

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505351	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2012
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE CENTER AT ARLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 620 SOUTH HAZEL STREET ARLINGTON, WA 98223
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced off hours FOSS Quality Indicator and Extended Survey conducted at Regency Care Center of Arlington on 07/09/12, 7/11/12, 7/12/12, 7/13/12, 7/16/12, 7/17/12, 7/18/12, 7/19/12, 7/20/12, and 7/24/12. The survey included data collection on 7/12/12 from 6:00 a.m. to 8:00 a.m. A sample of 40 residents were selected from a census of 68. The sample included 35 residents and the records of 5 former and/or discharged residents.</p> <p>On 07/13/12 an immediate jeopardy was identified related to F323 Accidents and Supervision. The facility abated the jeopardy before the completion of Extended Survey on 7/24/12.</p> <p>The survey was conducted by:</p> <p>Mary Vassey, RN, BSN, MBA/HCM Richard Woodrum, RN, BSN Louvenia Ringuette, RN, BSN</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, District 2, Unit A 3906 172nd St NE, Ste 100 Arlington, Washington 98223</p> <p>Telephone: (360) 651-6850 Fax: (360) 651-6940</p> <p><i>[Signature]</i> 8/2/12 Residential Care Services Date</p>	F 000	<p>AUG 15 2012 WASHINGTON REGION 1</p> <p>This Plan of Correction will serve as the facility's Allegation of Compliance.</p>	8/19/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 8/15/12
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution's 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 166 SS=D	<p>483 10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide prompt resolution of a grievance for 1 of 4 (131) residents reviewed for resolution of grievances. This failure resulted in the resident experiencing feelings of frustration, which placed the resident at risk for a decreased quality of life.</p> <p>Findings include:</p> <p>Resident 131 admitted to the facility on [REDACTED] 12 with the diagnosis of [REDACTED] 1 and a history [REDACTED] 1. The Minimum Data Set (MDS) assessment, dated 7/3/12, indicated Resident 131 was able to make herself understood, was alert/oriented and had no problems with memory/recall.</p> <p>On 7/9/23, at 3:50 p.m., Resident 131 stated the facility had not resolved several issues regarding her previous roommate. When her roommate used her (the roommate's) television remote control to turn the television on or change the channel, Resident 131's television would also turn on and also change channels. Resident 131 was forced to watch whatever her roommate was watching. She stated she would be right in the middle of enjoying a television program and the channel would change suddenly to another</p>	F 166	<p>F166</p> <p>Cited Resident; - The resident 131 has discharged home.</p> <p>All Residents; - All TV remote boxes have been secured by maintenance to aim only at resident beds to alleviate cross controlling.</p> <p>Systems Review/Education; - Dept. heads will randomly query residents if they have any complaints/ concerns. - Staff have been educated to place things in need of repair on maintenance log.</p> <p>Monitoring; - Maintenance Director will review maintenance log every morning for items in need of repair and sign when completed.</p> <p>Responsibility; - Admin. to monitor for compliance.</p>	8/19/12

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F 166	<p>Continued From page 2</p> <p>station. Also, her roommate kept the volume of the television " loud ". Resident 131 stated she informed the nurse on duty at the time of the incident and was told there was nothing that could be done about it. She stated no one got back to her. Resident 131 said she was unable to recall who she had spoken to, but could remember telling someone. She stated the television remote control problem and the noise were only resolved when her roommate went home. She did not think anyone was " listening and/or cared and just let the problem resolve itself by the roommate discharging " .</p> <p>On 7/17/12, at approximately 1:30 p.m., a licensed nurse (Staff A) stated she was aware of the television remotes changing channels on both residents ' televisions. She stated it had something to do with a control box, which needed to be aimed correctly, so as not to interfere with both roommates' televisions.</p> <p>On 7/17/12, the Social Services Director (Staff M) stated when a resident had a complaint, the facility procedure was to fill out a Grievance/Lost Item form. Review of the form indicated that, " Any staff member can file and report grievances " . Staff M stated once the form was completed it was turned into the social services department for follow-up. Staff M would log the complaint/grievance in the log book. Staff M stated she had no record of any form being completed by any staff member on behalf of Resident 131. Further, the Social Services Director said she would have offered Resident 131 another room if someone had let her know that her roommate had the television on so loud disturbing her sleep</p>	F 166		

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F 166	<p>Continued From page 3</p> <p>The Maintenance Director (Staff S) stated he was aware the remote controls could affect other residents in the same room in some of the facility rooms. Staff S stated all that needed to be done was to move each television control box so they were not facing each other. He said this was the fix. He went on to say staff could let him know there was a remote control problem in a room by documenting on the facility maintenance/repair Request log. Staff S went onto say that each nurses' station had a clip board with the facility Maintenance /Repair Request log.</p> <p>Review of the Maintenance/repair Request log indicated the television remote control issue reported by Resident 131 was not an isolated one. On 7/18/12, the residents in Room 404 indicated both of them were experiencing the " T V. remote change both T V. on each side " .</p> <p>On 7/19/12, at approximately 1:00p.m., Resident 131 stated she did not feel the facility would have done anything about the issues, she had voiced to them. She said this was only " fixed by my roommate leaving. As long as I do not have a roommate, the television works ok and I can sleep without the television blaring " .</p>	F 166		
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</p>	F 241		

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F 241	<p>Continued From page 4</p> <p>by:</p> <p>Based on observation, record review, and interview, the facility failed to protect or promote the dignity of three of three sample residents (# 60, 126, and 128) observed for dignity. This failure had the potential to diminish the quality of life and self worth for these residents</p> <p>Findings include:</p> <p>RESIDENT 60 The resident was admitted to the facility in [REDACTED] 0. His diagnosis included [REDACTED] and dementia. The resident had been assessed as being incontinent and required the use of briefs.</p> <p>During observations from a hallway on 7/17/12 at 2:10 p.m., the resident was observed in his room, lying in bed. The top sheet was pulled down to the resident's feet. He was exposed, wearing only a brief and a green tee shirt. An unidentified housekeeper was observed to exit the resident's room. The surveyor informed Staff Q, a nursing assistant, the resident was exposed. The staff member stated, "Oh, he likes that" and continued with her tasks. The resident was exposed during observations at 2:30 p.m., 3:20 p.m., and 3:55 p.m. on the same day.</p> <p>Observations on 7/18/12 at 10:45 a.m., and again at 3:30 p.m. revealed the resident lying in bed, wearing a shirt and brief with no cover or sheet. The resident was visible to anyone walking in the hallway past his room. On 7/19/12 at 2:50 p.m., the resident was observed from the hallway, lying in his bed wearing only a brief and shirt. A housekeeper was observed to exit the resident's</p>	F 241	<p>F241</p> <p>Cited Residents; -Res #60 & 126 will be provided privacy from being exposed. Res. 128 will be provided with shower/bathing as needed.</p> <p>All Residents; -All residents will be provided with dignity and privacy during care.</p> <p>System Review/Education: - staff have been reeducated to provide privacy and dignity for all residents. - staff have been inserviced to provide bathing/grooming to residents that will enhance self worth. - staff Q has received individual training.</p>	
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F 241	<p>Continued From page 5 room</p> <p>During a review of the resident's care plan on 7/18/12 at 1:15 p.m., there was no indication the resident desired to remove covers while in bed or preferred to lay in bed exposed. Additionally, there was no guidance for staff to either cover the resident or to pull his privacy curtain.</p> <p>RESIDENT 126 This resident admitted to the facility in [REDACTED] 2 for Hospice care. During an observation on 7/11/12 from 1:20 p.m. to 2:30 p.m., the resident was in a wheelchair in a hallway, wearing a hospital type gown. The gown was open along the back. The wheelchair, when viewed from the back, had a gap of approximately 9 inches between the back and seat through which the resident's buttocks were exposed.</p> <p>During an interview on 7/12/12 at 9:45 a.m., the resident stated he did not want people to be able to see his backside exposed in a hallway</p> <p>RESIDENT 128 Resident 128 was admitted to the facility on [REDACTED] 12 with diagnosis that included cellulitis, inflammation and infection in the resident's lower legs. According to the resident's Minimum Data Set (MDS) assessment, dated 6/19/12, the resident required physical assistance with bathing and walking. She had also been assessed as unsteady when standing.</p> <p>During an interview with the resident on 7/11/12 at 9:50 a.m., the resident put on her call light. Staff S, a nursing assistant, came to the</p>	F 241	<p>Monitoring; - RCM/charge nursing will conduct random Rounds with results referred to QA committee.</p> <p>Responsibility; -DNS will ensure compliance.</p>	8/19/12

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F 241	<p>Continued From page 6</p> <p>resident's room to answer the call light. When Staff S asked the resident what she needed, the resident asked if she could have a bath today because she felt "hot and sticky". Staff S told her she would have to check to see when she was to have a bath and that she thought it was scheduled for the following day. The resident told her she would like to clean up before she went to the "Ole Time Fiddlers" afternoon activity at 2 p.m.</p> <p>On 7/11/12 at 10:05 a.m. Staff S returned to the resident's bedside and told the resident according to the bath record she had a bath yesterday. The resident stated that she had not had a bath yesterday. Staff S replied, "But it is recorded you did have a bath yesterday. I can give you a bath tomorrow maybe." The resident told the surveyor if she could not have a bath she would have to go sponge herself down because she was "so hot and sweaty".</p> <p>On 7/12/12 at 1:30 p.m. the resident stated she had not gotten a bath prior to the "Ole Time Fiddlers" activity yesterday but she had sponged herself down. She added, "It is not like having your hair washed and all when your hair is all grimy."</p>	F 241		

