

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

PRINTED: 12/16/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/10/2014
NAME OF PROVIDER OR SUPPLIER WILLAPA HARBOR HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 JACKSON STREET RAYMOND, WA 98577		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Willapa Harbor Health and Rehab on 10/06/14, 10/07/14, 10/08/14, 10/09/14 and 10/10/14. A sample of 37 residents was selected from a census of 38. The sample included 24 current residents and the records of 13 former and/or discharged residents.</p> <p>The following complaint was investigated as part of this survey:</p> <p>#3045987</p> <p>The survey was conducted by:</p> <p>Rebecca Kane, RN, MN Erika Hurley, MS, CPG Rebecca Christiansen, RN, MS Gilda Warden, EdD, RN-BC Tammy Thompson, RN, BSN</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, District 3, Units A, D, & E. P.O. Box 45819 Olympia, Washington 98504-5819 Telephone: 360.664.8420 Fax: 360.664.8451</p> <p><i>L. Cramer for District 3</i> Residential Care Services Date 12/16/14</p>	F 000	<p>Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, alleged or the correctness of any conclusion set forth in this allegation by the survey agency. Accordingly, the facility has prepare and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under the state and federal law that mandate submission of a plan of correction within 10 days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. This plan of correction is submitted as the facility's credible allegation of compliance.</p> <p>IDR AMENDED by Lisa Cramer</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
X R. Barnett *X Administrator* *X 12/22/14* 10/29/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 160 SS=D	<p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH</p> <p>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure balances of trust accounts were returned to either the legal representative of a resident or the Office of Financial Recovery (OFR) within 30 days following the death of 1 of 3 current sampled residents (#56) reviewed for personal fund accounts. This failure to convey funds properly placed the legal representative or the State in a position of not being able to utilize the funds.</p> <p>Findings include:</p> <p>A record review showed Resident #56 expired on [REDACTED] with a balance of \$140.05 in a personal funds account.</p> <p>The personal funds account was closed on [REDACTED] with an ending balance of \$140.09. The ending balance was sent to the legal representative of Resident #56 on [REDACTED].</p> <p>On [REDACTED] at 10:45 a.m., during an interview with the Business Office Manager (BOM), she stated personal fund accounts are usually closed within 1 to 3 days after a resident expires and the funds returned to either the OFR or a legal</p>	F 160	<p>F 160 CONVEYANCE OF PERSONAL FUNDS UPON DEATH</p> <p>Upon the death of a resident Willapa Harbor Health & Rehab (The Facility) will continue to convey a final accounting of resident's funds and transfer those funds to the individual or probate jurisdiction administering the resident's estate with in 30 days of the death of the resident.</p> <p>Resident # 56 funds were discovered as not being returned timely during a routine facility audit. The funds were returned 15 days delinquent.</p> <p>No other residents were affected by this deficient practice.</p> <p>The Business Office Manager and her assistant were provided inservice training by the Administrator on 10/27/2014 regarding timely conveyance of resident funds to the appropriate party within 30 days of the resident's death.</p>	11/16/14	

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F 160	Continued From page 2 representative. The BOM reported the Assistant to Business Office Manager (ABOM) managed the trust fund accounts and was sure she "had just missed this one". On 10/8/14 at 11:40 a.m., during an interview with the ABOM, she validated trust accounts are to be closed and funds sent to a legal representative of the resident or OFR within 30 days after the death of a resident. The ABOM stated the account for Resident #56 had been discovered during a review of trust accounts in the beginning of October. The account was then closed on [REDACTED] and the funds were sent to the son of Resident #56.	F 160	The Administrator will monitor this plan of correction monthly. Any deficient practices will be reported to the QAPI Committee monthly for their review and recommendation. Completion Date 10/27/2014		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to	F 167	F 167 RIGHT TO SURVEY RESULTS READILY ACCESSIBLE The facility will continue to insure that the most recent survey results are readily accessible. A magnifying page has been added to the binder as well as a clearly marked divider identifying the location of the most recent survey.	11/16/14	

