

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

PRINTED: 05/17/2013  
FORM APPROVED  
OMB NO. 0938-0391

1313

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/03/2013
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NAME OF PROVIDER OR SUPPLIER  SAN JUAN REHAB AND CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 911 21ST STREET ANACORTES, WA 98221
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F 000 INITIAL COMMENTS

F 000

This report is the result of an unannounced, Staggered Quality Indicator Survey conducted at San Juan Rehab and Care Center on 04/28/13, 04/29/13, 04/30/13, 05/01/13, 05/02/13 and 05/03/13. The survey included data collection from 10:00 a.m. to 4:00 p.m. on Sunday, 04/28/13. A sample of 27 residents was selected from a census of 50. The sample included 24 current residents, the records of three former and/or discharged residents, and eight supplemental residents.

Survey team members included:

██████████, MSW  
██████████, RN, MN  
██████████, RN, BSN, MEd

The survey team is from:  
Department of Social and Health Services  
Aging and Long Term Support Administration  
Residential Care Services District 2, Unit B  
3906 172nd Street NE, Suite 100  
Arlington, Washington 98223-4740

Telephone: (360) 651-6850  
Fax: (360) 651-6940

RECEIVED  
MAY 28 2013  
ADSA/RCS  
Smokoey Point

*[Signature]* 5/7/13  
Residential Care Services Date

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Operations Manager	(X6) DATE 5-24-13
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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 156  
SS=D

483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:

F 156

The facility is now providing CMS form 1055 SNF ABN to residents who remain @ the facility after Medicare services end. The resident care coordinator will provide the form & assure the resident and/or responsible party know they have the option to continue services that would not be covered by Medicare. The resident care coordinator & the Director of nursing services will audit discharges monthly to assure 1055 SNF ABN has been

5/3/13

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F 156	<p>Continued From page 2</p> <p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by</p>	F 156	<p>provided according to regulations. The Director of Nursing Services will assure compliance.</p> <p><i>*San Juan no longer provides notice of Medicare provider Non-Coverage to residents who have used all 100 benefit days. The facility will issue Non-Coverage letters only per regulations. The Resident Care Coordinator will audit monthly The Director of Nursing Services will assure compliance</i></p>	5/3/13
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F 156	<p>Continued From page 3 such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide required liability notices for two (#s 71 and 12) of four residents reviewed for liability notices. In addition, the facility provided an inaccurate notice of appeal rights to Resident #82. These failures placed the residents at risk for not being fully informed of and/or understanding their Medicare benefits.</p> <p>Findings include:</p> <p><b>RESIDENT #71</b> Record review revealed Resident #71 received Medicare part A services. The services ended on 11/14/12. In an interview on 05/01/13 at 2:10 p.m., Staff F said the resident remained in the facility after the Medicare services ended. The Notice of Medicare Non-Coverage was appropriately provided and signed.</p> <p>The facility failed to provide an additionally required form to ensure the resident had the option to continue services that would not be covered by Medicare (CMS form 10055 SNF ABN). In an interview on 05/01/13 at 2:15 p.m., Staff F stated she was not aware of the form and had not provided it to any residents who required it.</p> <p><b>RESIDENT #12</b> Record review revealed Resident #12 received Medicare part A services. The skilled services</p>	F 156	<p>The facility will ensure that resident/family members have signed Notice of Medicare Non-Coverage &amp; have been provided a written copy.</p> <p>The family member of Resident #12 was sent, &amp; the facility received signed copy of the Notice of Medicare Non Coverage.</p>	5/15/13 ↓

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F 156	Continued From page 4 ended on 04/11/13. In an interview on 05/01/13 at 2:20 p.m., Staff F said the resident remained in the facility after the Medicare services ended. A Social Service progress note, dated 04/10/13, indicated the resident's family member had been contacted the previous day to inform her of the end of coverage. The note further revealed the family member would sign the Notice of Medicare Non-Coverage when she was at the facility, "in the next week or two." There was no further indication the notice had been signed or that additional steps had been taken to ensure the family member was provided with a written copy of the notice.  In addition, the facility failed to provide CMS form 10055 SNF ABN. In an interview on 05/01/13 at 2:17 p.m., Staff F acknowledged form 10055 was not provided to Resident #12. She further stated she had mailed the Notice of Medicare Non-Coverage to the resident's family but had not received a signed copy back. She failed to send the notice via certified mail to ensure proof of delivery.  RESIDENT #82 Staff F provided a Notice of Medicare Provider Non-Coverage to Resident #82 whose skilled benefits were exhausted on 11/29/12, as the resident used all 100 benefit days. Staff F stated she was unaware that form should not be provided as it included appeal rights Resident #82 did not have.	F 156	In cases where notices are sent by mail to responsible party: If no receipt of signed copy in 2 weeks, the facility will re-send the notice per certified letter and attach receipt to the copy of the notice.  The resident care coordinator & Director of Nursing services will audit Notices of Non Coverage a minimum of Monthly to assure compliance.	5/3/13	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE  An individual resident may self-administer drugs if	F 176	The Director of Nursing services will assure compliance ★		

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F 176	<p>Continued From page 5</p> <p>the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents were assessed for safety of medications at bedside, including self-administration, storage, and monitoring for five (#s 139, 25, 51, 71 and 74) of five residents noted with medications at bedside. This failure placed residents at risk of adverse effects from medication interactions, overdose and exacerbation of medical conditions.</p> <p>Findings include:</p> <p>The undated facility Self-Administration/Medication in Room policy indicated if a resident expressed desire to administer his/her own medications and or store medications in his/her room, staff were to complete the Self-Administration/Medication in Room form, which included directions to obtain physician's orders (PO) for "medication at bedside AND self-administration", ensure the medication was clearly labeled, including instructions, assess the resident's ability to self-administer and provide locked storage for the medication.</p> <p>RESIDENT #139 Observation on 04/28/13 at 2:09 p.m. revealed a container of cough drops at the resident's bedside. In an interview at that time, Resident #139 said, "once in a while I take one if I have a</p>	F 176	<p>Resident #139 has physician order for cough drops @ bedside and was assessed for safety per facility Self Administration/Medication in room form. He keeps cough drops in locked box. He no longer has Albuterol @ bedside.</p>	5/10/13