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F 241	Continued From page 7	F 241		
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 1 of 4 residents (128) reviewed for accomodation of need received reasonable accomodation for their individual needs. Failure to provide reasonable accomodation regarding the resident's ability to hear the television placed the resident at risk for a diminished quality of life</p> <p>Findings include:</p> <p>Resident 128 was admitted [REDACTED] 12 with known hearing loss. Her MDS Assessment, dated 6/19/12, showed the resident had a hearing deficiency. On the same MDS it was documented that the resident had difficulty hearing speakers if not in a quiet setting. Her TV volume needed to be loud in order for her to hear it. It was further documented that the resident had headphones to use for her radio, that she enjoyed listening to. The assessment stated that when staff was speaking to the resident they may</p>	F 246	<p>F246</p> <p>Cited Resident: Res # 128 has been offered head phones to use with the facility TV's.</p> <p>All Residents: -all residents with hearing deficits will be offered accommodations as needed.</p> <p>System Review/ Education: -staff have been inserviced to utilize the resident concern form for resident needs to include, but not limited to, headphones.</p>	

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NAME OF PROVIDER OR SUPPLIER GENEVA CARE CENTER AT ARLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 620 SOUTH HAZEL STREET ARLINGTON, WA 98223
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F 246	<p>Continued From page 8</p> <p>need to increase the volume of their voice and to face her directly.</p> <p>A review of the Activity Interest Form, dated 6/15/12, showed the resident enjoyed TV programs as one of her hobbies. Review of a progress note, dated 6/15/12, revealed the activity director had written "The resident ...enjoys TV the most and said she had an addiction to it."</p> <p>On 7/11/12 at 9:40 a.m. during an interview the resident stated, "The other night Judy Garland was on and I could not hear it, I was too tired to get up to see it, plus I am supposed to keep my legs elevated. Anyway, I almost cried I wanted to see it so bad." When asked if she had talked with anyone regarding her not being able to hear the TV, she stated she had brought ear phones from home. She said, "I was told the TV will not accommodate it because there is not a contraption on the TV." The resident said she had not told anyone else about how bad she felt about missing the TV program.</p> <p>On 7/19/12 at 10:50 a.m. Staff G said the resident was a little hard of hearing but she had never had a problem communicating with her. When asked if the resident had ever complained about not being able to watch the TV, Staff G stated, "Yes, in fact, her and her roommate have had words about the TV also. Once the resident's roommate said the resident and her [the roommate] were watching the same movie and the resident kept asking her what was going on, because she could not hear the TV. Staff G went on to say the resident's roommate was ok with it, but had complained she couldn't do this through the whole movie. When Staff G was asked if she</p>	F 246	<p>Monitoring; -RCM will monitor for resident needs and report to am standup meeting.</p> <p>Responsibility; -DNS/Admin will ensure compliance.</p>	8/19/12

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F 246	<p>Continued From page 9</p> <p>had reported the resident's TV concerns to anyone, she said, "No I didn't. I guess it was because I did not think it was important to her. The resident didn't seem like it was a big deal to her. She hardly ever watches TV." When asked if anything had been tried to improve the resident's ability to watch TV, Staff G stated, "No she just never made it seem like it was that important to her."</p> <p>During an Interview at 3:30 p.m., on 7/19/12 the Resident Care Manager, Staff A, stated the resident did have some hearing loss and would say, "Huh?", once in a while. As far as she knew there had been no issues about her TV. She said, "We usually have head phones available so we could offer her one and if we don't have one we can buy one." When informed of the resident's concern regarding the movie she missed and that the surveyor had observed the resident's TV up very loud one day, Staff A stated, "I know her roommate has been playing her music loudly lately, so maybe it was a thing where one was trying to hear over the over."</p> <p>On 7/20/12 8:45 a.m., Staff M, stated that when the resident first came in to the facility, the family brought in head phones, but they would not work with her TV. She stated she thought the family would be bringing in more.</p> <p>On 7/20/12 9:35 a.m., the Administrator stated he was unaware of the resident's concern with the TV until now. He said whenever he found out there was an issue, he went right down to radio shack to get appropriate headphones.</p>	F 246		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES	F 248		

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F 248	<p>Continued From page 10</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by Based on observation, interview and record review, the facility failed to provide for an individualized on-going program of activities for 1 of 7 sample residents (134). The failure to provide individualized activities for the resident, who was on hospice services, placed her at risk for isolation and a decreased quality of life.</p> <p>Findings include:</p> <p>Resident 134 was admitted to the facility on [REDACTED] 12, on Hospice Services. Her diagnoses included dementia [REDACTED]. According to her Minimum Data Set Assessment, dated 7/7/12, the resident was alert, but confused at times with some memory deficits. It was further documented on the MDS, the resident had stated during the staff interview that music, going outside, and pets were very important to her, but group activities were not important to the resident.</p> <p>On 7/11/12 at 11:35 a.m., the resident was observed in alone. She was in bed and the room was quiet. She provided delayed but appropriate answers to interview questions.</p>	F 248	<p>F248</p> <p>Cited resident; resident 134 is no longer in the building</p> <p>All residents; all residents will be provided an ongoing program of activities to meet their needs</p> <p>System review/education; will review current system for all staff to be aware and assist w/activities w/providing music or TV for residents who can't help themselves. - educate NAC staff to provide auditory stimulation in resident rooms.</p>	

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F 248	<p>Continued From page 11</p> <p>The resident was observed multiple times daily during the survey. Each time the resident was observed to be in her room with no music or radio on, the TV was turned off and she had no visitors. At times, the resident was lying with her eyes open, and at times she appeared to be sleeping. On two different days, the surveyor made frequent observations of the resident (approximately every 30 to 45 minutes). Only twice was the resident found to have anyone in her room with her. Both times were during lunch, and a caregiver was assisting the resident with her meal.</p> <p>The resident's admission plan of care, dated 7/2/12, was reviewed. It revealed that on 7/10/12, an activity care plan was developed for the resident. The activity issue listed for the resident was "Resident may self isolate". Goals for this issue were: "1) Resident to be out of bed for meals and, 2) Resident to attend 1 activity per week". Interventions included: 1) Post calendar at events in residents room; 2) Assist resident to and from activities as she will allow; 2) Encourage resident to come and participate."</p> <p>On 7/16/12 at 2:30 p.m., an interview was conducted with Staff A, the Resident Care Manager (RCM). She stated that the resident's alertness and confusion varied from day to day. When asked if the resident got up and participated in activities as indicated on the resident's careplan, the RCM stated, "No". She said the resident was a difficult one since her confusion varied. When asked how the resident's activity needs were being met, the RCM stated that she thought a friend brought sometimes</p>	F 248	<p>Monitoring; activities dept. will complete random visits to ensure compliance.</p> <p>Responsibility; Activity Director will assure ongoing compliance.</p>	8/19/12
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STATEMENT OF DEFICIENCIES ID: PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505351	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2012
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NAME OF PROVIDER OR SUPPLIER REGENCY CARE CENTER AT ARLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 620 SOUTH HAZEL STREET ARLINGTON, WA 98223
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(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 248	<p>Continued From page 12</p> <p>brought the spouse in the evening or on the weekend. Staff also talked to the resident with each interaction. She said the Activity Director went in to see her sometimes, and the RCM was sure they had offered the resident a TV and radio, but she preferred to sleep. The RCM said the resident was on hospice care, so staff was not forcing her to get up.</p> <p>On 7/16/12 at 3:35 p.m., when the Activity Director (AD) was asked if the resident came to activities as it stated in her careplan, she replied, "No". The AD further stated she had just left the resident's room in an attempt to offer to bring her something, but the resident was more confused and refused anything. She continued she just wants to sleep.</p> <p>On 7/17/2012 at 10:55 a.m., the resident she was observed to be more alert than the previous day. When the surveyor asked her how her day was, she stated, "Ok". When asked what kind of things she liked to do, the resident stated she liked to walk, read, exercise and paint. The resident nodded her head yes when asked if she liked music, but she did not respond except for a smile when asked what type of music she enjoyed. When asked if staff had offered to bring her in some music she stated, "No".</p> <p>On 7/20/12 at 10:00 a.m., the resident was observed alone in her room lying in her bed. A radio/CD player was noted at her bedside, but it was not turned on. Later that day, at 1:00 p.m., the resident was noted to have soft music playing at her bedside. She said she liked the music and smiled at the surveyor.</p>	F 248		
F 253	483.15(h)(2) HOUSEKEEPING &	F 253		