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F 167	<p>Continued From page 3</p> <p>ensure the results of the most recent survey were readily accessible to residents and the public for review.</p> <p>Findings include:</p> <p>On 10/6/14 at 12:25 p.m., the survey results binder was observed hanging in a metal holder just above the handrail in the main hallway. The first pages of the binder included a newspaper article, an obituary, and the survey results from 2012.</p> <p>On 10/10/14 at 9:47 a.m., the annual survey results binder was inspected for a second time. The first page of the binder was a newspaper article highlighting the facility's 2012 deficiency-free survey. The second page was an obituary dated September 11, 2014 mentioning the facility. The third page was the 2012 deficiency-free survey results. Pages 4 through 7 included the 2012 fire marshal report. Page 8 was a letter from the facility to the Residential Care Services (RCS) field manager. Page 9 was a letter from RCS to the facility. On the tenth page, the most recent survey results report from 2013 began, which outlined four deficiencies.</p> <p>On 10/10/14 at 10:01 a.m., the administrator indicated that the annual survey results were available in the binder (pointed toward metal holder in main hallway) and staff would hand residents the binder if they asked. When questioned about the other items in the survey binder, the administrator stated, "I can put anything I want in that book."</p> <p>The most recent survey results were difficult to locate behind nine pages of information. This</p>	F 167	<p>The Administrator will monitor the contents of the book monthly.</p> <p>Any deficient practices will be reported to the QAPI Committee monthly for their review and recommendation.</p> <p>Completion Date 10/10/2014</p>	
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F 167	Continued From page 4 placed residents and visitors at risk of not being fully informed of the facility's deficiencies.	F 167		
F 176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to assess safety for 1 of 1 current sampled resident (#50) reviewed for self-administration of medication. This failure placed the resident at risk for unsafe use of the medication.</p> <p>Findings include:</p> <p>The 30 day Minimum Data Set (MDS), an assessment tool, dated 9/20/14, revealed Resident #50 was admitted on [REDACTED]. The resident's diagnoses included [REDACTED].</p> <p>On 10/6/14 at 4:00 p.m., medication was observed on Resident #50's bedside tray.</p> <p>On 10/7/14, a review of the Medication Administration Record (MAR) documented an order dated 8/23/14 for Resident #50's knee pain. The MAR read, apply [REDACTED] (a compound anti-inflammatory) cream topically to</p>	F 176	<p>F 176 Resident Self -- Administer Drugs if Deemed Safe.</p> <p>The facility will continue to follow it's policy & procedures that allow individual residents to self-administer drugs if the interdisciplinary team as defined in the regulation has determined that it is safe and through resident assessment for safety.</p> <p>The facility failed to assess the safety of resident # 50 to self administer his topical cream.</p> <p>The Director of Nursing assessed resident #50 for self-administration of medications and determined he was not safe. The topical cream was taken from the bed side and administered by the nursing staff until he discharged.</p>	11/16/14

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F 176	Continued From page 5 affected area four times a day (QID) as needed (prn). At 8:40 a.m., the anti-inflammatory medication was observed sitting on the bedside tray belonging to Resident #50. At 12:10 p.m., the Director of Nursing Services (DNS) indicated a safety assessment for self-administration of medication had not been completed for Resident #50 to keep the medication at bedside. The Treatment Administration Record (TAR) for September 2010 documented on 9/6/14, pain cream at bedside apply QID to posterior knees. The TAR was inconsistently initialed indicating the resident was not taking the medication as ordered. The physician orders dated 9/6/14 documented the medication was scheduled QID. The initial order written on 8/23/14 was for QID prn. On 10/8/14, Resident #50 indicated he put the medication on his knees and shins twice a day before going to therapy.	F 176	The nursing staff will be provided inservice education by the Director of Staff Development on 11/4/2014 and again on 11/6/2014 of the facilities policy for self administration of medications, assessment for safety and documentation on the MAR or TAR as appropriate. No other residents are self administer their medications. There were no other residents affected by this isolated deficient practice. The Director of Nursing will monitor this plan of correction monthly. Any deficient practices will be reported to the QAPI Committee monthly for their review and recommendation. Completion Date 11/16/2014		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that	F 242	F 242 Self-Determination- right to make choices.	11/16/14	