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F 176	<p>Continued From page 6</p> <p>sore throat, it's usually from keeping my mouth open." When questioned about his NPO (nothing by mouth) status, the resident replied, "the cough drops themselves are not going down my throat, a lot of times I have to spit it out 'cus it (saliva) gets all clogged up in my throat."</p> <p>Record review revealed no PO for the cough drops themselves, nor a PO to keep the cough drops at the bedside. Record review did reveal a 04/04/13 PO to keep <del>          </del>, an inhaled medication, at bedside. There was no assessment through which staff determined the resident was safely able to self administer either the <del>          </del> or the cough drops.</p> <p>Additionally, review of the resident's record revealed a 04/04/13 signed Notice of Medication Policy that read, "It could be detrimental to my health to take medications other than those ordered by my physician and dispensed by the nursing staff, I understand it is against facility policy to keep medication in my room UNLESS the physician has directly advised the nursing staff that I may keep some medication in a locked box at my bedside."</p> <p>Similar findings were identified for Resident #25 who was observed on 04/28/13 at 11:05 a.m. with a bag of cough drops at the bedside. Resident #25 said "They help me if I really get to coughing, but I don't do it much." Additionally, Resident #51 was observed on 04/28/13 at 1:38 p.m. with a bag of cough drops at the bedside and said "I chew them once in a while." Record review revealed neither resident had a PO for the cough drops, nor a PO to keep the cough drops at the bedside, nor an assessment which indicated the</p>	F 176	<p>Resident # 25 has physician order for prn cough drops. She was assessed per facility self-administration form &amp; cough drops are kept in medication cart.</p> <p>Resident #51 has physician order for cough drops @ bedside, and was assessed per facility Self-Administration/Medication in room form. He keeps cough drops in locked box in his room</p> <p>Resident #71 bottles @ bedside removed &amp; discarded. Has physician order for Nasal spray @ bedside. New bottle ordered/dated. Assessed per facility Self-Administration/Medication in room. She keeps Nasal spray in locked box in her room.</p>	5/10/13 ↓

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F 176	<p>Continued From page 7</p> <p>residents were able to safely self-administer the medications.</p> <p><b>RESIDENT #71</b> Observations on 04/28/13 revealed two bottles at the resident's bedside. Neither bottle had open dates and the expiration dates were illegible. One of the bottles was for [REDACTED] nasal spray, which the resident said she used "About once a week." Review of POs revealed a 10/17/12 order for a different nasal spray, [REDACTED] ( [REDACTED] ), to be used PRN (as needed) for [REDACTED]. The record contained a 03/11/13 fax to the physician which stated "Not demonstrating good/reliable judgement with handling PRN meds when goes to dialysis." In response, the physician wrote an order "Do not send medications with res(ident) to dialysis or outings. Must have responsible party/dialysis handle any med needs." Record review revealed no PO for the nasal spray, no PO to keep medications at bedside, nor an assessment through which staff determined the resident was safely able to self-administer the medication.</p> <p>Similar findings were identified for Resident #74 who was observed on 04/28/13 with a bottle of liquid tears at the bedside, without benefit of POs or an assessment to self-administer.</p> <p>In an interview on 05/01/13 Staff B said if a resident had medications at the bedside the resident should have been assessed to be able to use them and provided a lock box in which to store them.</p>	F 176	<p>Resident # 74 liquid tears removed from bedside She has physicians order for PRN use. She was assessed per facility Self Administration/Medication in room. Her artificial tears are kept in Medication Cart.</p> <p>All Nurses were re-educated to: inform on admit of medication policy, monitor bed-sides for things visitors bring, assess residents for medication in the room when they request &amp; obtain physician order if they pass assessment.</p> <p>A letter was sent to all family's of current residents informing them of medication Policy. All staff educated to monitor resident bedside for meds. The DNS will spot-check on rounds Mon-Fri &amp; will assure compliance.</p>	5/10/13
F 248	483.15(f)(1) ACTIVITIES MEET	F 248		5/24/13

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F 248 SS=E	Continued From page 8 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, the facility failed to provide activities for three (#s 142, 23 & 13) of three residents reviewed for activities and one supplemental resident (#19). In addition, 20 (#s 8, 29, 24, 25, 141, 17, 7, 143, 139, 121, 51, 13, 33, 15, 10, 42, 16, 2, 137 & 5) of 23 residents interviewed in Stage 1 expressed concerns with a lack of activity on weekends and evenings. This failure did not promote the residents' mental and psychosocial well-being and placed them at risk for social isolation, boredom and a diminished quality of life.  Findings include:  DAY OF ENTRY From 10:15 a.m. through 4:00 p.m. on Sunday, 04/28/13, no activities were observed to occur in the facility. At 2:51 p.m., Resident #5 was observed propelling her wheelchair past the nurse's station. She spoke to an unidentified nurse who responded there was "no bingo today because it's Sunday. The church people come every other Sunday. Not this Sunday." The nurse commented that the resident was "looking for something to do." The resident was observed to	F 248	The facility will provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests & the physical, mental & psychosocial well-being of each resident.  The facility has assessed residents #142, 23, 13, & 19 and all other current residents to determine appropriate and/or desired activities for each & will provide an ongoing activity program to meet their needs. The facility will complete an activity assessment for new admissions within 48 hours & develop an activity plan of care to meet their needs. The facility will continue to provide both planned & spontaneous activities & will make ongoing adjustments	6/15/13	