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NAME OF PROVIDER OR SUPPLIER REGENCY CARE CENTER AT ARLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 620 SOUTH HAZEL STREET ARLINGTON, WA 98223
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(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 253 SS=E	<p>Continued From page 13 MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure housekeeping and maintenance issues were addressed throughout the facility, such as: stained carpets, soiled privacy curtains, damaged wall heater covers, and soiled overbed tables. In addition, damaged floor tiles were found in the Medicare Unit. This failure placed residents at risk for a diminished quality of life.</p> <p>Findings include, but are not limited to:</p> <p>CARPETS Observations on 7/9/12 at 11:30 a.m., 7/12/12 at 2:15 p.m., 7/16/12 at 3:00 p.m., and 7/20/12 at 9:17 a.m. revealed soiled carpets throughout the hallways of the facility. On 7/11/12 at 9:45 a.m., several large wet spots were noted on the west hallway carpet. When asked, a housekeeper stated the carpets had been spot cleaned. However, on 7/12/12, it was noted the soiled spots had reappeared. During an interview with the Housekeeping Supervisor on 7/20/12 at 10:15 a.m., she stated the carpets were cleaned when needed.</p> <p>PRIVACY CURTAINS During multiple observations, soiled privacy curtains were found in rooms 101, 106, 112, 206,</p>	F 253	<p>F253</p> <p>Carpets - carpets are cleaned once a week. Spot cleaned as needed. - ESS will monitor daily - Weekly rounds by Admin and ESS to ensure compliance.</p> <p>Curtains - affected residents' curtains rooms 101, 106, 112, 206, 209, 210, 211, 213, 403, 406, 407, 408 were replaced with clean ones. - 4 cubicle curtains are taken down daily, replaced with clean ones (M-F). Also, they will be cleaned upon discharge of resident and as needed. - monitored by ESS and Admin. during weekly rounds. - QA committee to review monthly the weekly Environmental rounds to ensure compliance.</p>	

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NAME OF PROVIDER OR SUPPLIER LEGACY CARE CENTER AT ARLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 620 SOUTH HAZEL STREET ARLINGTON, WA 98223
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(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 253	<p>Continued From page 14</p> <p>209, 210, 211, 213, 403, 406, 407, and 408. Rounds with the Housekeeping Supervisor on 7/20/12 at 10:15 a.m. revealed the facility policy was to clean the curtains when a resident discharged or if visibly soiled. When shown some of the curtains, she indicated they were not clean.</p> <p>WALL HEATER COVERS During observations on 7/9/12 at 11:30 a.m., 7/12/12 at 2:15 p.m., 7/16/12 at 3:00 p.m., and 7/20/12 at 9:17 a.m., the front covers of the wall heaters in rooms 101, 108, and 112 were lying on the floor.</p> <p>When asked on 7/20/12 at 9:15 a.m., about a policy for reporting broken items, the Maintenance Director stated staff were to write down their concerns in a log book located by the time clock. When reviewed by the surveyor, there were no entries pertaining to broken wall heater covers.</p> <p>OVERBED TABLES Observations on 7/9/12 at 11:30 a.m., 7/12/12 at 2:15 p.m., 7/16/12 at 3:00 p.m., and 7/20/12 at 9:17 a.m., revealed soiled overbed tables in rooms 101, 103, 105, 111, 208, 211, and 213. The tables appeared to have debris and a thick build up of dried liquid on the tops. Additionally, the table in room 111 had a thick, dark, sticky substance covering the area above the wheels and telescoping sleeve.</p> <p>DAMAGED FLOOR TILES ON MEDICARE UNIT Multiple observations made during the survey found all floors in the Medicare Unit had damaged floor tiles. Some of the tiles had a melted like appearance and all rooms had at least a 2 foot by</p>	F 253	<p>Wall Heater covers</p> <ul style="list-style-type: none"> - Affected covers in rooms 101,108,112 were repaired. - Housekeepers were inserviced to write on maintenance board any items/ concerns regarding repairs needed. - ESS will monitor maint. Board - Admin./ESS to ensure compliance with weekly rounds <p>Overbed tables</p> <ul style="list-style-type: none"> - affected tables in rooms 101,103,105,111,208,211 and 213 have been cleaned. - tables to be cleaned daily by hskprts. - ESS will monitor randomly - Admin/ESS will ensure compliance with weekly rounds. 	

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F 253	<p>Continued From page 15</p> <p>4 foot area of what appeared to be a liquid substance oozing from between the seams:</p> <p>On 7/20/12 at 10:15 a.m., the Housekeeping Supervisor stated, "Stuff oozes up all the time". "We try to clean up as much as possible". When asked on 7/20/12 at 11:30 a.m., the Administrator indicated this was an on-going problem.</p> <p>Rooms 402 and 404 had tile coming up along the edges by the wall at each entry door. The commode in the bathroom of room 403 had a black substance around the base at the floor</p>	F 253	<p>Floor tiles</p> <ul style="list-style-type: none"> - affected tiles in rooms 402,403,404 were repaired. - housekeepers will monitor daily and document on maint. Board if any repairs are needed in the future. - Admin/ESS will monitor during weekly rounds to ensure compliance. 	8/19/12
F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 3 of 10 residents (24, 64, and 66) that were dependent on staff to have their nutritional needs met, received adequate assistance with their meals. This failure placed the residents at risk for not maintaining an adequate nutritional status.</p>	F 312	<p>F312</p> <p>Cited resident; resident 24,64&66 will be provided necessary assistance to consume meals or will be offered a replacement if less than 50% of meal is consumed.</p>	

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NAME OF PROVIDER OR SUPPLIER AGENCY CARE CENTER AT ARLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 620 SOUTH HAZEL STREET ARLINGTON, WA 98223
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F 312	<p>Continued From page 16</p> <p>Findings include:</p> <p>Dining observations were made in the north dining room on 7/9/12 during lunch and on 7/12/12 at breakfast and lunch. At least 10 residents who required some level of assistance were observed being served meals in this dining room.</p> <p>RESIDENT 24 Resident 24 was admitted to the facility on [REDACTED] 04, with diagnoses that included Alzheimer's disease, malnutrition, arthritis, and circulatory problems. The resident's latest Minimum Data Set (MDS) assessment indicated the resident required supervision, encouragement, and cueing with meals. The resident's plan of care directed staff to assist the resident with meals by providing cueing and assistance as needed.</p> <p>On 7/12/12, during breakfast, Resident 24 received her breakfast plate at approximately 8:00 a.m., after the staff set her plate up including peeling her boiled egg. The resident played with her food. Staff did not offer the resident assistance or encouragement to eat. At 8:12 a.m., the resident picked up a bite of her food with her fingers and took her first bite of her breakfast. After the resident took the one bite, she looked around and occasionally played with her food. Again, staff had not offered the resident assistance or encouragement to eat since 8:00 a.m. At 8:45 a.m., Staff T asked the resident, "Are you not hungry today?" The resident replied, "No". The caregiver then stated back to the resident, "Here is your juice", and the caregiver left to assist another resident. The resident was not offered any further assistance, and she was</p>	F 312	<p>All residents; All residents who require assistance with meals will be provided assistance by staff.</p> <p>System review/education; nursing staff will be inserviced re: need to provide assistance for residents unable to feed self and offer replacements when less than 50% of a meal is consumed.</p> <p>Monitoring; LN's/RCM will make random rounds in Dining room to assure residents are being encouraged and assisted as necessary.</p> <p>Responsibility; DNS will ensure compliance.</p>	8/19/12
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F 312	<p>Continued From page 17</p> <p>not asked if there was something else she would prefer to eat. The resident 's breakfast intake was just the one bite she had taken after she received her plate.</p> <p>On 7/19/12 at 1:50 p.m., Staff B stated that Resident 24 was one of the residents that got lost in the larger dining room, so she was moved to the north dining room. She said she was not aware the resident was not receiving the assistance she needed and staff was not cueing her. She said the resident consumed her meal by herself most of the time as far as she knew</p> <p>RESIDENT 66 Resident 66 was admitted to the facility on [REDACTED] 09, with diagnoses included anemia, malnutrition, dementia and a history of a stroke [REDACTED]</p> <p>According to the resident's MDS, dated 6/20/12, the resident had swallowing problems, which included holding food in her mouth and liquids spilling out of her mouth. The resident was on a mechanically altered diet and was totally dependent on staff assistance for consuming her meals.</p> <p>On 7/9/12 at 12:03 p.m., the resident received her lunch tray. Staff began assisting the resident with her meal at 12:14 p.m.</p> <p>On 7/12/12 at 12:15 p.m., a family member was observed in the dining room assisting the resident with her meal. Two caregivers were present in the dining room to assist the remaining residents with their meals.</p> <p>On 7/12/12 at approximately 12.25 p.m., Resident</p>	F 312		

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F 312	<p>Continued From page 18</p> <p>66's family member stated she came in often. She said that budgets had been cut and staff just couldn't do it all with the time they had, so she came in to assist Resident 66 with her meal</p> <p>RESIDENT 64 Resident 64 was admitted to the facility on [REDACTED] 09, with diagnosis which included anemia, dementia, malnutrition, and anxiety. The resident's MDS, dated 5/23/12, indicated the resident had short and long term memory loss, and required extensive staff assistance with meals.</p> <p>On 7/12/12, during breakfast observation, there were 2 staff present in the dining room assisting residents. Resident 64, who was asleep at the table, was served her breakfast at approximately 8:00 a.m. At 8:13 a.m., a caregiver approached the resident, who was still sleeping, and called her name a couple of times. When the resident did not respond to the caregiver, the caregiver left and went back to assisting another resident at another table. At 8:19 a.m., another caregiver woke the resident up. He then placed a piece of banana on the resident's fork, and went back to assist another resident. Resident 64 ate the piece of banana from the fork and then went back to sleep. At 8:30 a.m., the first caregiver approached the resident and offered to assist her. The resident did not respond. The caregiver sat there, and then asked the resident again if she could assist her. The resident stated she did not feel well. The caregiver replied, "It is ok, you don't have to eat if you don't want to". The caregiver then left the resident.</p> <p>At 8:50 a.m., the second caregiver approached the resident. He asked her if she was going to</p>	F 312		