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F 242	<p>Continued From page 6 are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to consistently honor residents' preferences for bathing for 2 of 19 current sampled residents (#50 & #81) reviewed for choices. This failure prevented the residents from exercising the right to make choices regarding care and had the potential to decrease their quality of life.</p> <p>Findings include:</p> <p>Resident #81 was admitted to the facility on [REDACTED]</p> <p>Resident #81's Minimum Data Set (MDS), an assessment tool, dated 9/20/14, indicated the resident required one person physical assistance with bathing.</p> <p>On 10/6/2014 at 2:24 p.m., Resident #81 responded that showers were given whenever the staff scheduled them. The resident also stated she preferred to take a bath like she was used to doing at home but had only been able to take a shower since coming to the facility.</p> <p>On 10/9/14 at 11:00 a.m., the Director of Nursing Services (DNS) explained showers were recorded on the Treatment Administration Record (TAR). Showers were scheduled 2 times a week, unless a resident requested differently. The DNS reported there was not a tub in the facility and only showers were given to residents.</p>	F 242	<p>The facility will continue to ensure that all residents can make choices about aspects of his or her life in the facility that important and significant to the resident.</p> <p>Resident # 81's preference is to take baths rather than showers. She is satisfied with the schedule of bathing 2 times per week.</p> <p>The facility has made the required repairs to the bathtub in room 16, and it is now available for residents use if requested.</p> <p>Resident # 50 has stated that he would like more than two showers per week and after episodes of urinary incontinence. The nursing staff have adjusted his scheduled showers after he made his wishes known.</p> <p>In addition to the already existent non-skid strips in the shower rooms a bathmat was provided to resident #50 after he made his wishes known.</p>	

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F 242	<p>Continued From page 7</p> <p>On 10/9/14 at 11:05 a.m., NA D reported there was a tub that was used for storage and gestured to a room with a sign on the door that read "Bath Open".</p> <p>On 10/9/14 at 11:10 a.m., the immersion tub was observed full of slings used for transfer lifts, packages of disposable adult briefs, and other supplies.</p> <p>On 10/10/14 at 8:55 a.m., LN B reported residents' preferences were used for determining the shower schedule.</p> <p>On 10/10/14 at 9:00 a.m., LN A explained showers were given two (2) times a week as a standard for the facility and the residents' preferences were used when the shower schedule was made. LN A indicated the tub did not work and only showers were given to the residents.</p> <p><Resident #50></p> <p>Resident #50 was admitted to facility on [REDACTED]</p> <p>On the 30 day MDS, dated [REDACTED] Resident #50 was admitted with diagnoses including [REDACTED]</p> <p>The MDS documented, Resident #50 required extensive one person assistance with toileting and was occasionally incontinent. Resident #50 was totally dependent upon staff for assistance with bathing.</p> <p>On 10/6/14 at 3:39 p.m., Resident #50 revealed he would like more than two showers a week and</p>	F 242	<p>The facility conducted the Abaqis survey protocols on all residents. While reviewing choices, there were no residents that would prefer to take a bath vs. shower.</p> <p>Upon admission to the facility, the residents are interviewed by the social service staff and clinical staff members regarding their individual preferences.</p> <p>Quarterly, the Abaqis survey protocol is conducted where once again preferences and choices are reviewed with the residents and family members.</p> <p>No other residents were affected by this practice.</p> <p>This plan of correction will be monitored by the Director of Nurses and the Administrator on a monthly basis.</p> <p>Any deficient practices will be reported to the QAPI Committee by the Director of Nurses monthly for their review and recommendation.</p> <p>Completion Date 10/28/14</p>	

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F 242	Continued From page 8 after episodes of urinary incontinence. On 10/8/14 at 1:12 p.m., Resident #50 stated he would like to be able to stand in the shower but the shower floor was 'too slick' and he felt unsafe. At 1:44 p.m., the Social Service staff indicated it would not be difficult to look into having a mat placed for Resident #50's shower safety.	F 242			
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a homelike dining environment in 3 of 3 dining rooms for residents who received medication administration during meal service. This failure placed residents at risk for a diminished quality of life. Findings Include: On 10/6/14 at 12:15 p.m., LN D administered medication to two (2) residents, one being Resident #62, in the patio dining room without asking permission.	F 252	F 252 Safe Clean Comfortable Homelike Environment. Willapa Harbor Health & Rehab is proud of our achievements in providing a warm homelike environment that is safe, clean and comfortable. The licensed nursing staff have made it a practice of passing medications to specific residents while gathered in the dining rooms (Prior to meal presentation).	11/16/14	

