

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

PRINTED: 06/18/2014
FORM APPROVED
OMB NO. 0938-0391

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 06/13/2014
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	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at San Juan Rehabilitation and Care Center on 06/09/2014, 06/10/2014, 06/11/2014, 06/12, 2014 and 06/13/2014. A sample of 30 residents was selected from a census of 48. The sample included 23 current residents and the records of 7 former and/or discharged residents.</p> <p>The survey was conducted by: Nedra Vranish, R.N., B.S.N., M.S.Ed Ruth Futch, R.N., B.S.N., M.B.A Rick Woodrum, R.N., B.S.N.</p> <p>The survey team is from: Department of Social and Health Services Aging and Disability Services Aging and Long-Term Support Administration 3906 172nd St NE, Suite 100 Arlington, WA 98223</p> <p>Telephone: (360) 651-6850 FAX: (360) 651-6940</p> <p> <u>6/18/14</u> Residential Care Services Date</p>	F 000	<p>RECEIVED JUL 11 2014 ADSA/RCS Smokey Point</p>		

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

 Operations Manager 7-3-14

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 and interview, the facility failed to promote the dignity of two sample residents (19 and 69). By allowing a resident's bed to be located close to closets shared by three residents, it placed two of the residents at risk for a diminished quality of life.</p> <p>Findings include:</p> <p>Observations of the resident's room on 6/9/14 at 10:10 a.m. revealed three female residents in their beds. One bed was to the left of the entrance door, along a wall. Another bed was against a wall with a window. The third bed was close to the other wall. To the right of the third bed was a row of closets built into the wall. The location of the closets was approximately four feet from the side of the bed.</p> <p>During an interview with a family member on 6/10/14 at 2:00 p.m., it was stated "This is not a good set up!" "Staff and the other residents of the room have to go through the personal space of [Resident 19] to get to clothes or items in the closets."</p> <p>Resident 19 was interviewed on 6/11/14 at 2:45 p.m. When asked if the arrangement of the room was satisfactory to her, she replied "There isn't</p>	F 241	<p>Res 69 was moved to a 2-resident room & has full access to her closet & personal belongings & has privacy to change clothing, etc.</p> <p>Resident 19 will be moved further away from closet</p> <p>The only time this room will be used for 3 residents is if all residents are physically unable to independently access their personal items & require staff to do so</p> <p>All residents in facility have sufficient room to access their closets & personal belongings & rooms are set up to permit privacy for each</p> <p>Rooms will not be re-arranged w/o consent of Operations Manager (OM) Director of Nursing Services (DNS)</p>	7/15/14	

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F 241	Continued From page 2 anything you can do to solve this." On 6/11/14 at 7:20 a.m., the surveyor knocked on the resident's door. The surveyor was granted permission to enter. Resident 69 was observed to be naked and removing clothes from a closet. Resident 19 was in bed, on her side looking at Resident 69, The surveyor left immediately. After Resident 69 dressed and left the room, the surveyor reentered the room. Because of the layout of the three beds in the room, Resident 19 could not be afforded privacy when in the third bed. Resident 69 was forced to change clothing in a small space immediately adjacent to the bed of Resident 19. Additionally, there was very little space to allow residents access to their personal belongings in the closets. On 6/12/14 at 2:00 p.m., Resident 19 was interviewed again. When asked about the lack of privacy and the closeness of her bed to the closets, she stated: "If you can do something about it, that would be OK". "It's been so long I've learned to live with it."	F 241	or Resident Care Coordinator (RCC) Rounds will be made by OM @ least monthly to assure compliance		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253	Upholstered furniture in Activity Room has been cleaned. All other furniture has been thoroughly cleaned Activity Room will be cleaned	7-26-14	

