

1281

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505389	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/06/2013
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NAME OF PROVIDER OR SUPPLIER CASCADE PARK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 801 SOUTHEAST PARK CREST AVENUE VANCOUVER, WA 98683
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F 000

INITIAL COMMENTS

F 000

This report is the result of an unannounced Quality Indicator Survey conducted at Cascade Park Care Center on 12/02/13, 12/03/13, 12/04/13, 12/05/13 and 12/06/13. A sample of 41 residents was selected from a census of 81. The sample included 29 current residents and the records of 12 former and/or discharged residents.

The survey was conducted by:

- ██████████, RN, MN
- ██████████, MSW
- ██████████, MS
- ██████████, MCJ

The survey team is from:

Department of Social & Health Services
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[Signature]
Residential Care Services
Date: 12/13/13

RECEIVED
JAN 6 2014
DSHS/ADSA/RCS
Note: Faxed copy rec'd 01/03/14-eg

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Executive Director	(X6) DATE 12-27-13
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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 272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p>	F 272	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law</p> <p>F272</p> <p>Resident #89 MDS has been modified, and the oral assessment has been updated. The resident refuses to have her diet modified.</p> <p>Resident's dental status have been reassessed.</p> <p>LN's were inserviced on comprehensive assessment accuracy.</p> <p>Audits will be conducted for 3 months. Inaccuracies will be corrected; patterns will be reviewed in monthly PI.</p> <p>DNS to ensure compliance</p> <p>Date certain: 01-10-14</p>	1-10-14

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F 272	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to complete comprehensive assessments for 1 of 27 current sampled residents (#89) for care and services. This failure prevented the facility from obtaining necessary information to develop a care plan and to provide the appropriate care and services for each resident.</p> <p>Findings include:</p> <p>Resident # 89 was admitted on [REDACTED]/13 with diagnoses including [REDACTED] failure, [REDACTED] and [REDACTED].</p> <p>The Minimum Data Set (MDS), an assessment, dated 08/10/13 did not indicate that Resident #89 had dentures or difficulty chewing.</p> <p>The facility entitled "Oral Assessment Form" indicated Resident # 89 had her natural and no dentures.</p> <p>On 12/03/13 at 10:22 a.m., Resident #89 stated she had lost her bottom dentures before she was admitted to facility and told the facility staff that brings her food. Resident #89 stated, "They {staff} bring the same old food that I can't chew. I told them I couldn't chew it and nothing was done, they kept bringing me the same food."</p> <p>On 12/06/13 at 11:19 a.m., Licensed Nurse (LN) B stated that facility's "Oral Assessment Form" was utilized to complete the MDS, and would explain why the MDS was missing information about the resident having dentures.</p>	F 272		

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F 272	Continued From page 3	F 272		
F 309 SS=D	<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 consistently maintain dialysis communication and post dialysis monitoring for 1 of 4 current sample residents (#32) reviewed for treatment from an outside provider. This failure placed residents at risk for incomplete and/or delayed care and services.</p> <p>Findings include:</p> <p>Resident #32 was admitted to the facility on [REDACTED]/2013 with diagnosis including [REDACTED] failure, [REDACTED], [REDACTED] and [REDACTED] failure.</p> <p>The resident's Minimum Data Set, an assessment tool, dated 9/26/13, indicated resident was able to make needs known, was moderately cognitively impaired, required</p>	F 309	<p>F 309</p> <p>Resident #32 was assessed after she returned from dialysis, the clinic was contacted and the post dialysis information was obtained.</p> <p>Residents receiving Dialysis Services were audited to ensure care and services regarding post dialysis communication is intact.</p> <p>LN's were inserviced on post Dialysis communication. Pre and post dialysis communication will be communicated via fax. Should the contracted dialysis center fail to provide necessary documentation they will be contacted by phone to get the post dialysis information.</p> <p>Random audits will be conducted on post Dialysis care. Findings will be brought to PI.</p> <p>DNS to ensure compliance.</p> <p>Date certain: 01/10/2014</p>	1-10-14