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F 252	<p>Continued From page 9</p> <p>On 10/8/14 at 12:20 p.m., Resident #62 stated, "They never ask me if I want to take my pills in the dining room, they just give them to me. It's always been that way since I came here. Every meal is the same."</p> <p>On 10/9/14, during medication administration observations, LN D, LN F, LN A and LN E were observed to administer medication to residents in the main and assisted dining room without asking for the resident's permission.</p> <p>The nurses were observed to approach the residents and stated, "I have your medication." If the resident asked what the medication was for, the nurse stated the medical reason as specific to the medication in a voice loud enough for others to hear.</p> <p>At 10:40 a.m., LN D stated, "We usually give medications to residents when they are sitting in the dining room, unless they specifically request to not have their medications given in there. Sometimes we give them to the residents during the meal if they want them with food, but usually it is while they are waiting for the meal or after they finish."</p> <p>At 5:11 p.m., LN E gave Resident #33 medication in the dining room.</p> <p>At 5:32 p.m., LN E administered medication to Resident #2. Two food trays had been delivered to residents.</p> <p>On 10/10/14 at 1:44 p.m., LN D, without asking permission, administered medications to Resident #31 and 83 in the main dining room as</p>	F 252	<p>Some of our residents have preferences to take their medications with their meal, as well as issues related to seating and positioning, swallowing and the need for specific texture/liquid adjustments</p> <p>Licensed staff members have been provided with inservice education on 11/14/2014 and again on 11/16/2014 regarding passing of medications and asking the residents permission prior to administration.</p> <p>Additionally the licensed staff were instructed 10/13/2014 by the Director of Nurses to always be cognizant of not discussing what the medical condition that the physician has prescribed the medication for in a public area where they can be over heard.</p> <p>This plan of correction will be monitored by the Director of Nurses and Nursing Supervisors daily while observing the staff / resident interactions in public areas of the facility.</p>	
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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 252	Continued From page 10 they awaited food delivery.	F 252	There were no other residents affected by this deficient practice.		
F 285 SS=D	<p>483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR</p> <p>A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.</p> <p>A nursing facility must not admit, on or after January 1, 1989, any new residents with:</p> <p>(i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission;</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p>	F 285	<p>Any deficient practices will be reported to the QAPI Committee monthly by the Director of Nursing for their review and recommendation. Completion Date 11/16/2014</p> <p>F 285 PASSR Requirements</p> <p>The facility will continually follow its policy & procedures that all admissions be given a preliminary assessment to determine whether they might have MI or MR. during the "Level I screen".</p> <p>Review of Resident #50's medical records indicated that the facility failed to ensure PASSR Level 1 Screen assessments were completed after a 30-day exemption period.</p> <p>The Director of Social Services and Admitting Nurses were provided inservice education by the Director of Nurses on 10/13/2014 to insure that assessments are coordinated with PASSR requirements.</p>	11/16/14	

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F 285	<p>Continued From page 11</p> <p>For purposes of this section:</p> <p>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).</p> <p>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR) assessments were completed after a 30-day exemption period for 1 of 4 current sampled residents (#50) reviewed for PASRR. This failure placed residents at risk of not receiving timely and necessary mental health services.</p> <p>Findings Include:</p> <p>Resident #50 was admitted to the facility on [REDACTED]. The 30-day Minimum Data Set (MDS), an assessment tool, date [REDACTED] indicated the resident had a diagnoses of [REDACTED] and no response was marked in regard to whether a Level II evaluation had been completed for Resident #50.</p> <p>The Level 1 PASSR form, dated 8/28/14, indicated in Section I, the resident had [REDACTED]. In Section II Advanced Categorical Determinations, the 30-day care box was checked indicating the resident was requiring care not to exceed 30 days and requiring a physician signature.</p>	F 285	<p>After review of the Medical Records it has been determined that no other PASSR's were submitted late.</p> <p>No other residents were affected by this deficient practice.</p> <p>This plan of correction will be monitored by the Social Services Director on admission on a new resident.</p> <p>Any deficient practices will be reported to the QAPI Committee monthly for their review and recommendation.</p> <p>Completion Date 10/13/2014</p>	

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F 285	Continued From page 12 The physician signature was dated 8/28/14. Section III did not document whether a Level II evaluation was indicated for referral. On 10/10/14 at 12:36 p.m., the Social Services staff indicated the PASRR for Resident #50 had been missed and there had not been one completed following the initial 30 day exemption and stated, "that is the most current."	F 285			
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: 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: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. 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	F 356	F 356 Posted Nurse Staffing Information The facility revised its practice of posting nurse staffing information to include the number of hours worked and the daily census numbers 10/10/2014. This plan of correction will be monitored by the Administrator daily while making facility rounds. There were no residents affected by this deficient practice	11/16/14	