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F 253	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interviews, the facility failed to maintain clean furniture in an activity room, repair a non cleanable surface on the arm rest of a resident's wheel chair, to replace missing knobs on a storage cabinet in a dining room, and repair broken window blinds. These failures had the potential to lessen the resident's quality of life.</p> <p>Findings include:</p> <p>During observations on 6/10/14 at 9:45 a.m., six upholstered during room chairs were in the activity room in the 200 hallway. Along with the chairs, two settees were located along walls. Each piece of furniture had visible stains and, or dark substances on the cushions and armrest. Four round tables were in the room. Observations revealed residents ate at the tables during breakfast and lunch. Each table had sticky edges. The same conditions existed during observations on 6/11/14 at 9:30 a.m. and at 1:10 p.m.</p> <p>Resident 17 was observed on 6/12/14 at 2:07 p.m. in a hallway, sitting in her wheel chair. The left arm rest was torn and foam padding was observed to be breaking down. The surface could not be cleaned and the rest of the arm rest had dried debris on it.</p> <p>Observations on 6/12/14 at 9:00 a.m. revealed a piece of furniture with missing pull knobs in an alcove located adjacent to the main dining room. The alcove was set up to allow residents access to dry cereal and refrigerated items. The piece of furniture held packets of oatmeal, eating utensils, placemats, napkins, and condiments. An</p>	F 253	<p>after each meal service & will be deep cleaned every other week. Maintenance will make rounds every other week to assure clean Operations Mgr will assure compliance Resident 17 wheelchair armrest was replaced. Maintenance will assess, repair & /or replace } clean all wheelchair /other equipment parts needed & will monitor wheelchairs & resident equipment quarterly & provide all maintenance /cleaning needed. Additionally Rehabilitation Services Manager will assure all wheelchairs & equipment put into service is clean & in good repair All staff will report any concerns via maintenance board any equipment in need of repair/cleaning Maintenance Supervisor will assure compliance</p>	

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F 253	Continued From page 4 unidentified resident was observed trying to open some doors in the cabinet. After several attempts, she gave up and moved to a chair in the dining room. She asked a staff member to try and open the drawers and get her a spoon. Staff A was informed at 2:20 p.m. of the missing knobs. During multiple observations, window blinds in rooms 302 and 104 had broken or missing slats. Staff B, in housekeeping was interviewed on 6/12/14 at 10:10 a.m. He stated he tried to clean in the activity room at least weekly but admitted it may have been longer. When asked, he did not have a schedule to clean the chairs.	F 253	Knobs on furniture in alcove were replaced, Maintenance will make rounds @ least monthly to assure all areas residents have access to are in good repair. Staff will report via maintenance board anything noted in disrepair Window blinds in room 302 & 104 will be repaired. All other rooms checked & blinds are in good repair.		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure safe and reasonable accommodations for one resident (69) who required the use of a wheel chair. By not allowing enough space for the resident to use her	F 323	Housekeeping will check blinds every 2 weeks during deep cleaning & report any blinds in disrepair. Maintenance Supervisor will assure compliance Resident 69 has been re-located to a room where she has safe access to her personal items / closet space	7-26-14	

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F 323	Continued From page 5 wheel chair when accessing her personal items in a closet placed the resident at risk for injuries. Findings include: Observations of the resident's room on 6/9/14 at 10:10 a.m. revealed three female residents in bed. One bed was to the left of the entrance door, along a wall. Another bed was against a wall with a window. The third bed was near the other wall. To the right of the third bed was a row of closets built into the wall. The location of the closets was approximately four feet from the side of the bed. On 6/11/2014 at 7:20 a.m., Resident 69 was observed to be standing beside another resident's bed, removing clothes from a closet. The resident had moved her wheel chair to the foot of the other resident's bed. Because there was not enough space for the wheel chair, the resident was forced to stand and walk approximately six feet to gain access to her belongings in the closet. Resident 69 was interviewed on 6/12/14 at 2:35 p.m.. When asked, she stated "Sometimes it's a problem when I try to get to the closet." "I have to use a wheel chair and you see, I can't get my chair in there." "I've almost fallen because I wheel myself over there, and I have to get up and walk in that little space." On 6/12/14 at 3:00 p.m., the care plan was reviewed for Resident 69. According to the care plan, the resident was to be assisted by staff for all transfers because of past falls. Additionally, the resident was coded on the MDS (Minimal Data Set), an assessment tool, to use a wheel chair at all times when ambulating to prevent injury from falls.	F 323	via her wheelchair & has sufficient space & privacy to robe / disrobe She has been re-educated to have staff assist with all transfers and to use her wheelchair for ambulation until / unless cleared for independence. Nursing staff will continue to remind her daily. All residents requiring assist with transfers are educated & reminded by staff to use call light system for assist. Nursing Assistants will be re-educated to remind residents to use call light & will follow individual care plans to promote safety. Operations Manager & DNS will make rounds Mon through Friday		

