 1/2 hours</p>	<p>F 280</p> <p>F 309</p>	<p>F309 This will be corrected.</p> <p>1) Resident #2's care plan has been revised as part of previously scheduled review and quarterly MDS due 8/30/2013.</p> <p>2) Occupational therapy consultation was completed and recommendations will be incorporated into positioning plan for this resident.</p> <p>3) Restorative staff will review other residents for any similar issues.</p> <p>4) Nursing staff will receive in-service education on identifying problems and incorporating solutions into care plan to ensure highest practicable physical, mental, and psychosocial well-being of residents.</p> <p>5) Director of nursing will monitor for ongoing compliance.</p>	<p>10/1/13</p>
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F 309	Continued From page 8 each time, her right arm was sliding off the arm rest and her upper body leaned to the right side without support. There were no positioning devices to assist the resident to keep her body upright while up in the wheel chair. Per record review, there was no evaluation or plan of care to address the resident's lack of neck and torso positioning while in bed or up in the wheel chair. Per review of the resident's most recent plan of care, the care plan did not identify the resident had any problems with positioning. During an interview on 8/20/13 at 10:10 a.m., a family member stated the staff does not put her in her wheel chair correctly. He stated when he comes to visit the resident was slumped over to the right and he had instructed staff numerous times on how to position her properly. On 8/21/13 at 3:15 p.m., Staff #K stated the resident always leans over to her right side. She stated they try and use pillows to position the resident but she will pull them out. On 8/22/13 at 10:10 a.m., Staff #F stated the staff probably positioned her correctly when they get her up into the wheelchair but the resident only stays up for about an hour and a half so probably don't go back and check on her positioning. The facility was aware of the resident's poor positioning and the facility failed to re-evaluate her and provide appropriate interventions.	F 309	F309 See correction pg 8 of 13		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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.	F 312	F312 See correction pg 10 of 13		

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F 312	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to ensure oral care was provided for 1 of 40 residents (#2) reviewed for activities of daily living (adl's). Findings include: Resident #2 had diagnoses that included a [REDACTED] of her [REDACTED]. The resident was alert with some confusion and required extensive assistance with personal hygiene. Per record review, the resident had a tube inserted into her stomach for nutrition and could not have anything by mouth. Per review of the resident's most recent plan of care, it instructed staff that the resident was a set up for oral care as well as her other cares. There was no update in her careplan that she now needed extensive assist for adl's. Per observation, the resident appeared to have a dry mouth. A bag of toothettes were in the resident's drawer, however, for the days of the survey none of them had been used. On 8/21/13 at 9:30 a.m., Staff #M stated the resident was not allowed to have her teeth brushed because she couldn't have anything by mouth. She did state there were sponges that could be used. On 8/22/13 at 10:10 a.m., Staff #F confirmed the staff should be using toothettes for oral care and stated the careplan had not been updated since her most recent decline. The facility failed to consistently provide oral care for a resident that was unable to take	F 312	F 312 This will be corrected. 1) Resident #2's ADL care plan has been revised as part of previously scheduled review and quarterly MDS due 8/30/2013. 2) All resident's nursing care plans are being review for accuracy related to ADL care. 3) The process for updating nursing care plans has been reviewed and revised to ensure accuracy of nursing care plans including directions for ADL care. 4) Nursing staff will receive in-service education on identifying problems and incorporating solutions into care plan to ensure accuracy of ADL care directions. 5) Director of nursing will monitor for ongoing compliance.	10/1/13	

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F 312 F 323 SS=E	<p>Continued From page 10 anything by mouth which placed the resident at risk for dry mouth and mouth discomfort.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to protect residents from environmental hazards related to hot water from bedroom hand sinks in 2 of 10 rooms reviewed for safe water temperatures, and material accessible for ingestion 1 of 1 resident (#22) in a sample of 27 residents reviewed for environmental hazards.</p> <p>Findings include: 1. Observation of two resident rooms (#s 119 and #120) hand sinks on 8/20/13 at 12:15 p.m. included temperatures of running water maintaining 122 and 121 degrees Fahrenheit for one to two minutes. In an interview with Staff # B on 8/20/13 at 12:15 p.m., he confirmed "122 degrees is a bit hot". He further stated that water temperatures are checked once per month and the hot water tank for the block of room's #119 and #120 ran hotter than the other rooms in the facility. He said he would decrease the water tanks temperature</p>	F 312 F 323	<p>F323 This has been corrected.</p> <p>1) Water temperature was corrected at time of survey. Parameters for adjusting water temperature changed to 110 degrees +/- 5 degrees rather than between 100 and 120 degrees.</p> <p>2) Asper Flex cream was removed from resident room. Procedure for use of pain relieving creams was reviewed with staff.</p> <p>3) Facility staff will receive education on identifying and reporting potential hazards and being proactive participants in quality assurance and performance improvement goals for a safe environment.</p> <p>4) Administrator will monitor for ongoing compliance</p>	10/1/13

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505329	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2013
NAME OF PROVIDER OR SUPPLIER BUENA VISTA		STREET ADDRESS, CITY, STATE, ZIP CODE 151 BUENA VISTA DRIVE COLVILLE, WA 99114		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 11 for the rooms.</p> <p>Record review of the maintenance temperature logs indicated the resident's water temperature in hand sinks were checked on 7/19/13 and were 119 degrees.</p> <p>Many residents of long term care facilities have conditions that may put them at increased risk for burns caused by scalding. The facility failure to monitor resident hand sinks with known fluctuations in temperature of " running water " placed the residents at risk for avoidable accidents and injury from hot water temperatures.</p> <p>2. Resident #22 received a schedule [redacted] medication and had non-medical [redacted] interventions in place for treatment of [redacted]</p> <p>On initial tour of the facility on 8/19/13 a tube of Asper Flex Cream (medicated topical cream that contains Aspirin) was observed on top of Resident #22 's dresser. When brought to the attention of professional staff #C, she placed the cream in the resident's drawer. Staff #C stated to surveyor "the cream was considered a non - medical pain intervention "</p> <p>In an interview on 8/20/13 at 10:00 a.m. professional Staff #F said the medicated creams were kept in the medication carts until applied.</p> <p>In a confirming interview with professional Staff # A on 8/20/13 at 10:00 a.m. she stated the medicated creams are kept in the cart per facility practice.</p> <p>The Asper Flex cream was observed again on morning of 8/20/13 in the residents' room. The cream was removed when brought to the attention of the professional staff by the surveyor and locked in the medication cart.</p> <p>The facility failure to store the medicated cream per their policy placed the residents at risk for ingestion and contact with a potential toxic</p>	F 323	F323 See correction pg 11 of 13	

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F 323	Continued From page 12 material.	F 323	F323 See correction pg 11 of 13	
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