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F 356	Continued From page 13 standard. 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. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure all required components were included on the daily posting of staff working in the facility. This failure placed residents and visitors at risk of not being fully informed about the facility's staffing hours and census. Findings include: The facility's Staffing Posting was observed hanging on a wall in the main hallway on 10/06/14, 10/07/14, 10/08/14, 10/09/14 and 10/10/14. The postings did not include the current resident census or the actual hours worked by the different categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. On 10/10/14 at 9:35 a.m. the Director of Nursing Services (DNS) indicated that no hours were listed on the posting. The DNS stated, "It is an easy fix," and corrected the posting immediately. On 10/10/14 at 1:39 p.m., the Administrator stated, "we do not include the census on there either (referring to the daily staff posting)."	F 356	Any deficient practices will be reported to the QAPI Committee monthly for their review and recommendation. Completion Date 10/10/2014		
F 412	483.55(b) ROUTINE/EMERGENCY DENTAL	F 412		11/16/14	

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F 412 SS=D	<p>Continued From page 14 SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan), and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record reviews, it was determined the facility failed to arrange dental services for 1 of 3 current sampled residents (#24) reviewed for dental needs. This failure placed residents at risk of discomfort and not attaining their highest practicable level of well-being.</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS), an assessment tool, dated 9/8/14 noted Resident #24 was assessed with obvious or likely cavity or broken natural teeth. Resident #24's diagnoses included [REDACTED]</p> <p>The facility dental services policy stated, "Ultimately, the facility is directly responsible for the dental care needs of it's residents" and "If a resident declines dental services, nursing staff and the resident's Primary Care Physician will monitor for emergent needs based on pain,</p>	F 412	<p>F 412 Routine / Emergency Dental Services</p> <p>Willapa Harbor Health & Rehab has access to an outside resource for routine (to the extent covered under the State Plan) and emergency dental services to meet the needs of each resident.</p> <p>In the event that a resident needs an appointment and/or transportation for dental care, arrangements will be made by the Director of Social Services.</p> <p>Resident # 24's son who is also designated as the DPOA for the resident does not want a referral for dental care. Resident # 24, when questioned has not indicated that she has any pain or discomfort. The licensed staff assesses resident #24 for pain on a daily basis.</p>	

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F 412	<p>Continued From page 15 infection or oral cavity damage."</p> <p>On 10/7/14 at 10:38 a.m., Resident #24 was observed to have debris between the front teeth.</p> <p>On 10/7/14 at 12:04 p.m., a family member reported Resident #24 had "rotted out and gross teeth."</p> <p>The Resident Care Plan documented the resident had natural teeth with a goal for the resident to have no pain or discomfort in mouth through next review. Approaches for the goal included make dental appointment as needed and encourage resident and staff to perform good oral care.</p> <p>A review of the resident's medical records did not indicate the facility had attempted to refer the resident for dental care.</p> <p>On 10/8/14 at 11:00 a.m., the Social Services Director (SSD) stated there were not hygienists visiting the facility and there were no dentists visiting the facility from the community. The SSD reported all dental care was done by transporting residents out of the facility. Services were dependent on resident cognition and ability to sit in a dental chair.</p> <p>On 10/8/14 at 7:03 p.m. Resident #24's bottom teeth were noted as broken and brown natural teeth.</p> <p>The SSD could not find documentation about Resident #24's dental health and reported the resident had not seen a dentist since admission.</p> <p>The SSD reported the family supplied Resident #24 with chocolate when they visited, but recently</p>	F 412	<p>The Social Service Director was provided inservice training by the Administrator on 10/16/2014 regarding the dental services that are available in the community.</p> <p>There were no other residents affected by this practice.</p> <p>Completion Date 10/16/2014</p>		

