



AGING AND DISABILITY SERVICES ADMINISTRATION  
**Nursing Home Survey Report**  
STATE AND CORRESPONDING FEDERAL REQUIREMENTS

1. Page <u>1</u> of <u>2</u> Pages
2. DATES OF DATA COLLECTION <b>03/14/16</b>
5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Holiday
7. LICENSE NUMBER <b>1358</b>

3. NAME OF FACILITY <b>Avalon Care Center - Northpointe</b>	4. TYPE OF SURVEY <input type="checkbox"/> Full <input checked="" type="checkbox"/> Post <input type="checkbox"/> Complaint <input type="checkbox"/> Other: specify _____
6. STREET ADDRESS <b>9827 N. Nevada</b>	CITY STATE ZIP CODE <b>Spokane WA 99218</b>

**NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.**

8.	9. WASHINGTON ADMINISTRATIVE CODES 388-97	10. CODE OF FEDERAL REGULATION 42 CFR 483.	11. FEDERAL DATA TAG NUMBER	12. REPEAT DEFICIENCY FROM SURVEY DATED	13. NEW CITATION ON POST SURVEY	14. LICENSEE'S PLANNED DATE OF CORRECTION
<input type="checkbox"/> The requirements of the following WAC's and corresponding CFR's were not met. The text of the statements of deficiencies and the licensee's plan of correction may be read on CMS form 2567, dated: <u>02/11/16</u> .  **Licensee must complete column 14.  <input checked="" type="checkbox"/> The following deficiencies were determined to be corrected.	-0480	10(g)(1)	F-167		<input type="checkbox"/>	
	-1020(1),(2)(a)(b)	20(k)	F-279		<input type="checkbox"/>	
	-1620(2)(b)(i)(ii), (6)(b)(i)	20(k)(3)(i)	F-281		<input type="checkbox"/>	
	-1620	20(k)(3)(ii)	F-282		<input type="checkbox"/>	
	-1975	20(m)	F-285		<input type="checkbox"/>	
	-1900(5)(a-d)	25	F-309		<input type="checkbox"/>	
	-1060(2)(b)	25(a)(3)	F-312	01/09/15	<input type="checkbox"/>	
	-1060(3)(c)	25(d)(1)(2)	F-315		<input type="checkbox"/>	
	-1060(3)(h)	25(i)(1)	F-325		<input type="checkbox"/>	
	-1100(3) & -2980	35(i)(2)	F-371	01/09/15	<input type="checkbox"/>	
	--1060(2)(c), (3)(i)(vii)	55(a)(1)-(4)	F-411		<input type="checkbox"/>	
					<input type="checkbox"/>	

**15. SURVEYOR'S SIGNATURE(S)**

SIGNATURE <i>Henrich Adams</i>	DATE <b>03/15/16</b>	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

**16. LICENSEE OR AGENT**

SIGNATURE OF LICENSEE (OR AGENT)	TITLE	DATE
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 STATE AND CORRESPONDING FEDERAL REQUIREMENTS

1. Page 2 of 2 Pages

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**03/14/16**

5. TIME OF SURVEY  Day  Night  
 Weekend  Holiday

7. LICENSE NUMBER  
**1358**

3. NAME OF FACILITY  
**Avalon Care Center - Northpointe**

4. TYPE OF SURVEY  
 Full  Post  Complaint  Other: specify \_\_\_\_\_

6. STREET ADDRESS  
**9827 N. Nevada**

CITY STATE ZIP CODE  
**Spokane WA 99218**

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	-1300(2) & -2340	60(e)	F-431		<input type="checkbox"/>	
	-1320(1)(a)(c)	65(a)(1)-(3), (b)(3)	F-441		<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	

**15. SURVEYOR'S SIGNATURE(S)**

SIGNATURE <i>Hannah Adams</i>	DATE <b>3/15/16</b>	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