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F 312	<p>Continued From page 19</p> <p>finish her breakfast, and the resident stated, " Yes ". The caregiver placed a piece of pancake on the resident ' s fork and left the room. The resident placed the pancake in her mouth, chewed it and proceeded to fall back to sleep. The resident ' s breakfast intake included a bite of banana and a bite of her pancake, both of which had been placed on the fork for the resident. When the resident left the dining room, her fluids, two cups of juice and a cup of hot tea, remained. She had not been offered any assistance with her fluids.</p> <p>On 7/12/12 at 12:15 p.m , two caregivers and a resident family member were present in the dining room assisting residents with their meals. Resident 64 ' s plate showed evidence she had eaten at least a couple bites of her meal, however, during observation the resident was observed a sleep at the table, and staff was not providing her assistance.</p> <p>On 7/19/12 at 1:50 p.m., Staff B, a Resident Care Manager (RCM), stated, the north dining room was for residents that needed assistance with their meals. She said that a few residents, who ate in the North dining room now, were for the most part independent with their meal after their plate had been set up. She said those residents previously had dined in the larger dining room but they did poorly in there, so they were relocated to the North dining room. When asked how the level of staff for the North dining room was determined, Staff B stated it was predetermined on the staffing sheet. She stated there were other staff available to help if needed. Staff B was made aware of the meal observations. Staff B replied that she depended on staff to inform her</p>	F 312		

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F 312	Continued From page 20 of concerns in the dining room. She further stated, no one had informed her of concerns that would have warranted more staff to assist in the dining room.	F 312		
F 314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable, and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to consistently implement timely repositioning for 1 of 4 sample residents (134) who were assessed at risk for developing pressure sores. This failure placed the resident at risk for the development of an avoidable pressure sore.</p> <p>Findings Include:</p> <p>Resident 134 was admitted to the facility on [REDACTED] 12 on hospice services with diagnoses including [REDACTED]. According to the resident's assessment, she was alert, confused at times, and had some memory loss. The resident was assessed as dependent for care requiring extensive assistance of 1-2 staff with</p>	F 314	<p>F314</p> <p>Cited Residents: Res. #134 will be turned and repositioned every 2-3 hours or as much as needed.</p> <p>All Residents: All residents at skin risk will receive necessary treatment and services to ensure that residents do not develop pressure sores unless the individual's clinical condition</p>	

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NAME OF PROVIDER OR SUPPLIER GENEY CARE CENTER AT ARLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 620 SOUTH HAZEL STREET ARLINGTON, WA 98223
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F 314	<p>Continued From page 21</p> <p>her positioning. She was assessed to be at an increased risk for skin breakdown due her declining condition, dependence on staff for bed mobility, poor nutritional and fluid intake, and her already compromised skin condition.</p> <p>The NAC (caregiver) Consideration Sheet that provided guidance to the NAC on provisions of care, indicated that staff were to turn the resident every 2 hours, place pillows under the resident's heels and report open areas to the nurse. Documentation on the NAC Consideration Sheet indicated the resident was confused at times, became anxious and yelled out during position changes.</p> <p>On 7/16/12, the resident was observed several times between 10:00 a.m and 1:48 p.m. Each time the resident was observed lying on her left side on an alternating air flow mattress. The only resident initiated movement observed during this period was that she would move her feet slightly at times.</p> <p>On 7/16/12 at 1:50 p.m., a licensed nurse, (Staff G), was notified the surveyor would like to observe care when the resident was repositioned. At 2:35 p.m., the resident remained in the same position, on her left side. A nursing assistant (Staff V), was asked about the resident's care. Staff V stated he was not assigned to the resident today but added, " We check her every two hours and turn her. " At 4:00 p.m., the resident had still not been repositioned.</p> <p>Nursing assistant, Staff W, was asked when she would be repositioning the resident, and was told the surveyor would like to observe the care. Staff</p>	F 314	<p>demonstrates that they were unavoidable.</p> <p>System Review/Education; LN/NAC staff will be educated on preventative skin care and repositioning to prevent skin breakdown.</p> <p>Monitoring; LN/RCM will complete rounds and audit weekly.</p> <p>Responsibility; RCM/DNS will review for ongoing compliance.</p>	8/19/12

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F 314	<p>Continued From page 22</p> <p>W stated, " I just want to warn you, it takes 3 to 4 of us to do her care and she screams the whole time. "</p> <p>At 4:15 p.m., Staff W stated, I now have help to assist me with turning her. " Staff W and Staff X provided incontinent care and repositioned the resident. During care, the resident was observed to have adhesive 4 x 4 bandages on two different locations along her spine and 2 nickel to quarter size round open areas on both buttocks which were dry, pale and no drainage. According to the caregivers, the resident came in with those areas and " ... they look better than when she came in " .</p> <p>In an interview later with the resident care manager assigned to the resident, she confirmed the resident was admitted with the non-pressure related areas on her buttocks and her back. She stated Physician had said they developed from scaly area's that had flaked off, creating an opening and were not from pressure.</p> <p>The next day 7/17/12 at 10:55 a.m., the resident was observed lying in bed on her left side. The resident was again observed at 11:30 a.m., 12:00 p.m., 1:15 p.m., 2:00 p.m., and at 3:15 p.m. She continued to be on her left side during all of the observations. At 3:00 p.m., the resident's caregiver, Staff K stated, " I was told that the resident should be turned a little after 3:00 p.m., that is what I was doing, looking for help, and that can be hard sometimes. " At 3:15 p.m., the Director of Nursing Services (DNS) was notified that the resident had not been observed to be repositioned since at least 10:55 a.m.</p> <p>On 7/17/12, at 3:20 p.m., the DNS, Staff A (Resident Care Manager/RCM), and a caregiver</p>	F 314		

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F 314	Continued From page 23 repositioned the resident at the surveyors ' request. A skin check was performed, specifically on her left side. The resident's left hip area was deeply wrinkled and she was observed to have a long rectangular deep red area to the outer left area of her left buttock which measured approximately 2 cm by 6 cm. The resident was repositioned to her right side. The RCM stated when she did the resident's dressing change to her back earlier in the day she was sure she had been on her back. On 7/18/12 at 3:10 p.m., the resident's skin was observed and the redness that was present the prior day on the resident's left buttock had resolved. Failing to turn the resident as care planned placed her at risk for pressure sore development.	F 314		
F 323 SS=J	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 " no smoking " facility failed to recognize their responsibility to ensure the safety of 2 of 3 residents (121 and 104), who resumed active smoking habits while residing in the facility. When aware the residents were smoking, the	F 323		

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F 323	<p>Continued From page 24</p> <p>facility failed to do timely assessments of each resident's ability to smoke safely. When the assessments were completed and the facility determined the residents were unsafe to smoke without supervision, the facility failed to ensure these residents were provided with a safe place to smoke and had appropriate supervision while smoking. In addition, when Resident 121 was found by facility staff with cigarette ashes on her lap after smoking, the facility failed to recognize the increased danger for burns this represented for this resident, and did not put appropriate preventative interventions in place to address this. These failures placed the residents at imminent risk for harm from injury while smoking. On 7/13/12, this was determined to constitute an immediate jeopardy situation.</p> <p>Additionally, the facility failed to ensure 1 of 7 resident's (48) reviewed for accidents received adequate supervision to ensure safety measures interventions were consistently implemented. The facility also failed to ensure potential liquid hazards were stored in a secure location, to store over the counter medications in an area not easily assessable to residents and failed to monitor the locking of a door located at the entrance to a boiler room. These failures placed Resident 48 at risk of harm during a fall, and placed facility residents at risk for exposure to medications, dangerous chemicals, and/or harmful temperatures.</p> <p>Findings include:</p> <p>SMOKING</p> <p>RESIDENT 121 Resident 121 was admitted [REDACTED] 12 with diagnoses</p>	F 323	<p>F323</p> <p>Cited resident: 121 has discharged #104 has been issued a notice of intent to discharge which she is appealing at this time. Resident 48 has had care plan modified and staff trained to follow care plan to ensure safety.</p> <p>All residents: residents who enter the facility and begin smoking after admission will have a smoking assessment completed to identify safety risks. Staff will monitor residents smoking until discharge. Residents who violate the non smoking policy will be issued a Notice of Intent to Discharge and facility will begin discharge process. Residents at risk for falls will have their environment as free of accidents as possible, and each resident will receive</p>	
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F 323	<p>Continued From page 25 including aftercare of a [REDACTED] and tobacco use disorder. Her admission orders included a daily Nicotine Patch for smoking cessation. The resident was wheelchair dependent for mobility.</p> <p>A review of the resident's record revealed the facility was aware that Resident 121 continued to smoke after her admission to the facility. Both nursing and the social service staff documented in the progress notes that the resident struggled in her efforts to stop smoking and continued to smoke despite the resident's use of a nicotine patch.</p> <p>Although aware of the resident's continued smoking, the facility did not do a timely assessment of her ability to smoke safely. Once the facility assessed the resident as being unsafe to smoke unsupervised, they failed to ensure the resident had a safe place to smoke and failed to provide the supervision for the resident that she was assessed as needing.</p> <p>According to a social service progress note, dated 5/22/12, the resident had cigarettes and matches in her room. That same day, staff added to the resident's care plan that the resident was smoking while wearing a nicotine patch and that staff explained the risk and benefits of doing this to the resident.</p> <p>Review of progress notes found documentation that the resident continued to go outside to smoke. On 5/30/12, social services recorded the resident was observed by staff smoking alone outside.</p>	F 323	<p>adequate supervision and assistance as needed.</p> <p>System review/education; LN/RCM have been educated on completing a smoking evaluation for any resident identified as being a smoker. Staff have been educated on smoking safety protocols and monitoring. NAC's have been re-educated on following the NAC care directive. Boiler room has been secured with an auto lock door knob. Liquid hazards have been removed from the cabinet. Signage has been posted on the cabinet to identify what is to be stored inside. Staff has been inserviced as to safe storage of hazardous chemicals.</p>	