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F 248	<p>Continued From page 9</p> <p>propel herself towards her room. No staff, including the nurse who spoke to her, offered the resident a suggestion or assistance with an activity.</p> <p>A dry-erase white board in the Dining Room was observed on Sunday, 04/28/13, to be labeled "Saturday, April 27." There was nothing else written on the board. On 04/30/13 at 7:50 a.m., Staff E stated the white board was where the Activity schedule for each day was posted.</p> <p><b>STAGE 1 INTERVIEWS</b></p> <p>Twenty of 23 residents interviewed during Stage 1 identified concerns with a lack of activities available in the evenings and/or weekends. For example, on 04/29/13 at 10:42 a.m., Resident #10 stated she was not aware of activities that occurred in the evenings or on weekends. On 04/29/13 at 1:05 p.m., Resident #5 stated there was "sometimes" things that occurred on the weekends, however staff did not always think to tell her about them. On 04/29/13 at 1:55 p.m. Resident #16 stated she could not think of anything that occurred on the weekends. On 04/29/13 at 3:19 p.m., Resident #2 stated the previous day, Sunday, the only thing she had done was watch television. She stated it was a "slow day." Her roommate, Resident #71, interjected at that point the weekends were "slow, very slow."</p> <p><b>RESIDENT #142</b></p> <p>Resident #142 was observed in her bed throughout the survey. In an interview on 04/29/13 at 3:01 p.m., Resident #142's family member stated she was at the facility to receive therapy. The family member stated staff had not</p>	F 248	<p>based on current clientele, change of conditions &amp; change of resident goals/interests.</p> <p>Planned activities will be legibly posted daily in Main Dining area. Activities will be listed with corresponding time &amp; location. Additionally, staff will verbally inform residents of activities of the day. The facility will provide a variety of activities to meet varied physical abilities, psychosocial needs, mental status, interests &amp; abilities of residents.</p> <p>The hours &amp; days of activities will be extended to accommodate desires &amp; needs of all residents. Activities will be available 7 days a week. Activity staff will be available until 6 pm most evenings. Should residents prefer activity later in evening NAC &amp; other staff will assist</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>SAN JUAN REHAB AND CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>911 21ST STREET ANACORTES, WA 98221</b>		
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F 248	<p>Continued From page 10</p> <p>offered the resident any activities that they were aware of, nor were they aware of any assessment conducted to determine the resident's interests.</p> <p>Record review revealed the resident admitted to the facility on 04/22/13. There was no Activity Assessment located in the resident's chart as of 05/02/13. The Initial Care Plan (CP) included only the interventions, "Introduce to activities offered. Interview to interests."</p> <p>On 05/02/13 at 10:36 a.m., Resident #142 was observed lying in bed with her eyes open. There was no television or radio on and the room was quiet. When asked, she stated she was "Just lying here. No, not sleeping. Just, nothing." She was unable to state if there was anything she would like to do or needed. On 05/02/13 at 3:25 p.m., the resident was again observed in bed, her eyes open, with no television, music, or other stimulation or activity.</p> <p>In an interview on 05/02/13 at 1:21 p.m., Staff H acknowledged an activity assessment had not been conducted to determine the resident's interests. He stated he had asked the resident if she needed anything, but he did not know if she enjoyed television or music. He stated she had not participated in any activities since her admission.</p> <p><b>RESIDENT #23</b> Resident #23 was observed on 04/29/13 at 8:58 a.m. in bed. She was awake and interacted with staff who entered her room. Neither the television or radio were on at that time. On 05/01/13 at 1:29 p.m., eight residents were observed in Bingo, however Resident #23 was not among them.</p>	F 248	<p>residents as needed, to accomplish their goals.</p> <p>Each residents preferred activities will be posted on the Individual Plan (IP)- an in-house form used by all staff. Staff will be re-educated to help/direct/assist residents to individually preferred activities.</p> <p>The facility will continue to encourage volunteers. To ensure resident safety all volunteers have a background check</p> <p>Activity interests of each resident will be careplanned: goals &amp; approaches will be individualized. Each residents activity plan will be reviewed &amp; updated quarterly and as needed for change of condition /interests/abilities. Activity staff will document monthly.</p>	

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F 248	<p>Continued From page 11</p> <p>On 05/02/13 at 9:14 a.m., the resident was observed in her bed, fully dressed. Neither the television or radio were on. At 10:46 a.m. four residents made a coffee cake in the dining room. Resident #23 was observed in her bed, awake and fidgeting. There was no television, radio or other stimulation present, nor was she observed to be invited to the activity. At 3:28 p.m. Resident #23 was again observed in bed with no television, radio or other stimulation.</p> <p>The resident's Activity CP identified she enjoyed watching television and playing bingo.</p> <p>In an interview on 05/02/13 at 1:50 p.m., Staff H stated Resident #23 attended an outing a few months previously. He stated she enjoyed music, television and visiting with people. He explained he visited with her almost every weekday morning. He stated she no longer enjoyed bingo however if given an activity such as washcloths to fold, she enjoyed that. He acknowledged that information was not included in her care plan nor was he aware if she had been provided with the opportunity during the previous week.</p> <p><b>RESIDENT #13</b></p> <p>In an interview on 04/28/13 at 2:41 p.m. Resident #13 stated the organized activities met his interest and he enjoyed participating in them when "he feels better." He further stated activities were available on some, but not every, weekend.</p> <p>In an additional interview on 05/02/13 at 9:19 a.m., Resident #13 stated he particularly enjoyed playing cards and had helped get the poker group organized. He stated he had suffered a decline in</p>	F 248	<p>To assure compliance, the Operations Manager (OM) will monitor that daily activities are occurring per schedule. Spot checks of individual / 1:1 activities will be done weekly (OM) Monthly resident council meetings will include discussion regarding desired activities &amp; satisfaction with the program. Residents &amp; responsible parties will be asked about Activities during care conferences. At least monthly, the Activity staff will meet with OM and/or Director of Nursing Services to discuss the program. The Operations Manager will assure compliance</p>	

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F 248	<p>Continued From page 12</p> <p>his health over the past few months and had not been involved in many activities in that time.</p> <p>An activity assessment was not located in the resident's chart. The care plan identified he enjoyed playing cards.</p> <p>Resident #13 was not observed to attend any activity out of his room throughout the survey.</p> <p>In an interview on 05/02/13 at 1:50 p.m., Staff H, stated Resident #19 had not been able to attend activities recently due to his physical health. When asked if staff had considered the change in the resident's routine specifically related to his activity participation, Staff H stated he brought in snacks "from home to connect to him" and some residents made coffee cake today with Resident #13 in mind. Staff H further explained he tried to stop in and visit with the resident throughout the day, however there was no record of the visits so he was unable to assess the resident's response to the change in his activity programming.</p> <p><b>RESIDENT #19</b> Record review revealed Resident #19 admitted to the facility in 2012 with diagnoses that included [REDACTED] and [REDACTED]. According to the 04/17/13 Minimum Data Set (MDS) assessment, Resident #19 required extensive assistance with all activities of daily living including transfers and locomotion. This MDS also assessed the resident did not exhibit any behaviors, including rejection of care or verbal or physical behaviors, and had severe cognitive loss.</p> <p>During Stage 1 of the survey, on 04/28/13 and</p>	F 248			