**16. LICENSEE OR AGENT**

SIGNATURE OF LICENSEE (OR AGENT)	TITLE	DATE
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AGING AND DISABILITY SERVICES ADMINISTRATION

**Nursing Home Survey Report**

STATE REQUIREMENTS

1. Page 1 of 2 Pages
2. DATES OF DATA COLLECTION 03/14/16
5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Holiday
7. LICENSE NUMBER 1358

3. NAME OF FACILITY Avalon Care Center at Northpointe	4. TYPE OF SURVEY <input type="checkbox"/> Full <input checked="" type="checkbox"/> Post <input type="checkbox"/> Complaint <input type="checkbox"/> Other: specify _____		
6. STREET ADDRESS 9827 N. Nevada St.	CITY Spokane	STATE WA	ZIP CODE 99218

**NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.**

8. <input type="checkbox"/> The requirements of the following Washington Administrative Code (WAC) were not met:  <u>WAC 388-97-0580(1)(b)</u>  <input checked="" type="checkbox"/> The following deficiencies were determined to be corrected.	9. REPEAT DEFICIENCY FROM SURVEY DATED	11. LICENSEE'S PLAN OF CORRECTION	12. LICENSEE'S PLANNED DATE OF CORRECTION
	10. NEW CITATION ON POST SURVEY <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
DEFICIENCY <b>WAC 388-97-0580 (1)(b) Roommates/rooms. (1) A resident has the right to:</b> <b>(b) Receive three days notice of change in room or roommate except:</b> <b>(i) For room changes: The move is at the resident's request; and</b> <b>(ii) For room or roommate changes: A longer or shorter notice is required to protect the health or safety of the resident or another resident; or an admission to the facility is necessary, and the resident is informed in advance. The nursing home must recognize that the change may be traumatic for the resident and take steps to lessen the trauma.</b> <b>This requirement was not met as evidenced by:</b>  <b>Based on interview and record review, the facility failed to ensure 1 of 3 residents reviewed for a room change (#206) received notification 3 days before he was asked to move. This failure caused Resident #206 frustration, and placed him at risk for diminished quality of life. Findings include:</b>			

13. SURVEYOR'S SIGNATURE(S)			
SIGNATURE <i>Handwritten Signature</i>	DATE 03/15/16	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

14. LICENSEE OR AGENT		
SIGNATURE OF LICENSEE (OR AGENT)	TITLE	DATE

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DEFICIENCY In an initial interview on 02/05/16 at 9:22 a.m., Resident #206 reported he had been moved to a different room while in the facility, and that he did not receive notice.  Review of the record revealed the following progress note dated 01/06/16: "Resident will be moving... this afternoon as he is no longer under a medicare stay, and will possibly be here... for several more weeks. Resident made aware, and expressed frustration, but agreed to move..." The note indicated the resident was only notified the day of the move.  In an interview on 02/11/16 at 10:32 a.m., Staff G, Social Services Director, was asked for any additional information regarding any other considerations regarding Resident #206's reasons for a room change. None was provided.			

13. SURVEYOR'S SIGNATURE(S)			
SIGNATURE <i>Harold Adams</i>	DATE 03/15/16	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

14. LICENSEE OR AGENT		
SIGNATURE OF LICENSEE (OR AGENT)	TITLE	DATE



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8. <input type="checkbox"/> The requirements of the following Washington Administrative Code (WAC) were not met:  388-97-1800  <input checked="" type="checkbox"/> The following deficiencies were determined to be corrected.	9. REPEAT DEFICIENCY FROM SURVEY DATED	11. LICENSEE'S PLAN OF CORRECTION	12. LICENSEE'S PLANNED DATE OF CORRECTION
	10. NEW CITATION ON POST SURVEY <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
DEFICIENCY WAC 388-97-1800 requires but not is not limited to: The nursing home must have a valid criminal history background check for any individual employed, directly or by contract, or any individual accepted as a volunteer or student who may have unsupervised access to any resident; and a background check must be repeated every two years.  This requirement was not met as evidenced by:  Based on interview and record review, the facility failed to ensure that 1 of 7 personnel (Staff S) reviewed for background checks, had the required background check completed for 2014.			