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F 323	<p>Continued From page 26</p> <p>On 6/28/12, a nurse recorded in the progress notes, " The resident stated she is just not ready to quit smoking " On that same day a LN wrote, " Resident is known to exit facility property to smoke. The resident was reminded that she had agreed not to smoke prior to facility admission. The resident stated she remembered that and was doing what she had agreed. When the nurse asked her where she got her cigarettes from, the resident stated from a family member. The nurse documented that she told the resident she needed "to confiscate " the cigarettes. The nurse removed a pack of cigarettes with 2 butts and a lighter from the resident's room. The LN continued, "The resident verbally agreed not to smoke. "</p> <p>Another LN progress note, dated [REDACTED] 2, read, "Resident outside off property smoking, came back into the facility with ash on her clothing, no burn marks, no holes on clothing. Appears resident may need to have someone with her even off property. " The LN documented that at that time (two months after admission), a Smoking Safety Assessment was completed for the resident</p> <p>A review of the facility's Smoking Safety Evaluation for Resident 121, dated [REDACTED] 12, revealed the resident was assessed to need supervision when smoking, due to her allowing ashes to fall on her clothing. The resident's care plan was revised to include a statement that read, "The resident is not to have smoking paraphernalia in facility, if found notify LN. The resident is to be observed after returning from out of the building for ash or burn holes on clothing &</p>	F 323	<p>Monitoring; Smoking to be monitored by staff during scheduled smoking times. Falls- RCM's to complete bimonthly rounds for compliance with NAC care directive. Weekly environmental rounds will be conducted to check for boiler room security and appropriate storage of chemicals.</p> <p>Responsibility; Admin will ensure ongoing compliance</p>	8/19/12

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F 323	<p>Continued From page 27</p> <p>hands." The resident's revised care plan did not mention the need for supervision to ensure the resident's safety while she was smoking.</p> <p>A subsequent nursing note written on 7/2/12, read, "The resident has befriended another resident who also goes off property to smoke with a friend... appears resident will be going with other resident and [named friend], whom is keeping the resident's smokes". The named "friend" was a non-related individual who lived in the neighborhood and had met the resident while she was outside smoking.</p> <p>On 7/8/12, a LN's progress note stated that a call was received by a staff member, who was not on duty at that time, but "just happened to drive by" and saw Resident 121 outside the facility smoking by herself. When the LN went to speak with the resident, the resident was found in her wheelchair by the street between the facility and a house next door. The resident stated the "friend" next door lit her cigarette, then went back into the house to answer a phone call.</p> <p>On 7/11/12 at approximately 12:30 p.m., as the surveyors left the facility, the resident was observed outside in her wheelchair alone, with her back to the road. The resident was located across the road from the facility, sitting at the corner of a cross side street that ran beside the facility. Her wheelchair was parked at the entrance to the ramp leading to the sidewalk, with her back wheels in the street. The area where the resident was sitting was not visible from facility or the facility parking lot due to bushes and evergreens located around the parking lot. The unsupervised resident's safety was also at risk.</p>	F 323		

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F 323	<p>Continued From page 28 due to the location where she was seated.</p> <p>On 7/12/12, a LN's progress note indicated the Resident was found outside alone, down the street by fire hydrant smoking and talking on the cell phone. The LN wrote, "She is not to be out smoking off property without someone with her due to her coming back with ash on her clothing. Resident stated, named friend lit her cigarette, and went home. "</p> <p>Another progress note dated 7/12/12, stated that when the DNS asked the resident if she had any smoking paraphernalia on her person, the resident "pulled out a green tube with a cigarette and a pink lighter " The Resident was also found to have a cigarette inside a box on her bed.</p> <p>At 4:35 p.m. that same day, an interview was conducted with the DNS and Staff B, a Licensed Nurse. When asked if the resident was provided the risks and benefits of smoking, and for smoking without supervision, Staff B stated, " The resident knew it was a non-smoking facility prior to coming into the facility, however, we haven't been able to find the form she signed showing she was informed. "</p> <p>When asked who had been supervising the resident while she was smoking, the DNS stated that a friend of another resident usually supervised the resident and kept her cigarettes. When asked if this " friend " was educated by facility staff about smoking safety measures including not leaving the resident unsupervised while the resident smoked, the DNS answered, " No ". When asked if the facility had provided supervision after the resident's smoking</p>	F 323		

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F 323	<p>Continued From page 29</p> <p>assessment showed she was unsafe to smoke without supervision, the DNS stated, "No, we are a non- smoking facility and the resident is smoking off the premises. "</p> <p>RESIDENT 104 Record review revealed Resident 104 was admitted to the facility on [REDACTED] 12, with diagnoses that included [REDACTED] diabetes and [REDACTED]. The resident was wheelchair dependent.</p> <p>On the day of admission to the facility, the resident signed the facility's no-smoking policy form, in which the resident agreed not smoke during her stay, either in the building or on the grounds. It was also indicated that she understood smoking paraphernalia would not be allowed on the property.</p> <p>In an interview with Resident 104 on 7/13/12 at 1:00 p.m., she stated she had done pretty well with not smoking for a few days after first being admitted to the facility. As she became more anxious she wanted to smoke. The resident stated she asked the administrator about it and he told her it was okay as long as she smoked off the premises and she did not bring smoking items into the building. She said she then smoked outside off the property many times. Even though the facility had knowledge the resident was actively smoking, they did not assess her ability to safely to do so without supervision at that time.</p> <p>According to a licensed staff progress note, dated 6/4/12, the Director of Nursing Services (DNS) and the nurse manager (RCM) spoke with the resident regarding the resident's tendency to also</p>	F 323		

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F 323	<p>Continued From page 30</p> <p>go outside of the facility at night alone to smoke. The resident had requested the facility's outside door remain unlocked at night in order for her to get back into the facility after smoking. The DNS explained the risks and benefits, including the safety risk for all residents if the facility door was not locked at night.</p> <p>On 6/28/12 (over 3 months after her admission to the facility), staff completed a Smoking Safety Evaluation for Resident 104. It read, "Resident is alert and oriented to person, place and time, and takes narcotics at times may not make good decisions. Resident has limited range of motion in her right lower leg and the resident has left hand numbness at times. Resident self propels her wheelchair. The resident's medications include narcotics, hypnotics, anti-anxiety medications and muscle relaxants. Smoking habits: many years, smokes off property, no ashtray, will need supervision secondary to all narcotics psychotropic's and muscle relaxants as well has complaints of left hand numbness...Resident had neighbor friend whom keeps her smokes and comes to take her. Plan is staff to monitor resident not out smoking on her own, give her risk and benefits, ask to return to building and if she had smoking items on her and document "</p> <p>On 6/28/12, the resident's careplan was updated with the following: "If resident goes outside to smoke or not, Licensed nurse (LN) is to go check if by self, if smoking res is unsafe d/t(due to) narcotic use. If outside alone ask if she has cigarettes, if so is to hand over to licensed staff. Interventions also included no smoking allowed on facility property. Cigarettes, lighters, matches, and all smoking paraphernalia not allowed on</p>	F 323		

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F 323	<p>Continued From page 31</p> <p>person or premises. Notify licensed staff of violating smoking policy. Violating smoking policy could result in 30 day notice of intent to discharge. Administrator is aware of violation of smoking agreement. "</p> <p>A Licensed staff nursing progress note, dated 6/28/12 read, " New care plan implemented. If resident goes outside to smoke or not LN is to go check if she is by herself. If smoking then resident is unsafe due to narcotic use and needs to come into building. resident currently outside with friend. " The careplan did not include a plan to provide the resident a safe place to smoke or safe supervision while the resident was smoking.</p> <p>A later nursing progress note written on that same day (6/28/12) read, " Resident continues not to follow facility smoking policy. Resident goes out on sidewalk, in front of the building and smokes often with friend ...who resident states keeps her cigarettes. ...Due to amount of narcotics and muscles relaxants and her [REDACTED] puts resident at risk for sleepiness, which makes her safety questionable to be outside off property smoking by herself, as well her [REDACTED] makes her at risk for numbness in her hands as documented in 5/26/12 progress note, and her legs. This makes her at risk for inability to hold a cigarette and at that point increases the risk of getting burned. Therefore resident is not safe to smoke without someone accompanying her off the property. resident care manager and minimum data assessment LN went out to where resident was smoking off property on side walk south corner of driveway. No butts, but lots of ashes in the grass. There were no ashtrays. "</p>	F 323		