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F 323	Continued From page 6	F 323	to monitor that care plans are followed. Operations Manager will assure compliance.		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain correct holding temperatures of a hot food and to maintain cold temperatures for beverages in one of two dining rooms. The facility also failed to maintain a sanitary area to store dishes and bowls located in cabinets in the dining/activity room. Additionally, the facility failed to follow acceptable infection control principles while providing feeding assistance to residents. These failures placed residents at risk for contracting foodborne-illnesses. Findings include:	F 371	Milk & other cold foods & beverages will be maintained @ or below 41° dearees. Cold Beverages will be kept in refrigerator or on sufficient ice between serving to assure appropriate temperature. Cold items will have temperature checks prior to serving and anytime outside of refrigerator All cold food / beverages > 41° will be discarded immediately. Hot foods will be served only @ 135° or greater Hot foods will be kept in oven or on heating device to maintain temperature & will be checked prior	7-26-14	

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F 371	<p>Continued From page 7</p> <p>FOOD TEMPERATURES Milk is a Potentially Hazardous Food (PHF) and a Time/Temperature Controlled for Safety (TCS) food. PHF/TCS foods must be maintained at or below 41 degrees to ensure they are safe for consumption.</p> <p>Per the Code of Federal Regulations, Cold foods should be at or below 41 degrees when served, hot foods should be at 135 degrees or above when served.</p> <p>During observations on 6/12/14 at 7:33 a.m., residents were being served an egg and cheese casserole. The casserole was in a pan with hot water, sitting on two eyes of an electric stove. When asked to check the temperature of the food, Staff A retrieved a thermometer. When placed in the casserole, a temperature of 150 degrees was noted.</p> <p>A gallon of milk and a pitcher of juice were observed to be sitting in two inches of water with some ice. At 7:45 a.m. Staff A was asked to take the temperatures of the beverages. The milk was at 50 degrees and the juice was 60 degrees. Staff A stated it was too warm and proceeded to place them in a refrigerator.</p> <p>Observations in the same dining room at 9:10 a.m. revealed Staff C serving residents. When asked if he was taking temperatures of the food, he replied "It felt kind of cold so I turned up the stove a bit." When the thermometer was placed in the casserole, it showed a decrease to 110 degrees. When asked if this was acceptable, he replied "I'm not sure."</p> <p>The Dietary Manager was informed of the</p>	F 371	<p>to serving.</p> <p>Kitchen & serving staff will be re-educated on safe temperatures & checking temperatures prior to serving, & discarding foods / beverages @ unsafe temperatures. All food handlers will be re-educated @ least 2 times yearly. Dietary Manager will spot check all food service areas twice monthly & report concerns to the Operations Manager. OM will assure compliance</p> <p>The Activity Room Dining area has been deep cleaned, will be cleaned after each meal service & deep cleaned every</p>	

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F 371	<p>Continued From page 8</p> <p>findings at 9:15 a.m. She stated the casserole was not at the proper temperature and was removed immediately.</p> <p>During an interview on 6/12/14 at 7:45 a.m., Staff A stated temperatures were taken several times during the meal time. She also stated temperatures were recorded each time an item was removed from the microwave and given to a resident.</p> <p>Observations revealed a notebook on top of the microwave. Inside were pages with information including a date and temperatures. There was no time. All the items recorded were either instant oatmeal, or a beverage. There was no indication the temperatures of main dishes were conducted or recorded. When asked about the missing information, Staff A indicated she should have recorded more information.</p> <p>SANITARY, CLEAN STORAGE</p> <p>Observations of the dining room located in the 200 hall on 6/9/14 at 11:10 a.m. revealed a kitchen unit located along a wall. This included a counter top with a sink, stove, cabinets, and a refrigerator. Upon examination, the handles of the cabinets were sticky and greasy. When opened, dishes were observed to be stored on shelves that were brown and yellow with grime and grease. When wiped with a wet paper towel, a clean, white spot appeared on the laminated surface of the shelves.</p> <p>Similar observations revealed the same conditions on 6/10/14 and 6/11/14. During the breakfast meal on 6/11/14, dishes that were stored on the shelves were being utilized by staff for the residents to eat off of.</p>	F 371	<p>other week. The O.M. will check @ least monthly to ensure entire Activity dining area & equipment is clean & will assure compliance.</p> <p>Staff E & F were re-educated on proper hand hygiene before/ during feeding & handling food, not handling food with bare hands, proper handling of all dishes, glasses, utensils.</p> <p>All staff involved in serving & feeding residents will be re-educated upon hire & twice yearly.</p> <p>Management staff will spot-check during meals & all concerns will be reported to O.M.</p> <p>O.M. will assure compliance.</p>	