13. Surveyor's Signature(s)			
SIGNATURE <i>Harold</i>	DATE 03/15/2016	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

14. Licensee or Agent		
SIGNATURE OF LICENSEE (OR AGENT)	TITLE	DATE



AGING AND LONG-TERM SUPPORT ADMINISTRATION

**Nursing Home Survey Report**

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 Full  Post  Complaint  Other: specify

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6. STREET ADDRESS  
9827 N. Nevada.

CITY  
Spokane

STATE ZIP CODE  
WA 99218

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1358

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8.  The requirements of the following Washington Administrative Code (WAC) were not met:

388-97-1800

The following deficiencies were determined to be corrected.

9. REPEAT DEFICIENCY FROM SURVEY DATED

10. NEW CITATION ON POST SURVEY

Yes  
 No

11. LICENSEE'S PLAN OF CORRECTION

12. LICENSEE'S PLANNED DATE OF CORRECTION

DEFICIENCY

A review of staff records indicated that there was no evidence Staff S had a background check completed between October of 2012 and January of 2016.

During an interview with Staff Coordinator/Staff T on 02/11/16 at approximately 10:00 a.m., Staff T confirmed that if there was no record of a background check in the files provided to surveyor for review, it could safely be assumed that there was not one done.

**13. Surveyor's Signature(s)**

SIGNATURE  
*Handwritten Signature*

DATE  
03/15/2016

SIGNATURE

DATE

**14. Licensee or Agent**

SIGNATURE OF LICENSEE (OR AGENT)

TITLE

DATE



# Nursing Home Survey Report

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	10. NEW CITATION ON POST SURVEY <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
<p>DEFICIENCY</p> <p>WAC 388-97-1380 Tuberculosis (TB)-Testing required (1) The nursing home must develop and implement a system to ensure that facility personnel and residents have tuberculosis testing within three days of employment or admission; (2) and that facility personnel are tested annually.</p> <p>These requirements were not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to ensure that 4 of 9 staff (Q,R,S, X) reviewed for tuberculosis (TB) testing, had testing within 3 days of employment and/or failed to ensure that these staff were tested or assessed for signs and symptoms annually according to individual staff requirements. This failure placed residents at risk of exposure to a communicable illness, due to inadequate screening. Findings included:</p>			

<b>13. Surveyor's Signature(s)</b>			
SIGNATURE <i>Harold Adams</i>	DATE 03/15/2016	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE
<b>14. Licensee or Agent</b>			
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DEFICIENCY The facility's tuberculin test policy and procedure, as provided to surveyor states in part that "newly hired personnel will be tested using the two-step method," and "will (testing) be repeated annually for residents and staff using the one-step method." The policy also notes that residents/staff with previously positive test results should be questioned/assessed annually for signs and symptoms, unless otherwise specified by regulations.  In an interview with Staffing Coordinator/Staff T on 02/10/16, at approximately 10:15 a.m., Staff T had a list of four staff members that were past due for their TB tests. Staff T confirmed that this list was accurate and that there was no additional information that the facility could provide.			

**13. Surveyor's Signature(s)**

SIGNATURE <i>Hand Ales</i>	DATE <b>03/15/2016</b>	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

**14. Licensee or Agent**

SIGNATURE OF LICENSEE (OR AGENT)	TITLE	DATE
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DEFICIENCY A review of these 4 staff and 5 others sampled, indicated that Staff S was missing TB testing/assessment for 2013 & 2015; Staff Q, for 2012, 2013, & 2015; Staff R, for 2015; and Staff X for 2013 & 2015.  A review of payroll records for Staff Q, Staff R, Staff S, and Staff X indicated that these staff had access to residents during the timeframes in which TB testing was not done as required.			