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F 323	<p>Continued From page 32</p> <p>On 7/2/12, in a progress note the night licensed staff documented that the resident had received her sleeping pill at 10:30 p.m. and had a narcotic pain pill at 11:30 p.m., after which the " Resident left building with friend at midnight and was seen in the south parking lot smoking with friend. " A review of the resident's sign in and out sheets from 6/23/2012 to 7/12/12 found the resident had intermittently signed out of the facility to smoke at 10:00 p.m. or later.</p> <p>On 7/2/12 evening licensed staff documented, " This resident and another resident have befriended each other and [friend] is taking them off property to smoke as well as a new person [named person] was also out with this resident while she was smoking.</p> <p>On 7/10/12 a licensed progress note read, " This RCM notified the administrator that this resident had a can of butane setting inside her wheelchair. administrator spoke with resident butane given to administrator."</p> <p>In a social service progress note, written for 7/11/12, it was documented that the " Resident had smoking paraphernalia [butane fluid] in her room, administrator aware and will follow-up.</p> <p>The DNS and administrator were interviewed on 7/12/12 at 1:45 p.m., regarding the how the resident was being supervised while smoking. The DNS stated "the friend" came and got the resident to smoke and kept the resident's cigarettes. When asked if the staff had discussed the need to stay with the resident while smoking with the friend, the DNS stated they had not. The administrator said the friend had not</p>	F 323		

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F 323	<p>Continued From page 33</p> <p>been talked to because the resident was smoking off the facility premises. They both also stated they did not know anything about the friend other than what the resident told them.</p> <p>According to a progress note in the resident's clinical record dated 7/12/12, the facility issued the resident a 30 day notice for discharge due to non-compliance with the no smoking policy. The Administrator confirmed he had issued the 30-day notice for discharge.</p> <p>In an interview with the resident on 7/13/12 at 1:45 p.m., the resident stated she was just coming in the door from the outside when the butane was found on her chair. " I had forgotten it was there, I had helped my friend fill up the lighter then sat it down on my chair. I didn't even make it in the door. "</p> <p>RESIDENT 48 Resident 48 was readmitted to the facility on [REDACTED] 12 with diagnoses that included anxiety, [REDACTED] history of falls, history of [REDACTED] and dementia. According to resident 's 14 day Minimum Data Set (MDS) assessment, dated 6/12/12, the resident had a recent history of falls prior to her admission to the facility. The MDS assessment indicated the resident had memory loss and required extensive assistance with toileting, bed mobility, transferring, and ambulation.</p> <p>The resident 's fall risk plan of care/safety plan, dated 5/29/12, indicated a goal for the resident was for her to have " No injury with falls ". Interventions to meet that goal included: low bed</p>	F 323		

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NAME OF PROVIDER OR SUPPLIER AGENCY CARE CENTER AT ARLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 620 SOUTH HAZEL STREET ARLINGTON, WA 98223
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F 323	<p>Continued From page 34</p> <p>at all times, use of a personal alarm while in bed and the wheelchair, staff to provide safety checks on the resident every 2 hours, to assist the resident with toileting before and after meals and as needed, and to ensure the resident wore non-skid socks at all times.</p> <p>On 7/9/12, at approximately 11:00 a.m., the resident was observed lying in bed with the bed at normal height not in low position. A fall mat (a padded mat used beside a bed to reduce injury in case of a fall) was observed folded up, upright and leaning against the end of the resident's bed.</p> <p>On 7/11/12 at 10:57 a.m., Resident 48 was again observed in her bed. The height of the bed remained at a normal not low height and the fall mat was observed completely under the bed. The resident had a personal alarm in place. The resident was observed to be restless, and the caregiver answered the resident's sounding alarm twice in a 20 minute period. The first time the caregiver answered the alarm, the resident was asked what she needed. When the resident did not respond the caregiver showed her the call light and reminded her to use it. The caregiver did not move the fall mat from under the bed and the height of the bed was not adjusted by the caregiver to the lowest position, as was indicated in the resident's plan of care. The plan of care did not mention use of a fall mat.</p> <p>According to a facility incident report, the resident had a fall from her bed on 7/13/12 that resulted in a bump on the resident's head. The investigation report indicated the resident was found on the floor at the end of her bed, the fall</p>	F 323		

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F 323	<p>Continued From page 35</p> <p>mat was in place. The facility incident report further documented the personal alarm was not on the resident and had not sounded when the resident got up. It was documented that the resident had a history of removing the personal alarm when she could reach it.</p> <p>On 7/17/12, at 9:10 a.m., the resident was observed in bed. Her bed was in the low position, approximately knee high, and a fall mat was positioned at the resident's bedside.</p> <p>On 7/20/12, the licensed nurse, (Staff A), stated Resident 48 had a previous admit to the facility and had a history of being impulsive. " She would just get up. " When readmitted to the facility, staff implemented the following fall precautions immediately. The resident was placed in a room closer to the nursing station, her bed was to be kept in the low position, the resident was to have a personal alarm, and a fall mat was to be kept in place beside the resident's bed. When asked to clarify when the fall mat intervention was put into place Staff A stated, " I think we put the fall mat into place when she was readmitted because of her history "</p> <p>LIQUID HAZARDS</p> <p>During observations in the main dining room on 7/9/12 at 10:55 a.m., four bottles of alcohol, one bottle of shampoo, and two bottles of lotion were found unsecured in the cupboard above a sink. A warning label located on all the bottles warned "keep away from children".</p> <p>Observations at 12:10 p.m. that same day revealed 22 residents in the dining room. Staff</p>	F 323		

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F 323	<p>Continued From page 36</p> <p>and several residents were observed to open the cupboard doors and retrieve items. Observations on the same day at 2:30 p.m., 3:15 p.m., and 4:20 p.m. showed the bottles of liquids remained in the cupboard. At 4:22 p.m., Staff A, a Resident Care Manager was shown the items by a surveyor. When asked if the liquids should be located there, the RCM replied, "No". I have no idea how they got there because they can be dangerous". The bottles were then removed.</p> <p>BOILER ROOM DOOR</p> <p>On 7/9/12, at approximately 11:40 a.m., the entrance door to the boiler room containing the facility's two boilers (hot water heaters) was observed to be unlocked. The entrance was located in the 300 hallway, and a key was hanging on a cord just outside the boiler room. The door remained unlocked throughout the day and residents were observed going up and down the hallways past the boiler room. None were observed attempting to open the boiler room entrance.</p> <p>On 7/9/12, at 5:25 p.m., the Administrator stated the entrance to the boiler room was to be kept locked at all times. He said the door of the boiler room automatically closed and locked when the door closed. Upon accompanying the surveyor to the boiler room entrance, the Administrator turned the knob on the door and the door opened. A key was not used to open the door. The Administrator stated the door was supposed to be locked and the key was hanging beside the door to remind staff that it should be kept locked. The Administrator locked the door. When asked if the residents would have been in danger had they entered the boiler room, the Administrator stated,</p>	F 323		

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F 323	Continued From page 37	F 323		
F 354 SS=F	<p>" If a resident got in there and they were able to get to the pilot light that could be a problem. "</p> <p>483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON</p> <p>Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.</p> <p>Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.</p> <p>The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a registered nurse was on duty to provide care and services to residents for at least 8 hours a day, 7 days a week for 9 of 14 days reviewed (6/25/12 to 7/8/12). This failure placed the residents at risk for not receiving necessary care and services with appropriate registered nurse supervision</p> <p>Findings include: A review of the facility staffing sheets revealed no registered nurses were scheduled to work on the facility's units for the provision of resident care and services on 6/26/12, 6/27/12, 6/28/12, 6/29/12, 6/30/12, 7/1/12, 7/2/12, 7/3/12, and</p>	F 354	<p>F354</p> <p>-facility continues to advertise for RN staff. -facility will interview competent applications and hire qualified staff. -staffing coordinator will staff to use the services of a registered nurse for at least 8 consecutive hours per day, 7 days a week. -DNS will ensure compliance.</p>	8/19/12

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F 354	Continued From page 38 7/7/12. Further review of the previous months' staffing schedules for May, June and July 2012, also revealed a consistent pattern of no registered nurses scheduled multiple days throughout these months.	F 354		
F 356 SS=B	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the <u>beginning of each shift</u>. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p>	F 356	<p>F356</p> <ul style="list-style-type: none"> - The facility will post the number of nursing staff working at the beginning of each shift. -DNS will monitor this process. -Admin. will ensure ongoing compliance. 	8/19/12

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F 356	<p>Continued From page 39</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to publicly post the required information regarding the number of nursing staff actually working each shift. This failure placed the residents at risk for not knowing the actual number of nursing staff working each shift to provide them care and services.</p> <p>Findings include:</p> <p>During all days of observation, the facility posted a work sheet each morning that listed the number of nurses and nursing assistants scheduled to work that entire 24 hour period. There was no correlation as to the number of staff scheduled and the actual number of staff that worked each shift.</p> <p>An interview on 7/20/12 at 12:45 p.m., revealed Staff R, the Central Supply Clerk, was responsible for posting the staffing sheet. When asked if she had a policy regarding the required information she stated, "No. All I do is post the nursing staff that is scheduled to work".</p>	F 356		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F 364		