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F 248	<p>Continued From page 13</p> <p>04/29/13, the resident was not observed involved in any activity.</p> <p>According to the 04/19/13 Activity CP, the resident "loves live music".</p> <p>On 05/01/13 at 10:00 a.m., Resident #19 was observed in the dining room. She was talking aloud to no one in particular. According to Staff C, the resident "is not usually that talkative". The resident then asked to go to the bathroom. An aide propelled her to her room where she was assisted with toileting. She was then placed in bed. At 10:35 a.m., the planned activity of live music occurred in the dining room. Resident #19 was observed in her bed, with her eyes open, still talking, although no one was present. According to an unidentified CNA, the resident was placed in her bed as she usually took a nap around that time.</p> <p><b>ACTIVITY PROGRAM</b></p> <p>In an interview on 04/30/13 at 7:50 a.m., Staff E explained the facility did not develop a monthly activity calendar. She stated in order to meet the changing needs and desires of the residents, Staff H asked residents each morning what they wanted to do that day. She stated that was when the activities were planned for the day.</p> <p>The Activity calendar for the week of survey contained the following schedule: Monday (04/29/13) Poker group, Mother's Day craft, Bingo @ 12:45, Price is Right; Tuesday (04/30/13) Poker group, Mother's Day Craft, Make Cookies, Bingo @ 12:45. Yoga at 10:30 in Activities room; Wednesday (05/01/13) Waffle breakfast, Music with Steve @ 10:15 in Act.</p>	F 248		

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F 248	<p>Continued From page 14</p> <p>room, Poker at 10:30, Bingo at 1; Thursday (05/02/13) Make coffee cake @ 10:30, Poker Group, Bingo @ 11:00; Friday (05/04/13) Cinco De Mayo Craft, Bingo 12:45, Movie. No times or locations were noted for many of the activities.</p> <p>On 04/30/13 several residents were observed to ask multiple staff where Bingo would be held. A nurse told Resident #5 it would be in the Activity room while a CNA stated it would be next to the nurse's station. Both staff stated the location was not listed on the white board and it sometimes changed depending on what else was happening.</p> <p>At 1:09 p.m., six residents were observed playing Bingo next to the nurse's station. Resident #5 was not among them. At 1:24 p.m., Resident #5 entered the area and approached the table where Bingo was being played. At that point there were seven residents and Staff G at the table. There was not enough room at the table for Resident #5. Resident #5, who was seated directly behind Staff G, was given a Bingo card, by Staff G. Staff G continued to call out numbers. At 1:31 p.m., another resident left the table and Resident #5 was moved into the vacant spot. Staff G stated, "There, that's better."</p> <p>Review of every activity CP, excluding the newly admitted residents who only had an initial care plan, revealed the goal was the same for each resident. The goal stated, "I will participate in one activity of choice each week." In an interview on 05/02/13 at 1:45 p.m., Staff H stated the MDS Coordinator developed the activity care plans. He acknowledged that the goal was not appropriate for all residents and should have been individualized based on each resident's needs</p>	F 248		

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F 248	Continued From page 15 and desires.  In an interview on 05/02/13 at 1:01 p.m., Staff H explained the Activity assistant had been promoted to another department approximately two months earlier. He stated she was still responsible for conducting activity assessments, despite being the manager of another department. He acknowledged the assessments for new admissions were not as timely as desired.  Staff H further explained the Activity Assessment reflected the MDS questions regarding how important daily and activity preferences were to residents while in the facility. The form had minimal direction to staff to assess specific activities the resident might enjoy or equipment the resident might need in order to direct independent activities. Staff H stated the assessment, which was conducted on admission and quarterly, allowed staff to write a narrative of the resident's activity involvement, however as the facility did not monitor the resident's activity participation, it was typically a generalization of what the resident enjoyed.  Staff H stated all staff were responsible for notifying residents of formal activities, as well as assisting residents with getting to the proper location. He said if the location was not listed on the White Board, he would usually mention to staff where the activity would be held when he decided or he would try and go room to room to notify residents. He also stated all staff should ask residents if they would like to watch television or listen to the radio if a resident was in their room. He stated all staff interacted and communicated with residents throughout the day	F 248			

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F 248	<p>Continued From page 16</p> <p>and that was a part of the activity program.</p> <p>Additionally, Staff H stated he tried to visit with residents who did not attend group activities up to three times each weekday. He stated he would offer a magazine or ask if there was anything needed. He stated the visits might only last a minute or two, but sometimes as many as five.</p> <p>Staff H acknowledged he worked weekdays from 5:30 a.m. until 2:00 p.m. and that he was currently the only official activity staff. He stated the facility previously tried to have an evening activity but residents "were not interested". He said there was no record of what activity was attempted, residents response to it or consideration that residents and their needs were constantly evolving. He explained the facility expectation was that evening or weekend activities be provided by the staff who were present at those times.</p> <p>Staff H stated he discussed activities at monthly Resident Council meetings and gathered ideas of what residents wanted. He stated activities were planned daily in order to meet the needs of residents who were interested in group activities. He acknowledged the activity calendar looked similar each day and stated some residents really enjoyed Bingo and Poker so he felt they should be offered daily. He stated approximately six to eight residents attended those activities daily.</p> <p>Failure to assess resident's activity preferences, abilities and desires; develop individualized care plans; and provide an ongoing activity program designed to meet the needs of all residents, including on weekends and evenings, placed</p>	F 248			

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F 248	Continued From page 17 residents at risk for unmet activity needs, boredom and a diminished quality of life.	F 248			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Two of five Licensed Nurses (Staff C & D) failed to follow physician's orders and/or manufacturer's recommendations for three of 25 medications observed, which resulted in a medication error rate of 12% with two (#s 142 & 137) of eight residents reviewed experiencing medication errors. These failures placed residents at risk to experience adverse side effects or less than the intended therapeutic effects of medications.  Findings include:  RESIDENT #142 During observation of medication pass on 05/01/13 at 10:00 a.m., Staff C prepared medications for Resident #142. Staff C was observed to administer two tablets of [REDACTED] 500 milligrams (mg) for a total dose of 1,000 mg. Staff C verified she administered two 500 mg tablets. Review of Physician's Orders (POs) revealed an 04/22/13 order directing staff to administer [REDACTED]	F 332	Staff C is demonstrating correct administration of Combigan Eye drops & administering correct dose of acetaminophen  All nurses have been re-educated on proper technique for eye drop administration. All nurses have access to & are advised to use the current year's Nurses Drug book.  All nurses educated on 'prevention of Medication errors' including assuring correct dose. Nurses educated to double check bottle labels with each administration of med. Staff D is correctly administering & cueing/teaching residents correct inhaler use - specifically cueing ahead to "wait 2	5/15/13	

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F 332 Continued From page 18  
650 mg. In an interview on 05/01/13 at 8:07 a.m. Staff B confirmed Staff C did not follow physician's orders. This constituted one medication error.