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F 371	<p>Continued From page 9</p> <p>During an interview on 6/12/14 at 7:55 a.m., Staff A stated housekeeping was responsible for cleaning the counter and cabinet areas. When shown the cabinets and shelves, she agreed they were not clean.</p> <p>Staff B in housekeeping was interviewed on 6/12/14 at 10:10 a.m. When asked if he was responsible for cleaning the dining/activity room kitchen counter area, he stated "Yes." When asked how often, he replied " I try to clean the area at least once a week, but sometimes its more like two or three weeks." "Do they need cleaning now?"</p> <p>DINING OBSERVATION On 6/9/14 from 11:45 a.m. to 12:40 p.m. observations of the noon meal were made in the Activity Room. Residents who required a higher level of cueing and assistance with eating dined in this area. There were two nursing assistants helping residents during the delivery and consumption of the meal: Staff E and Staff F.</p> <p>Staff E was providing assistance to a total of 5 residents, 3 at one table and 2 at another. Staff F was providing assistance to 2 residents at a third table. Staff E washed her hands upon entry to the dining areas, Staff F did not.</p> <p>Each of the residents had a selection of beverages in front of them. One of the menu items for some residents was a turkey wrap. Once the meals had been delivered to the individual residents Staff E moved back and forth between her 2 tables to cue and assist; Staff F stayed seated between the residents she was assisting at the third table.</p>	F 371		

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F 371	<p>Continued From page 10</p> <p>At 12:10 p.m. Staff E picked up Resident 67's turkey wrap with her bare hand and fed a bite to the resident. She continued to feed a series of bites as well as cueing residents with eating. At 12:15 p.m. Staff E went to reposition Resident 10. She picked up the resident's drinking glass by the rim and moved it within his reach. She went to the sink, washed her hands and returned to assist Resident 67. During this activity by Staff E, Staff F was observed to pick up the drinking glass, of one of the two residents she was assisting, by the rim.</p> <p>At 12:21 p.m. Staff E moved over to Resident 10, standing by his side to feed him a bite. At 12:22 p.m. Staff E went to the window looking out to the hallway to get the attention of a staff member. She opened the door to the room, touching the door handle. She returned to Resident 67, sat down, picked up the turkey wrap once again, with her bare hands, and gave the resident a bite. Resident 67 stated she did not like the turkey wrap. Staff E moved over to Resident 10, picked up his turkey wrap with her bare hands and fed him a bite. Staff E noticed Resident 10 did not have his oxygen cannula on so proceeded to adjust it in his nose. Staff E picked up the turkey wrap of Resident 10 two more times during the observation, as well as picking up his drinking glass by the rim. In between bites Staff E touched her face and lips.</p> <p>By failing to wash their hands after touching contaminated surfaces and then handling resident's food; Staff E and F placed these residents at risk for potential food-borne illness.</p>	F 371			

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

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FORM APPROVED
OMB NO. 0938-0391

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 06/13/2014
NAME OF PROVIDER OR SUPPLIER SAN JUAN REHAB AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 911 21ST STREET ANACORTES, WA 98221		
(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 371	Continued From page 11	F 371			
F 469 SS=D	<p>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM</p> <p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain proper measures to ensure pests were not in one of two dining rooms. This failure allowed ants access to the dining/activity room located on the 200 hallway.</p> <p>Findings include:</p> <p>Observations on 6/10/14 at 12:40 p.m. revealed five residents seated at tables eating. Ants were observed crawling on the floor. Staff D, the Operations Manager was asked to verify the ants. She explained the floor was dirty and that was why they were probably in the dining room. "I will call the exterminator today."</p> <p>During observations on 6/13/14 at 8:10 a.m., ants were again observed in the same dining room. Nine residents were eating in the room. A review of the pest control log revealed the exterminator had been to the facility on 6/10/14. Staff D stated "We have used that same pest control company for 20 years." "I'll call him again."</p>	F 469	<p>Pest Control is currently making weekly visits to treat ants & will continue weekly visits until no ants & will then resume every 2 week visits</p> <p>All dining rooms will be cleaned after each meal & be deep cleaned every 2 wks other week</p> <p>Resident rooms will be deep cleaned every 2 weeks</p> <p>All staff will be educated to assure food not stored in resident rooms or left uncovered in facility. Housekeeping & Maintenance will assure compliance.</p>	7-26-14	