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F 364	<p>Continued From page 40</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance, and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure each resident received foods and beverages served at the proper temperature. This failure placed residents at risk for poor oral food intake.</p> <p>Findings include:</p> <p>During Stage I of the survey, Residents 13, 40, 67, 126, 131, 133 and 206 complained to the surveyors regarding food palatability due to the temperatures of the food and beverages as served to them.</p> <p>During observations of the kitchen on 7/19/12 at 7:10, a.m., a test tray was ordered by the surveyor. The beverages were removed from a refrigerator by staff and placed on a meal tray delivery cart at 7:15 a.m., The actual test tray was made at 7:25 a.m. A dish from a plate warmer was used by the kitchen staff and placed on a hallway delivery cart. The cart left the kitchen at 7:32 a.m., which according to the posted schedule, was 15 minutes late. Two nursing assistants and two students retrieved the delivery cart and proceeded to pass trays in the Medicare unit. At 7:46 a.m., the test tray was received by the surveyor. The beverages consisted of milk</p>	F 364	<p>F364</p> <p>Cited Residents; - residents #13,40,67,126,131,133 and 206</p> <p>All residents; -all residents will be served foods and beverages at the proper temperature.</p> <p>System Review/Education; Plate warmer will be turned on 1 -2 hours ahead of meal service to ensure proper food temp is kept. Beverages will be kept in tubs of ice prior to service and temp checked to ensure they are correctly chilled prior to serving. Cold plate foods will have plates pre-chilled to ensure proper temps are maintained.</p>	
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F 364	<p>Continued From page 41</p> <p>and juice. When temperatures were taken, the beverages were each 56 degrees. A hot cereal was 132 degrees and eggs were 105 while the potato cake was at 110 degrees. The eggs and potato cake were luke warm when tasted. The plate was not warm to touch.</p> <p>Another test tray was ordered for lunch on 7/20/12. The test tray was made in the kitchen at 11:35 a.m. with a dish from a plate warmer. It was placed on a hallway delivery cart. Nursing assistants retrieved the delivery cart at 11:43 a.m. and the surveyor received the tray at 11:50 a.m. Again, the beverages were milk and juice, which registered at 54 and 56 degrees respectively. A meat patty with gravy was recorded at 122 degrees while the mixed vegetables were at 135 degrees. A whipped potato with brown gravy was recorded at 138 degrees. While the potato tasted warm/palatable, the meat with gravy was luke warm. The plate was not warm to touch.</p> <p>During an interview with the Dietary Manager on 7/20/12 at 1:40 p.m., she indicated she was aware of complaints from residents regarding the temperatures of food. When asked about the beverage temperatures, she stated they were too warm. She said the issues would be addressed through the facility's QA Committee.</p>	F 364	<p>Temps to be taken of food and beverage prior to service.</p> <p>Monitoring; DSM will have test trays 4 times/week.</p> <p>Responsibility; RD/Admin will run test trays weekly to assure quality and compliance.</p>	8/19/12
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	<p>Continued From page 42</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a sanitary kitchen and ensure sanitary food service in 1 of 3 dining rooms. Failure to ensure food preparation equipment was maintained in a sanitary condition and failure to maintain cleanable surfaces on counter tops and flooring had the potential to introduce foodborne pathogens to residents receiving their meals prepared in the kitchen. Staff's use of bare hands while handling food placed residents at risk for food-borne illness from cross contamination.</p> <p>Findings include:</p> <p>KITCHEN During observations of the kitchen on 7/9/12 at 10:28 a.m., a meat slicer was found to be covered with a black trash bag. When asked, the Dietary Manager stated it was clean and the trash bag was to help ensure it didn't become contaminated. When the trash bag was removed by the surveyor, dried food debris was noted on the blade, the sliding block, and the bolt and nut used to hold the sliding block onto the base.</p>	F 371	<p>F371</p> <p>All residents; All residents will have food prepared and served in a sanitary condition.</p> <p>System review/education; Affected countertops and floors will be repaired by maintenance. All kitchen equipment will be cleaned and sanitized by dietary personnel after each use. A checklist has been developed for the PM cook to recheck each piece of equipment prior to end of shift and validate it being done. Staff has been retrained regarding washing hands and food handling to prevent cross contamination.</p>	

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F 371	<p>Continued From page 43</p> <p>When asked about this, the Dietary Manager stated, "No, that's not clean". She then asked a staff member to immediately take it apart and have it cleaned.</p> <p>Observations of the kitchen on 7/19/12 at 11:00 a.m., revealed the same meat slicer under a trash bag. When the bag was removed, food debris was again noted on the sliding block and the bolt and nut used to hold the sliding block onto the base.</p> <p>During all days of observations, a counter top located to the left of the refrigerator had a missing laminate strip two inches wide by 14 inches long. The wood particle board was underneath and could not be properly sanitized. The flooring underneath this counter was warped. Food and liquids were observed to have accumulated in the gaps and underneath the linoleum.</p> <p>Flooring located by the stove and food preparation counter had a 5 foot by 2 inch seam missing. Additionally, the edges had pulled away from the bare floor. This area was observed to be encrusted with dried food debris. When asked during an interview, the Dietary Manager stated the floor was cleaned as best as they could, but sanitization of those areas was not possible.</p> <p>During a dining room observation of the north dining room on 7/12/12 at 8:05 a.m. 2 staff, Staff T and Staff O, were observed handling two separate resident's food without gloves. Neither staff had washed their hands prior to handling the residents' food.</p>	F 371	<p>Temps to be taken of food and beverage prior to service.</p> <p>Monitoring; DSM will have test trays 4 times/week.</p> <p>Responsibility; RD/Admin will run test trays weekly to assure quality and compliance.</p>	8/19/12

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F 371	<p>Continued From page 44</p> <p>On 7/13/12 at 4:00 p.m., in an interview with the Director of Nursing Services, she stated that the facility did not require caregivers to use gloves in the dining room when handling food. She said, "Handwashing is important and the caregivers might forget to change gloves so the facility emphasizes good handwashing instead."</p> <p>FOOD HANDLING WITH BARE HANDS During dining room observations in the north dining room on 7/12/12 at 8:05 a.m. Staff T, a caregiver, approached a resident and asked if she needed assistance with peeling a banana. The resident stated, yes. Staff T took the 1/2 banana off the resident's plate, peeled the skin off the banana, took the edible part of the banana with her bare hands and placed the banana back on the resident's plate. The caregiver did not wash her hands before touching the banana or before moving on to assist the next resident.</p> <p>A second caregiver, Staff O, approached a resident and asked if the resident needed assistance in peeling the hardboiled egg. The caregiver peeled the egg with his bare hands, and then he placed the peeled egg back onto the resident's plate. Staff O did not wash his hands before assisting the resident with the egg, or before moving to the next resident he assisted.</p> <p>On 7/13/12, at 4:00 p.m. the DNS stated that the facility did not require caregivers use gloves in the dining room. She continued, "We stress hand washing. If staff used gloves, they might not change the gloves between residents, so we stress good hand washing instead."</p>	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505351	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2012
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NAME OF PROVIDER OR SUPPLIER AGENCY CARE CENTER AT ARLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 620 SOUTH HAZEL STREET ARLINGTON, WA 98223
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(4) 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 431	<p>Continued From page 45</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record</p>	F 431	<p>F431</p> <ul style="list-style-type: none"> -OTC meds have been moved to med rooms accessible only to LN's. -All OTC meds will be stored in facility med rooms accessible only to LN's. -LN's will be inserviced re: OTC meds – LN's will accompany CS person while stocking OTC meds in med room. -DNS will monitor. -DNS will assure compliance. 	8/19/12

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NAME OF PROVIDER OR SUPPLIER AGENCY CARE CENTER AT ARLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 620 SOUTH HAZEL STREET ARLINGTON, WA 98223
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F 431	<p>Continued From page 46</p> <p>review the facility failed to ensure that access to medications was limited to only authorized staff and did not have a system in place to ensure pharmacy over-site for 1 of 3 medication storage areas. These failures placed the residents at risk for not having their medications stored in a safe manner.</p> <p>Findings Included:</p> <p>According to federal guidelines, "authorized staff" include: professionals that hold a professional license or certificate allowing them access to medication. An assistant who have been delegated by the facility ' s pharmacist as a function of their job is recognized as authorized staff.</p> <p>On 7/9/12 at 10:16 a.m., a storage room off the Medicare dining room was observed to contain 4 open shelves with bottles of various " over the counter medications " (OTC) on them. The room had a desk inside which was assigned to Staff R. Staff R reported she was a non-licensed staff member and had not been delegated by a pharmacist to have unsupervised access to the medications.</p> <p>On 7/9/12, at approximately 1:30 p.m., the facility ' s Central Supply- Staff Coordinator Job Description was reviewed for information specifically regarding access to stored medications. According to the job description, a staff member was required at a minimum to have a high school diploma. Duties included: " ... to check nursing storage areas for supplies, order necessary supplies, including oxygen, concentrators, and enterals (tube feeding formula</p>	F 431		