During observation of medication pass on 05/01/13 at 10:00 a.m., Staff C was observed to administer ████████ 0.2% eye drops to Resident #142, one drop in each eye. Staff C failed to apply pressure to the lacrimal gland after administration and instead cued the resident to blink and patted the wet area surrounding the resident's eyes. The Nursing 2013 Drug Handbook lists ████████ as a combination drug of brimonidine tartrate and timolol maleate and listed administration instructions which included, "Apply light finger pressure on lacrimal sac for 1 minute after instilling drug to minimize systemic absorption." The 2006 facility Eye Drop Administration policy instructed the the nurse to "instruct the resident to close the eye slowly and keep it closed for one or two minutes." This constituted one medication error.

RESIDENT #137  
During observation of medication pass on 04/30/13 at 11:17 a.m. Staff D was observed to administer ████████ two puffs via a meter dose inhaler to Resident #137. The resident was observed to inhale two quick puffs and Staff D failed to cue the resident to wait between inhalations. The Nursing 2013 Drug Handbook Administration Inhalation instructions included, "If more than 1 inhalation is ordered, wait at least 2 minutes between inhalations." The Patient teaching instructions included, "...inhale deeply as you release a dose from inhaler, hold breath for several seconds, remove mouthpiece, and exhale

F 332 Minutes between inhalations:  
All nurses have been re-educated on correct inhaler administration & resident cueing/teaching.  
  
Each nurse will have a Medication Pass Audit by Director of Nursing or Pharmacy staff and will have a minimum of quarterly audits thereafter  
  
The Director of Nursing Services will assure compliance.

6/15/13

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F 332	Continued From page 19 slowly, if prescriber orders more than 1 inhalation, tell patient to wait at least 2 minutes before repeating procedure." This constituted one medication error.	F 332		
F 360 SS=E	483.35 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT  The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide 16 (#s 146, 145, 23, 2, 12, 5, 42, 19, 25, 15, 71, 17, 24, 144, 66 & 7) of 50 residents with a nourishing, well-balanced diet that met the daily nutritional and special dietary needs of each resident. Failure by the facility to ensure liquids were thickened to the ordered consistency, mechanically altered diets were served as ordered, residents received the appropriate portion sizes and/or adaptive equipment as ordered placed the residents at risk of aspiration and/or weight loss.  Findings include:  RESIDENT #146 During lunch on 04/28/13 at 12:23 p.m., Resident #146 was observed in the main dining room. He had been served a bowl of soup and drank most of his beverage. Staff J had not thickened his	F 360	Resident # 146, 145, 15, 17, 144, 66, 7 no longer @ facility. Resident # 23, 2, 5, 12, 42, 19, 71, 24, 25 are being provided nourishing, palatable, well-balanced diet that meets daily nutritional & special dietary needs of each. They are receiving liquid consistency & texture as ordered, appropriate portion sizes and are being provided with adaptive equipment as ordered.  All residents will be served the correct liquid consistency as ordered. All staff who prepare or serve liquids will be re-educated by the facility Speech Therapist (ST) regarding following correct orders & correctly	6/15/13

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F 360	<p>Continued From page 20</p> <p>soup. Staff J offered the resident a sandwich and served him 1/4 egg salad sandwich on white bread. According to the listed diet the resident was ordered a Dysphagia Mechanical with Nectar Thick Liquids (NTL). In an interview on 05/02/13 at 9:57 a.m. Staff N said Resident #146 should have been served the equivalent of a whole sandwich with no bread.</p> <p>On 05/01/13 Staff O was observed to serve trays for residents who ate in the Assisted Activity Room which included trays for four Residents (#s 145, 146, 23 &amp; 2) with orders for Dysphagia Mechanical diets. Staff O served regular unthickened soup to three residents (#s 145, 146 &amp; 23) with orders for NTL and Resident #2 who had orders for Honey Thick Liquids (HTL).</p> <p>RESIDENT #12 On 04/30/13 at 12:11 p.m. Staff M was observed to pour a bowl of beef barley soup and put a couple of non measured spoonfuls of thickener in the bowl and stir it before serving it to Resident #12. According to the diet list, Resident #12 was ordered HTL.</p> <p>Similar findings were observed on 04/28/13 during lunch when Staff J poured soup into bowls then added thickener from a plastic cup into the bowls and stirred without measuring before serving to two residents.</p> <p>On 05/01/13 at 10:48 a.m. Staff O was observed to add thickener to a pureed watermelon/cantaloupe/peach juice mixture. Staff O said the ratio should be one tablespoon thickener per one cup of fluids, or eight tablespoons per two quarts of liquid. Staff O was</p>	F 360	<p>preparing thickened liquids. New staff will be educated upon hire. Staff will follow the (Thickeners) manufacturers' instructions for thickening liquids and then verify that the correct consistency was achieved. Soups will be thickened to @ least as thick as ordered. The ST, Registered Dietitian (RD), Director of Nursing Services (DNS) and/or Operations Manager (OM) will be available for 1:1 education and will spot-check the preparation and serving of liquids @ least weekly (after accuracy achieved) to ensure proper procedure is followed &amp; residents are receiving liquid consistency as ordered. Should errors be noted, further education will be</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 360	<p>Continued From page 21</p> <p>observed to add six tablespoons and commented, "I know eight is preferable, but I don't want it to get too thick, everything thickens differently."</p> <p><b>RESIDENT #5</b> On 04/30/13 at 11:57 a.m. Staff T, NAC, commented Resident #5 needed NTL with a straw and was observed to pour thickener from a small bowl into a glass estimating the amount required. At 12:14 p.m. Staff T added 1.5 heaping soup spoons of thickener in a bowl of soup for Resident #5. Staff K served Resident #5 1/2 grilled cheese sandwich and provided no adaptive equipment. According to the diet list, Resident #5 was ordered a Mechanical Soft diet, NTL, a plate guard and foam handles for silverware. In an interview on 05/02/13 at 9:57 a.m. Staff N said according to the diet ordered, the resident should have been served a whole sandwich and adaptive equipment.</p> <p>The facility policy on thickened liquids was reviewed and administrative staff stated all staff were to follow the policy guidelines for thickening liquids.</p> <p><b>RESIDENT #42</b> On 04/30/13 at 12:43 p.m. Resident #42 was observed to have been served lunch on a plate, without a plate guard. A regular spoon was observed in a bowl of cantaloupe. On 05/02/13 at lunch the resident was observed without a plate guard or a foam handled spoon with which to eat the soup that was served. Review of the resident's record revealed a 03/07/13 Nutrition Care Plan (CP) instructing staff to provide a plate guard and foam handled silverware.</p>	F 360	<p>provided &amp; monitoring increased. The O.M. will assure compliance.</p> <p>All residents will be served the correct diet texture according to dietary breakdown. All staff who prepare and/or serve food will be educated by the ST regarding dietary textures. The ST, DNS, OM, and/or RD will spot check the serving of meals @ least weekly after accuracy achieved. The OM will assure compliance.</p> <p>All residents will be served the type of diet ordered by physician. Physicians will be informed of the types of diets served @ the facility: General,</p>	