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F 412	<p>Continued From page 16</p> <p>Resident #24 did not want chocolate anymore.</p> <p>No documentation was found indicating the family did not want Resident #24 to get oral care.</p> <p>On 10/9/14 at 1:14 p.m., NA C stated Resident #24 sometimes complained of pain when her teeth were being brushed and reported Resident #24 was possibly uncomfortable.</p> <p>On 10/9/14 at 1:23 p.m., NA B reported Resident #24's teeth are missing and it's uncomfortable for the resident to have her teeth brushed every now and then. NA B indicated Resident #24 might be uncomfortable because the resident made faces during oral care.</p> <p>The Social Service Assessment, dated 12/9/10, indicated the resident was "readmitted to facility after a hip fracture and was unable to express wants, needs, preferences, and concerns; staff anticipated needs." The assessment documented Resident #24 "may benefit from dental consult ..."</p> <p>At 5:18 p.m., the SSD indicated the thought of Resident #24 going out for dental care could be approached again to the family. The SSD reported the facility had dental contracts in the past. The last approach to the community dentists was about 2 years ago, but the dentists in practice are the same and don't want to come to the facility, and taking Resident #24 to the community would be too distressing for the resident.</p> <p>The DNS said an outreach to community dentists was done more recently than 2 years ago. The DNS indicated that if emergent needs came up</p>	F 412			

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F 412	<p>Continued From page 17</p> <p>for Resident #24 they would be met through the facility medical director providing pain medication or antibiotics, and nursing care would be provided. DNS reported that the nature of long term care included poor dentation and that the facility was a rural one.</p> <p>At 8:40 a.m., NA A reported Resident #24 refused dental care due to mouth pain when the tooth brush was placed in the resident's mouth. NA A had not reported the pain to the nurse.</p> <p>At 8:47 a.m., The Administrator (ADM) revealed there was a community dental practice that accepted Medicaid and they have a hygienist that could come to the facility to determine who needed a consult to see a dentist. The ADM stated the SSD would have a list of residents who needed dental care. The hygienist had been available for about 18 months. The ADM said the interdisciplinary team had discussed Resident #24's mouth pain a while ago and that the staff should be aware of Resident #24's teeth pain.</p> <p>At 9:25 a.m., LN A stated morning staff had reported Resident #24's teeth hurting during oral care by the NA, that morning. LN A reported it was the 1st time she had heard that Resident #24 had oral pain.</p> <p>LN A indicated Resident #24 reported no pain during an oral assessment conducted after NA A reported the resident's pain. LN A stated she was not sure if Resident #24 had a potential for mouth issues.</p> <p>At 9:22 a.m., the SSD stated there was not a list of residents who needed a dental assessment. The SSD reported the MDS correctly noted</p>	F 412			

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F 412	Continued From page 18 Resident #24's oral condition and dental care triggered into the Care Area Assessment. The SSD reported Resident #24 was afraid anytime care was given and the resident does better with mouth swabs than with toothbrushes. On 10/10/14 at 10:15 a.m., LN C stated there had not been an oral care in-service in the facility for staff since before January 2013. LN C stated there had been turnover of NAs since the last training.	F 412			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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. 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. 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. The facility must provide separately locked,	F 431	F 431 Drug Records, Labeling, Storage of Drugs & Biologicals The facility will continue to follow it's policies & procedures regarding the recording, labeling, and storage of Drugs and Biologicals. Resident #50 was given the approval by his attending physician to keep a jar of topical cream for anti-inflammatory pain containing [REDACTED]. The resident did not put the cream back into his bedside cabinet after use.	11/16/14	

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F 431	<p>Continued From page 19</p> <p>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 review, it was determined the facility failed to ensure safe storage of a medication found at the bedside of 1 of 1 current sampled residents (#50) reviewed for medication self administration. Failure to keep the medication locked and supervised at all times placed residents at risk for potential injury/accidents related to the improper ingestion of medications.</p> <p>Findings include:</p> <p>Resident #50 was admitted to the facility on [REDACTED] with diagnosis including [REDACTED]</p> <p>On 10/6/14 at 3:54 p.m., a jar of topical cream was observed at Resident #50's bedside. The cream, a compound anti-inflammatory, contained [REDACTED]</p> <p>Resident #50 reported using the compound anti-inflammatory twice a day, before going to therapy. Resident #50 indicated he sometimes had assistance from nurse aides in the evening to apply the ointment.</p>	F 431	<p>The Licensed Staff will be provided inservice training by the Director of Staff Development on 11/14/2014 and again on 11/16/2014 to address the importance of providing keys to the bedside cabinets in the event of approved self-administration of drugs or to protect any personal items they may have.</p> <p>A review of the medical records and MAR's there are no other residents with medications at the bedside. In the future, should a resident request self administration of medications, after a safety and IDT review, if meds are allowed at the bedside, a locked cabinet will be provided.</p> <p>No other residents were affected by this deficient practice.</p> <p>This Plan of Correction will be monitored by the Administrator, Director of Nurses and Nursing supervisors on a monthly basis.</p>	