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F 431	<p>Continued From page 47</p> <p>and supplies), and to work with vendors and suppliers to achieve the most cost effective purchases " The job description did not mention requirements for access to stored medications.</p> <p>On 7/9/12, at 5:45 p.m. the Director of Nursing Services (DNS) stated the medications were stored in medication rooms at each nursing station. " I know that she [Staff R] keeps sealed over-the-counter medications in her office. " The DNS said that Staff R had been in her position a long time. She added, " Everywhere I have worked the central supply personnel have had access to the over-the-counter medications. " When the DNS and Administrator were asked if the pharmacist had delegated Staff R to have authorized access to the medications, both stated that the facility pharmacist had not provided over-sight of the storage area or for Staff R.</p> <p>On 7/11/12, at 1:30 p.m. the Administrator provided the " Medication Storage in the Facility Policy " for review. He stated it was taken from the facility pharmacy book. Review of the policy under Procedures read: " B Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications are allowed access to medications, medication rooms, carts, and medication supplies are locked or attended by persons with authorized access "</p> <p>On 7/11/12 at 1:30 p.m., the Administrator presented the Medication Storage in the Facility policy he had located from the pharmacy book. Under Procedures it stated, " B Only licensed nurses, pharmacy personnel, and those lawfully</p>	F 431		

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NAME OF PROVIDER OR SUPPLIER AGEENCY CARE CENTER AT ARLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 620 SOUTH HAZEL STREET ARLINGTON, WA 98223
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F 431	Continued From page 48 authorized to administer medications are allowed access to medications, medication room, carts, and medication supplies are locked or attended by persons with authorized access. An attached e-mail from the pharmacy regarding the storage of over the counter medications only addressed the issue of where the medications could be stored but did not cover who could have authorized access to the storage area. The medications stored in the room off the medicare dining room were removed.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident, and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441		

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IDENTIFICATION OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505351	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/24/2012
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NAME OF PROVIDER OR SUPPLIER NORTHVALE CARE CENTER AT ARLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 620 SOUTH HAZEL STREET ARLINGTON, WA 98223
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441	<p>Continued From page 49</p> <p>direct contact will transmit the disease</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure staff consistently implemented infection control measures regarding isolation precautions when providing care for two residents (#13 & #50) on the 200 hall. This failure placed residents at risk for being exposed to communicable infections due to cross contamination.</p> <p>Findings Included:</p> <p>On 7/9/12, at 4:15 p.m., Staff Q, a caregiver on the 200 hall was observed answering a Resident 50's call light on one side of the hall. That resident requested fresh ice water. The caregiver picked up the resident's pitcher, and as she left the resident's room with the resident's water pitcher. At that time, Resident 13 from across the hall called out that she too would like fresh ice water. Resident 13 had a sign on her door alerting staff she had an infection that required special isolation precautions.</p>	F 441	<p>F441</p> <p>Cited residents; resident #13 is no longer in isolation precaution.</p> <p>All residents; All residents could be affected by this practice. The facility will maintain an Infection Control Program designed to provide a safe, sanitary environment.</p> <p>Systems review/education; Facility will review and amend how ice is passed to prevent potential cross contamination. Staff has received education re: Infection control practice and cross contamination. Appropriate staff have been re-educated regarding infection control protocols.</p> <p>Monitoring; RCM will randomly audit and complete infection control rounds.</p> <p>Responsibility; DNS will ensure compliance.</p>	8/19/12

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F 441	<p>Continued From page 50</p> <p>Staff Q entered Resident 13' s room across the hall, still carrying the Resident 50's water pitcher. The caregiver then took both of the water pitchers to the ice machine located in the dining room. After she filled the two residents' pitchers, she took both water pitchers back into the Resident 50' s room, and then walked across the hall and delivered Resident 13' s water pitcher. Resident 13' s room had an isolation cart at the doorway, and a sign posted on the door alerting staff and/or visitors to see the nurse prior to entering.</p> <p>Staff E, a licensed nurse, who was caring for the residents on the hall was asked at 4:20 p.m. on 7/9/12, about the residents who had assigned precautions in place. Staff E stated Resident 13 was on contact precautions (use of gloves required when handling items potentially contaminated with the communicable infection).</p> <p>At 4:46 p.m. Staff Q, the caregiver, was asked whether anyone on the 200 hall was on special infection control precautions. Staff Q stated, " I do not know because I have not worked in that hall for a long while until today. " When asked how she would normally be informed about residents with special infection control precautions in place, she stated she usually found out by seeing an infection control cart outside a resident ' s room and the note posted on a resident ' s door. She said that to find out what kind of precautions to use for a resident, she would have to ask the nurse assigned to the resident. Staff Q placed Resident 50 and other residents who recieved ice from the facility's ice machine at risk for contracting a communicable infection.</p>	F 441		

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F 441	<p>Continued From page 51</p> <p>Staff Q stated, when she had entered the Resident 13' s room in the 200 hall, she had not noticed the infection control cart or the sign on the door. She said she did not normally take resident use items from one resident ' s room into another resident ' s room. When asked by the surveyor to demonstrate how the pitchers were filled with ice, Staff Q showed the surveyor an ice machine that required each pitcher to come in contact with the front surface of the ice machine when it was being filled.</p> <p>On 7/9/12 at 5:10 p.m., the Director of Nursing Services (DNS) provided the facility's infection control records for review. Review of the records did not reveal trends or patterns of infection.</p> <p>On 7/20/12, at 12:15 p.m., the DNS stated that regardless of a resident ' s infection status, one resident ' s personal items should not have been taken into another resident ' s room. She went onto say, " It is just not good practice " When asked how staff were made aware of what type of infection control precautions they should use, she said when a resident was placed on infection control precautions, an infection control cart was placed outside the resident ' s doorway. She stated staff had been instructed to check with nursing to see what type of precautions were needed whenever a cart was placed outside a resident ' s door. She said that a particular infection control consultant she often called on had recommended that staff be informed of what precautions were needed, and that they did not need to know the infection type a resident had. Using the recommended precautions, and good hand washing was the key to preventing the spread of infection.</p>	F 441		

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F 490 SS=J	<p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to administer services effectively and efficiently in order to ensure each resident received the necessary care and services to attain, and/or maintain, their optimal level of physical, mental and psychosocial well-being. The "non-smoking facility" admitted and retained at least 3 residents who actively smoked. Failure to provide a safe smoking area with staff supervision for 2 residents (104 & 121), who were assessed by the facility as being as being unsafe to smoke independently, placed both residents at imminent risk for harm from injury while smoking. On 7/13/12, this was determined to be an immediate jeopardy situation, which was abated on 7/24/12. In addition, the facility failed to ensure adequate Registered Nurse staffing levels to ensure safe supervision of resident care and services</p> <p>Findings include: Residents 104 and 121 were both assessed by the facility as needing supervision while smoking due to their medical conditions and physical functioning levels. However, even after the facility identified smoking hazards for these</p>	F 490	<p>F490</p> <p>Refer to PoC's for F323 and F354</p>	8/19/12

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F 490	Continued From page 53 residents, the facility continued to require that the residents go off the facility property to smoke and did not ensure their smoking was safely supervised.	F 490		
F 508 SS=D	Refer to CFR 483.25(h) , F-323, Accidents and Supervision 483.75(k)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure the timeliness of obtaining diagnostic services to meet the needs of 1 of 3 sample residents (128). The facility's failure to attempt to make the resident an appointment for an ultrasound test placed the resident at risk for delayed treatment and potential psychological harm for the resident. Findings included: Resident 128 was admitted to the facility on [REDACTED] 12 with diagnosis that included anemia, malnutrition, and non-insulin dependent diabetes On 6/20/12 the resident's physician was contacted by licensed nursing staff to inform the physician the resident continued to report she was having bloody spotting when she urinated, blood had been observed on the resident's	F 508	F508 Cited Resident; - Res. #128 is followed for diagnostic follow up. All Residents; -all residents will obtain timely diagnostic services. System review/education; - all orders will be reviewed in am clinical for timely follow up. Monitoring; -RCM will monitor orders and faxes on an ongoing basis. Responsibility; DNS will ensure compliance.	8/19/12

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F 508	<p>Continued From page 54</p> <p>underpants by staff, and the resident was continuing to have night sweats. The physician ordered an ultrasound test to assess the cause of the resident's spotting. The physician ordered the test on 6/20/12. Staff did not attempt to make the appointment for the resident's ultrasound test until 6/25/12, five days after the order was received by the facility. The ultrasound was scheduled for 6/29/12.</p> <p>On 7/2/12, the physician received the results of the ultrasound. It indicated the resident had an endometrial mass. The physician ordered a referral for a biopsy and work-up to rule out cancer.</p> <p>On 7/17/12, the resident stated she had not had the biopsy yet, so she did not know anything. She said, "The hardest part is the waiting and just not knowing."</p> <p>On 7/19/12, at 3:55 p.m., Staff A, a licensed nurse, stated that some of the licensed staff were better than others in following through with physician orders, such as with making residents' appointments. She said some of the licensed staff would receive the physician order, then place the order in Staff A's box to follow through with the order. Staff A stated, she thought during the time frame with this order was received, she had been on leave a few days. She said when she returned to work, she made an appointment for the resident.</p>	F 508		