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F 360	<p>Continued From page 22</p> <p><b>RESIDENT #2</b> During lunch on 05/01/13 Resident #2 was observed to have been served milk and juice in regular glasses without lids. Review of the resident's record revealed a 02/15/13 Nutrition CP instructing staff to "Please serve all liquids in lidded cups..." to prevent aspiration. In an interview Staff G said she thought the lids had been discontinued and noted that only hot fluids were served in lidded cups. Staff G was unaware the CP still included lids for all liquids.</p> <p><b>RESIDENT #19</b> On 05/01/13 Staff O was observed to set up Resident #19's tray which consisted of two four ounce beverages served in standard glasses. According to the diet list, Resident #19 was to receive her beverages in Nosey cups.</p> <p>In an interview on 05/02/13 at 9:57 a.m. Staff N indicated kitchen staff should send out adaptive equipment as ordered. In an interview on 05/02/13 at 10:34 a.m. Staff G noted the adaptive equipment was in a plastic tub/box on the prep cart in the kitchen and said the kitchen was not sending them out because, "They're (servers) supposed to come in and get them."</p> <p><b>RESIDENT #25 &amp; 15</b> On 05/01/13 Staff O said he had made mechanical soft sandwich wraps by chopping up the ingredients before rolling in a wrap, which had then been placed on a separate sandwich tray. During tray distribution on 05/01/13 Staff Q was observed to plate the food and Staff R was observed to offer and distribute residents their lunches. According to the diet list, Resident #25</p>	F 360	<p>No concentrated sweets, No added salt, Upon admission, the nursing staff will clarify diet orders to ensure diets ordered are for those provided by the facility. All staff who serve or prepare meals will be re-educated on each type of diet. The DNS, OM, &amp;/or RD will spot-check weekly to ensure correct diets are served. The OM will assure compliance</p> <p>Diet orders for all current residents have been <del>also</del> verified &amp; clarification made if needed. Two diet binders &amp; a Rolodex were set up. Information in each includes: Diet Type, Texture, Liquid consistency, adaptive</p>	

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F 360	<p>Continued From page 23</p> <p>was ordered a Mechanical Soft diet and was served 1/2 a regular texture turkey wrap rather than a whole mechanical soft turkey wrap.</p> <p>Similar findings were observed for Resident #15 who was served a regular turkey wrap rather than the mechanical soft wrap as ordered.</p> <p>RESIDENT #s 71, 17, 24 &amp; 144 Additional residents were served portion sizes less than their ordered diet irrespective of resident choice. Resident #s 71 and 17 both had diet orders for No Concentrated Sweets (NCS) Regular and were served 1/2 a wrap rather than a whole wrap as indicated. Similar findings were observed for Resident #s 24 and 144 who were served 1/2 a wrap when both of their respective diet orders indicated they should have been offered and/or served a whole wrap.</p> <p>In an interview on 05/01/13 at 1:54 p.m. Staff P said a lot of the residents choose to have small portions. She then stated staff should offer the portions according to the breakdown menu and a whole sandwich would have been two wraps.</p> <p>Additional observations of inaccurate portion sizes served to residents occurred during lunch in the main dining room on 04/28/13 when Staff K served residents cantaloupe from a large bowl using a slotted spoon. The number of cantaloupe cubes per resident varied as Staff K did not use an approved size scoop. In an interview on 04/30/13 at 2:04 p.m. Staff P said staff should use the appropriate scoop as directed by the menu. In an interview 05/02/13 at 9:57 a.m. Staff N said she expected staff to "follow according to the menu."</p>	F 360	<p>equipment, &amp; any other special dietary information. All staff who prepare or serve food will be educated to check the Diet binder/Rolodex to assure all aspects of each residents diet are being followed. The diet binders/Rolodex will be updated by the OM or designated person each time a diet order is changed or new order received. Nurses will give all dietary orders to the OM. The DNS will audit this weekly. Medical Records will audit diets to assure orders match the binders/rolodex twice monthly. Diet Binders will be kept</p>	

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F 360	<p>Continued From page 24</p> <p>On 04/28/13 during the lunch meal in the main dining room Staff J was observed to offer residents "Tea or Lemonade". According to the menu the residents were to be offered milk. Observation of Room Tray distribution on 05/01/13 revealed Staff Q and Staff R offer and distribute Peach juice to all the residents. They did not offer milk as indicated on the menu. In an interview on 05/01/13 at 1:54 p.m. when informed the menu indicated each resident was to receive eight ounces of milk for lunch which not observed to be on the trays, Staff P said "they have choice... that's what they get... have to ask." In an interview on 05/02/13 at 9:57 a.m. Staff N said the calculations for the provisions of the day to meet the calories, calcium, protein, etc. needs of the residents included two cups of milk a day. "They should be offering milk."</p> <p>On 05/01/13 in kitchen prep for lunch, Staff P was observed to make Lemonade and Ice tea. "That's their favorite at lunch." The lemonade was not sugar free and had 80 cal/8 oz. Review of the diet lists revealed 11 residents with orders for NCS diets (#42, 18, 134, 133, 26, 110, 143, 17, 33, 71 &amp; 50).</p> <p>RESIDENT #66 During observations of medication pass on 04/30/13 at 11:19 a.m. Staff D was observed to check Resident #66's blood sugar before lunch, the results of which were high at 354 mg/dl. Staff D inquired as to what the resident had eaten for breakfast. Resident #66 replied her "regular breakfast", toast with jelly. Review of the resident's record revealed a 03/28/13 physician's order for NCS Dysphagia Mechanical Soft diet</p>	F 360	<p>In the Activity room &amp; @ the Alcove by the main dining room, the rolodex will be kept on the room service cart. The Kitchen will also maintain up-to-date dietary information on each resident. Nursing will continue to update the Kitchen of diet changes. The O.M will assure compliance.</p> <p>All residents will be offered portion sizes per guidelines of dietary breakdown. Proper size scoops are being used to further ensure correct portion size. The Kitchen staff informs staff who serve dining rooms &amp; room trays of portion sizes for each meal.</p>	

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F 360 Continued From page 25 with HTL. A subsequent 04/03/13 order was for a diet clarification to advance the diet texture to regular textures and thin liquids per waiver signed. In an interview on 05/02/13 at 9:57 a.m. Staff N said the NCS aspects of the diet "should have been carried through, or discussed with her."