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F 309	<p>Continued From page 4</p> <p>assistance with activities of daily living, and received dialysis treatments.</p> <p>On 12/5/13 at 8:50 a.m., LN C stated the Pre/Post Dialysis Checklist form is sent with the resident each day then sent back with the resident. If it's not sent back then staff will contact the dialysis clinic and have the information faxed to the facility.</p> <p>Review of the current Pre/Post Dialysis form showed it had been filled out on 11/21/13 for pre and post dialysis, the second section had no date but had the post dialysis information. The pre dialysis information had been filled out for 12/5/13 for the same day dialysis appointment.</p> <p>Upon review of the resident's medical chart a Pre/Post Dialysis Checklist form was located with the first of 4 entries being dated 11/5/13 with pre and post information completed, 11/7/13 and 11/8/13 were also completed with pre and post dialysis information, the last of 4 entries dated 11/12/13 contained only post information for weight upon return, no other pre or post information was completed.</p> <p>At 10:12 a.m., the resident was observed in her room watching television with the dialysis packet, including the Pre/Post Dialysis Checklist form, on her bed and dialysis bag on her chair.</p> <p>At 7:35 p.m., the resident was observed in her room with the dialysis packet on her bed and dialysis bag on her chair. The resident stated she was unaware of who to give the packet to or where it went.</p> <p>On 12/6/13 at 11:00 a.m., LN E stated the</p>	F 309		
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F 309	<p>Continued From page 5</p> <p>Pre/Post Dialysis Checklist forms are kept in the slot next to the resident's medical chart. The dialysis packet was not observed in the stated location.</p> <p>At 11:23 a.m., LN E confirmed the nurse looks at the form upon return and puts it in the slot next to the chart.</p> <p>At 11:23 a.m., LN D stated the form didn't come back and she didn't call the dialysis center to have the information sent.</p> <p>At 11:24 a.m., LN E was informed by the surveyor, the dialysis packet was observed on the resident's bed on 12/5/13 at 7:35 p.m.</p> <p>At 11:28 a.m., LN E asked the resident about the dialysis packet. The resident stated that no one could tell her what to do with it so she threw it in the trash. After checking the trash, LN E confirmed it was not there.</p> <p>At 11:56 a.m. LN D stated, the nurse is to review the dialysis packet and then check vitals for the resident upon the resident's return from the dialysis clinic. LN D indicated the resident returned about 4:30 p.m. LN D confirmed she completed blood sugar and vital checks for the resident before dinner but, "I didn't see the packet, I kinda spaced that."</p> <p>This had the potential for staff to have incomplete information necessary to assess Resident #32's condition upon return from the dialysis clinic and/or timely identification of complications that required immediate attention putting the resident at risk for delayed care.</p>	F 309		

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F 315
SS=D

483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER

F 315

F315

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

Resident # 85 catheter bag and tubing were changed. Catheter bag tubing was anchored to his leg, and peri care and catheter care was provided using a different clean cloth between the meatus, shaft and catheter tubing per policy. LN has contacted the physician for reevaluation for continued need of the catheter.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, it was determined the facility failed to ensure management of indwelling catheters per facility policies and procedures for 1 of 2 current sample residents (#85) reviewed for catheter care. The failed practice placed residents at risk for the wrong treatment and related complications.

Residents with indwelling catheter's will be assessed to ensure proper treatment and services are being provided.

All staff were inserviced on catheter care per policy.

Findings include:

Resident # 85 was admitted on [redacted]/13 with diagnoses including [redacted], [redacted] disease, [redacted] of [redacted] and [redacted].

Audits will be conducted on catheter care weekly X4 weeks, then monthly X 2. Findings will be immediately addressed; patterns will be brought to PI. Skills competency checks on catheter provision will continue annually.

DNS to ensure compliance.

Date certain: 01/10/14

F371

Resident #85's admission Minimum Data Set (MDS), an assessment tool, dated 7/8/13 indicated that resident was cognitively intact and continent of bladder and bowel. Resident #85's functional status from the re-admission/return MDS dated [redacted]/13 identified the resident needing extensive assist

1-10-14

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F 315	<p>Continued From page 7 for toilet use and bed mobility, and limited assistance needed for walking in room and transfers.</p> <p>Facility policy entitled "Urinary Tract Infection Informational Handout" indicated "A long term indwelling (>2 to 4 weeks) increases the chances of having a symptomatic UTI and urosepsis ..." and also indicated "Recurrent symptomatic Urinary Tract Infections (UTI)... should lead the facility to check whether perineal hygiene is performed consistently to remove fecal soiling ... to re-evaluate the techniques being used for perineal hygiene and catheter care, and to reconsider the relative risks and benefits of continuing the use of an indwelling catheter."</p> <p>Facility policy entitled "Catheterization Information Handout" reads "Because of the risk of substantial complications with the use of indwelling urinary catheters... The assessment should include consideration of risks and benefits of an indwelling catheter; the potential removal of the catheter... Based on the resident's individualized assessment, the catheter may need to be changed more or less often than every 30 days."</p> <p>Facility policy entitled "Indwelling Catheters" indicated "Catheters must be anchored to avoid excessive tugging on the catheter ...during the delivery of care to prevent ...tissue injury ..."</p> <p>On 12/04/13 at 5:58 p.m., as Nursing Assistant (NA) A was preparing resident for catheter care, the indwelling catheter was observed being stretched taut until catheter was straight. The indwelling catheter was not anchored.</p>	F 315		