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F 431	Continued From page 20 A physician's order dated 8/23/14, stated to apply the compound anti-inflammatory to resident's posterior knees four times a day (QID) as needed (prn). A physician's order dated 9/6/14, documented Resident #50 could have the compound anti-inflammatory at his bedside. Throughout the survey period Resident #50 kept his room door open. On 10/7/14 at 2:25 p.m., the Director of Nursing Services indicated it had been nurses, not nurse aides, that were assisting with the application of the compound anti-inflammatory. At 5:30 p.m., the compound anti-inflammatory was observed at resident's bedside. On 10/08/14 at approximately 6:30 p.m., the DNS indicated she thought she had told him (resident #50) to put the compound anti-inflammatory away in his drawer so no one could get a hold of it.	F 431	Any deficient practice identified will be reported monthly by the Administrator to the QAPI Committee for their review and recommendation. Correction Date 11/16/2014		
F 441 SS=D	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	F 441	F 441 Infection Control, Prevent Spread, Linens Willapa Harbor Health & Rehab will continue to diligently follow it policies and procedures within our infection control program which has been designed to provide a	11/16/14	

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F 441	Continued From page 21 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 direct contact will transmit the disease. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to follow its infection control procedures to prevent possible urinary tract infections (UTI) when staff did not complete hand washing before conducting catheter care for 1 of 1 current sampled residents (#65) reviewed for catheter care. Findings include:	F 441	safe, sanitary and comfortable environment and to prevent the development and transmission of disease and infection. One of our Nursing Assistance was observed not washing her hands before and after while peri-care was given to the resident. All Clinical staff will be provided inservice education on 11/14/2014 and again on 11/16/2014 by the Director of Staff Development on hand washing. There were no other residents affected by this practice. The licensed staff and supervisors will monitor hand washing 3 times per week while doing house/resident rounds. Any deficient practice will be reported to the Director of Nursing. Monthly the Director of Nursing will report any identified deficient practices to the QAPI Committee for their review and recommendations.		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505349	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/10/2014
NAME OF PROVIDER OR SUPPLIER WILLAPA HARBOR HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 JACKSON STREET RAYMOND, WA 98577		
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F 441	<p>Continued From page 22</p> <p>Resident #65 was admitted on [REDACTED] with diagnoses including [REDACTED]</p> <p>On 10/09/14 at 9:49 a.m., nursing assistant (NA) B was observed providing peri-care and catheter care to Resident #65. Licensed Nurse (LN) A was standing by to perform a dressing change to the resident's tail bone area. The staff assisted Resident #65 to her right side and unfastened the brief. NA B used 3 clean washcloths with a spray referred to as "peri-wash" to clean bowel movement (BM) from the resident's bottom. NA B removed the soiled brief and placed a clean brief under the resident.</p> <p>LN A and NA B assisted resident to her back. NA B took a clean washcloth with peri wash and cleansed the resident's outer labia and inner thighs. NA B grasped the top of the resident's catheter (near the meatus) with her left hand and used a clean wash cloth in her right hand to wipe down the length of the catheter from the meatus away.</p> <p>No hand washing or changing of gloves was observed between the step of cleaning the resident's bowel movement and conducting catheter care.</p> <p>On 10/09/14 at 10:24 a.m., LNA indicated that the NA should have washed her hands and changed gloves between cleaning BM and</p>	F 441	Completion Date 11/16/2014	

FOR AMENDED

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F 441	Continued From page 23 conducting catheter care. On 10/09/14 at 11:00 a.m., LN C provided a document titled "Hand Hygiene" which was used to conduct hand washing education with staff. Page 2 stated, "wash hands if moving from a contaminated-body site to a clean-body site during resident care." Page 3 indicated hand washing is expected, "before and after catheter care." Not performing hand hygiene before conducting catheter care placed resident #65 at increased risk of acquiring a catheter-associated urinary tract infection.	F 441			

IDR AMENDED