RESIDENT #7  
On 05/01/13 the kitchen staff prepared and served only a broccoli and cheddar soup to Resident #7. Review of the diet list revealed Resident #7 was ordered a 2 Gram NA Heart Healthy diet and should have been offered low sodium soup which he was not. When asked Staff P said "we don't do low salt soup, if we have a diet that requires it then we use a low salt canned soup."

F 371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  
SS=E  
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 store, prepare and serve food under sanitary conditions. Failure to cover and/or date

F 360 The OM, DNS, RD, and/or Dietary Manager (DM) will spot check @ least weekly to assure compliance. The OM will assure compliance. Unless contraindicated, all residents will be offered 2 glasses of milk daily. Residents with No Concentrated Sweets diets will be served sugar free beverages. Residents with orders for Adaptive equipment are provided & said equipment @ each meal. The OM, DNS, DM, RD will spot-check weekly.

F 371 Adaptive equipment is listed on rolodex / binders / kitchen info. The OM will assure compliance.

The facility will store, prepare, & serve food under sanitary conditions. Foods stored in refrigerators will be covered, dated, & labeled. Staff will handle food to be served to residents properly. Kitchen doors will be kept closed during food preparation to provide a sanitary environment.

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F 371	<p>Continued From page 26</p> <p>foods stored in the refrigerator, to ensure staff properly handled food served to residents, and to ensure doors were closed during food preparation to provide a sanitary environment placed residents at risk for food borne illnesses.</p> <p>Findings include:</p> <p><b>FOOD STORAGE</b> During the initial kitchen walk through on 04/28/13 at 10:18 a.m. eight blackened bananas were stored with two cloth hot pads in a bin underneath the Cleveland Steamcraft. In an interview on 04/30/13 at 8:09 a.m. Staff G indicated the bananas should have been thrown out and the cloths sent to the the laundry to be cleaned.</p> <p>Observations in the Alcove on 04/28/13 at 10:30 a.m. revealed three bins/tubs of cereal; raisin bran dated 3/20, rice crispies dated 3/18 and corn flakes dated 3/10. There were no scoops observed in the area, just a four ounce glass. In an interview on 04/30/13 at 8:28 a.m. Staff G said the cereal "should be refreshed". When asked how staff served the cereal, Staff G replied they "have a cup that they dip it out with." The facility failed to ensure sanitary serving utensils and practices were in place.</p> <p>Observation of the Supply Room on 04/28/13 at 10:44 a.m. revealed the following: a bag of potatoes, a one fourth filled box of potatoes which felt warm to the touch and a box of red potatoes which were soft to the touch. The ambient temperature in the area of the potatoes was 75.8 degrees Fahrenheit (F). When informed on 04/30/13 Staff G said "We got rid of those."</p>	F 371	<p>All items that were improperly stored, labeled, and/or dated were discarded. Over-ripe foods will be discarded promptly. Soiled Kitchen linens will be sent to laundry promptly. The Kitchen Manager (KM) or person in charge (PIC) will monitor daily to assure compliance. The Registered Dietitian (RD) will spot-check the kitchen on weekly visits. The OM will spot check the kitchen at least weekly and will assure compliance.</p> <p>Cereals kept in bins @ the alcove were replaced. Cereals in bins @ alcove will be dated &amp; <del>trashed</del> un-used portions will be discarded per protocol. Each cereal will have a scoop &amp; storage container. The scoops &amp; containers will be washed/sanitized daily by kitchen staff. The OM will assure compliance.</p>	

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F 371	<p>Continued From page 27</p> <p>The supply room also contained seven boxes of beverage concentrate which were stored under a vent of heat coming from the freezer. The label on the boxes noted the ideal storage temperature range was 50-75 F. At 10:57 a.m. a thermometer laid on top of the boxes measured 96.7 F.</p> <p>Across the supply room was located two boxes of cantaloupes, five of which contained indents and were soft to the touch. In addition a whole watermelon was present. The ambient room temperature was measured at 87.3 F. A fan was observed in a window which allowed air to circulate from outside. The air temperature by the fan was measured at 86.6 F.</p> <p><b>REFRIGERATORS</b></p> <p>During the initial tour of the facility on 04/28/13 at 10:45 a.m., the following were observed in the Activity room refrigerator: Ten cartons of Health Shake with no thaw date; two large tubs of butter heavily coated with a layer of what appeared to be dark brown crumbs; a can of biscuits with a use by date of 03/03/13; and a large container of yogurt with no open date. A box of frozen bacon that was not sealed or dated was noted in the freezer.</p> <p>Observations of the Activity room refrigerator on 05/01/13 at 11:04 a.m. revealed three Health Shakes in the fridge with no thaw date and four partially used containers of yogurt, none of which were dated when opened. In an interview at that time, Staff G stated the yogurt and Health Shakes were used quickly, before their manufacturer's expiration dates, so they did not need to be dated when opened. She acknowledged that directions</p>	F 371	<p>The food storage room will be kept at appropriate temperature (per regulations) to safely store food. The foods &amp; beverages that were stored in the area that was too warm were discarded. A new fan was placed in the storage room &amp; temperatures are being checked daily at varying times. Temperatures have remained in 60's since survey date. A daily temperature log will be maintained by maintenance. The OM will assure compliance.</p> <p>All health shakes will be dated with thaw date &amp; discarded after 14 days (per manufacturer instructions) if unused. All items in refrigerators will be dated when opened &amp; will be discarded according to "USE-BY" posted in the kitchen. All expired items will be discarded. All items in refrigerators &amp;</p>	