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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F 315	<p>Continued From page 8</p> <p>During catheter care, NAA pulled foreskin back and swiped the head of the penis three times consecutively with the same side of a moist towelette from the corona (rounded base of the head of the penis) towards the tip of the penis, and then with the same side of towelette proceeded down the catheter tubing.</p> <p>During catheter care, the catheter bag and tubing was observed on the floor. After completing catheter care, LNA did not perform perineal care and left catheter bag and tubing on the floor without reporting to a licensed nurse.</p> <p>On 12/05/13 at 2:24 p.m., when asked how Resident #85 indwelling catheter was attempted to be removed Licensed Nurse (LN) E stated that she asked Resident #85 and he refused to have catheter removed. LN E stated, "It is his {Resident #85's} right if he wants the catheter left in, he's alert and orientated. He has the right to refuse care and treatment." LN E indicated no consultation with physician regarding removal of indwelling catheter.</p> <p>When asked about facility policy for changing indwelling catheter, LN E stated she would change catheter as needed, for example if the catheter was clogged or leaking.</p> <p>On 12/06/13 at 12:16 p.m., Director of Nursing Services (DNS) stated that the UTI Resident #85 experienced on 10/25/13 was probably not related to the resident's indwelling catheter considering the resident had several infections including lung and heel infections.</p> <p>When asked about Resident #85's care plan regarding UTI and indwelling catheter, DNS stated, "Why would we need to revise the care</p>	F 315		

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F 315	Continued From page 9 plan, all we would do is list catheter care per facility policy. There would be no need to change it." The facility failed to provide Resident #85 with proper catheter care and failed to implement facility policies for maintaining indwelling catheters to prevent complications.	F 315		
F 371 SS=D	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, interview, and record review, it was determined the facility failed to serve food under sanitary conditions. This failure created the potential for food contamination for all residents receiving food served in the facility. Findings include: Facility policy entitled "Tips on Handling Resident Food" reads "Glasses and cups may not be touched around the rim of where the resident will be drinking."	F 371	F371 No residents were affected by this practice. All staff were inserviced on "Handling resident food" to prevent contamination. Random audits on "handling resident food" to prevent contamination ongoing. Deficiencies will be addressed immediately; findings will be brought to PI DNS to ensure compliance. Date certain: 01-10-14	1-10-14

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F 371	<p>Continued From page 10</p> <p>On 12/02/13 at 12:02 p.m. in main dining room, Nursing Assistant (NA) C was observed pouring resident drinks and then adjusted a resident's blanket, and returned to serving drinks without washing hands.</p> <p>On 12/03/13 at 12:11 p.m. in main dining room, NA C was observed touching the rim of a glass when pouring and serving drinks.</p> <p>On 12/03/13 at 12:22 p.m. in main dining room, NA D was observed touching the rim of a glass when taking the glass off the tray to place it on the table.</p> <p>On 12/04/13 at 5:22 p.m., the Activity Assistant (AA) assisted a resident into the dining room. The AA moved chairs to make room for this resident's wheelchair. The AA offered the resident a beverage. The AA then took a clean glass from the beverage cart, and while holding the rim of the glass poured a beverage into the glass and then gave it to the resident.</p> <p>The AA then offered another resident a beverage and poured this resident a drink while holding the rim of the glass.</p> <p>At 5:25 p.m., the AA delivered trays to various residents in the dining room.</p> <p>At 5:27 p.m., the AA washed her hands after delivering two (2) beverages and two(2) trays to residents.</p> <p>On 12/06/13 at 2:55 p.m., Assistant Director of Nursing Services stated, "I do not provide any training for serving food, they receive their training in CNA School, but I will correct failed</p>	F 371		

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F 371	Continued From page 11 practice if I see it."	F 371		
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