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F 371	<p>Continued From page 28 on each Health Shake carton read, "Use within 14 days of thawing".</p> <p>Observation of the kitchen refrigerator on 04/28/13 at 10:18 a.m. revealed the following: Two 32 ounce containers of raspberry yogurt without an open date; two, five pound containers of cottage cheese without open dates; a five pound container of sour cream without an open date; one open bag of salad mix which was dark black and wet at the bottom of the bag which was dated 4/19; five hard boiled eggs dated 4/23; and one gallon of sweet and sour sauce dated 1/23. In an interview on 04/30/13 at 8:09 a.m. Staff G said "everything has to be dated when opened" and anything after three days should be discarded. In review of the above items, Staff G confirmed the items should have been dated and/or discarded.</p> <p>Observation of the Supreen Refrigerator on 04/28/13 at 10:44 a.m. revealed the following: a 12 ounce bottle of horseradish sauce with an open date of 10/18 and a manufacture's expiration date of 03/05/13, and eight pounds of enchilada sauce dated as opened 01/25. In review of the above items on 04/30/13, Staff G confirmed the items should have been dated and/or discarded.</p> <p>Observation of the Supply Room Freezer on 04/28/13 revealed one open bag of what looked like sausage patties which had no date when opened, no expiration date and no identifying label as they were no longer in the receiving box. In addition, the meats were stored in tubs above the vegetables.</p>	F 371	<p>freezers will have identifying information. Meats will not be stored above vegetables, the KM or PIC will check refrigerators &amp; freezers daily. The RD will spot check on weekly visits. The OM will assure compliance</p> <p>An additional refrigerator was purchased and is being used exclusively for items brought in by residents &amp; their family/friends. All items will be covered &amp; dated &amp; will be discarded according to the "USE BY" posted in Kitchen. The KM or <del>RD</del> PIC will check the refrigerator daily. The DNS will check weekly and will assure compliance.</p> <p>Kitchen doors will be kept closed during food preparation. All staff will be educated. The OM will spot check. The</p>	

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F 371	<p>Continued From page 29</p> <p>Observation of the Alcove Refrigerator on 04/28/13 at 12:40 p.m. revealed Resident #33 sitting in front of the refrigerator with the door open. Resident #33 pointed inside the refrigerator and said, "There's my yogurt, I can't reach it." In an interview on 05/01/13 at 2:22 p.m. Staff G said the refrigerator was used by residents, family members and the facility. The facility kitchen stocked the refrigerator with breakfast items, milk, juice, sausage and hard boiled eggs for the weekend breakfasts. In addition, applesauce used by the nursing staff was stored there.</p> <p><b>GENERAL KITCHEN OBSERVATIONS</b> On 04/28/13 at 10:18 a.m., during the initial kitchen walk through, the back door to the outside and the screen were both observed to be open. In addition, the door to the hallway was propped open. Staff U was observed without a hairnet, while the doors were open, to pour two containers of liquid eggs into a large pan and placed the pan in the oven for cooking.</p> <p>On 04/29/13 at 11:34 a.m. a man was observed to walk freely through the kitchen, without a hairnet, and stopped to talk to the dishwasher. In an interview on 05/01/13 at 2:18 p.m. Staff G said based on the description it had been one of the dishwashers who was off duty at the time. The kitchen door to the hallway was propped open, the door to the foyer was open and the back door to the outside was open. A kitchen staff member was observed to be making what appeared to be sandwiches at the time.</p> <p>Observation on 05/01/13 revealed the kitchen door to the foyer open. In the foyer was a bird cage with the cage door open. Staff O pured</p>	F 371	<p>PIC will monitor daily The OM will assure compliance A new screen door will be installed to replace the broken one. Staff has been educated to immediately notify maintenance when anything in the kitchen is in disrepair. Maintenance will do walk-through checks weekly &amp; will provide required maintenance promptly The OM will assure compliance.</p> <p>The bird located in foyer near the kitchen has been re-located away from food preparation and dining areas. All staff who prepare food will wear hair restraints per federal regulation. Smocks/Aprons will be worn by staff who prepare/serve food. The OM will assure compliance.</p>	

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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:  <b>505381</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/03/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>SAN JUAN REHAB AND CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>911 21ST STREET ANACORTES, WA 98221</b>		
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F 371	<p>Continued From page 30</p> <p>cheesy broccoli soup. At 10:45 a.m. the sink with the eyewash station broke. Maintenance entered the kitchen, took a part off the sink, and left the door and screen door open while the soup was being made when he left. At 10:55 a.m. the maintenance staff returned and again left the doors open while he fixed the sink. When the maintenance staff left the room although he closed the screen door, it was observed to not completely close as the frame was bent. At 11:02 a.m. an insect was observed flying around the kitchen.</p> <p>On 05/01/13 at 11:35 a.m., as Staff O began making pureed sandwiches, the door to the foyer with the open bird cage was still open. The back door was open, the screen door ajar, and the back door toward the hallway was propped open with a wedge. Similarly at noon while Staff O checked the temperatures of the foods before serving all the doors were wide open, including the screen door.</p> <p>In an interview on 05/01/13 at 2:18 p.m. Staff G said she was unaware the doors needed to be closed during food preparation. Staff G indicated a request had been made for the screen door to be replaced.</p> <p>The facility failed to ensure effective partitioning and closing doors to separate the common areas which contained pets from food preparation areas.</p> <p><b>FOOD SERVICE</b> On 04/28/13 at 10:30 a.m. in the Alcove, Staff L and J were observed preparing and serving breakfast to residents. Neither staff wore hairnets</p>	F 371	<p>Thermometer &amp; list of recommended temperatures will be provided @ the microwave to assure foods are served @ recommended temperatures. Staff will be educated re: checking temperatures and maintaining clean/sanitary thermometer.</p> <p>An ice scoop &amp; bucket are available @ ice machine. Staff will be re-educated not to handle ice with bare hands. The ice bucket &amp; scoop will be washed / sanitized after each use. The OM will assure compliance.</p> <p>Staff will be re-educated on correct handling of dishware &amp; silverware &amp; will refrain from touching tops of plates, insides of bowls, &amp; eating end of utensils. Serving staff</p>		

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F 371	<p>Continued From page 31</p> <p>or aprons. Staff J was observed to retrieve from the refrigerator and place a serving of bacon, sausage, and a hard boiled egg on a plate and microwave the foods before serving. Staff J did not check the temperature of the food prior to serving.</p> <p>Observation of the lunch service on 04/28/13 in the main dining room revealed the following: Staff J retrieved ice, barehanded, out of a clear bucket with a small glass rather than a scoop. At 12:08 p.m. Staff K was observed to move clean plates with bare hands/thumbs placed on top of the plates where the food would be served. In addition, Staff K picked up bowls by the edge with a bare thumb inside the bowl. Staff I was observed to serve two bowls of soup with bare thumbs over the tip and inside the bowls.</p> <p>Similar observations were noted on 04/30/13 during lunch service by Staff M and Staff K.</p>	F 371	<p>Will be monitored @ least weekly by DNS, RD, OM The OM will assure compliance.</p>	
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