13. Surveyor's Signature(s)			
SIGNATURE <i>Heard</i>	DATE 03/15/2016	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

14. Licensee or Agent		
SIGNATURE OF LICENSEE (OR AGENT)	TITLE	DATE

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

PRINTED: 02/26/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505496</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/11/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>AVALON CARE CENTER AT NORTHPOINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9827 NORTH NEVADA SPOKANE, WA 99218</b>	
(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><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced and abbreviated Quality Indicator Survey conducted at Avalon Care Center at Northpointe on 02/04/16, 02/05/16, 02/08/16, 02/09/16, 02/10/16, and 02/11/16. A sample of 36 residents was selected from a census of 117. The sample included 25 current residents, and the records of 11 former and/or discharged residents.</p> <p>The following complaints wre investigated as part of this survey:</p> <p>#3182464 #3188409 #3186769 The survey was conducted by: Hai Nguyen, R.N. Hannah Adams, R.N. Angel Button, B.A. Stacy Durham, R.N. Heather Moore, R.N. Kathleen Robl, R.N. Tamara Smith, M.S.W.</p> <p>The Survey team is from: Department of Social &amp; Health Services Aging and Long-Term Support Administration Residential Care Services, Region 1, North 316 West Boone Avenue, Suite 170 Spokane, Washington 99201-2351</p> <p>Telephone: (509) 323-7300 Fax: (509) 329-3993</p> <p><i>Cindy CoVille</i> 2/25/16 Residential Care Services Date</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 and is also not to be construed as an admission of interest against the facility or the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and 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. <b>This Plan of Correction is submitted as the facility's credible allegation of compliance.</b></p>	3-7-16

**RECEIVED**  
MAR 10 2016  
DSHS ADSA RCS  
SPOKANE WA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Mary Ellen* TITLE: *Administrator* (X8) DATE: *3-14-16*

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.

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

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NAME OF PROVIDER OR SUPPLIER  AVALON CARE CENTER AT NORTHPOINTE			STREET ADDRESS, CITY, STATE, ZIP CODE 9827 NORTH NEVADA SPOKANE, WA 99218		
(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 167 SS=C	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure survey results were readily accessible to all residents for review, and failed to post signs to direct residents and visitors to the location of the survey results. This failure placed residents and visitors at risk of not being aware of recent survey results, and the facility's plan to correct the cited deficiencies. Findings include:</p> <p>On 02/04/16 at 9:30 a.m., a survey results book was observed in the corner of the main lobby, on the lower shelf of an end table. There were two couches on either side of the end table, that were very close to each other, and restricted access to the survey book (particularly for those who were wheelchair bound). There was no sign in the lobby indicating the location of the survey book. A sign was observed, posted on an office door to the left of a side entry door in the north hall, stating survey results were available in the main lobby.</p> <p>The Resident Council President was interviewed</p>	F 167	<p><b>F 167 §483.10 (g) RIGHT TO SURVEY RESULTS – READILY ACCESSIBLE</b></p> <ol style="list-style-type: none"> <li>1. A sign indicating the location of the survey results binder has been posted in the front lobby entrance. The binder is placed in a location that is easily accessible to everyone.</li> <li>2. The resident council, including the resident council president were educated by the Recreation Therapy Director, on the posting of the survey results and location of the survey results binder on 3/3/16.</li> <li>3. Audits will be conducted 3 times per week by Business Office Manager/designee to ensure that the signage is in place and that the survey results binder is located in an area that is easily accessible to everyone.</li> <li>4. Results of the audits will be reported to the QAPI committee for a period of 3 months or until a lesser frequency is deemed appropriate.</li> <li>5. Date of compliance is 3-7-2016.</li> <li>6. The Nursing Home Administrator is responsible to ensure compliance.</li> </ol>	3/7/16	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505496</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/11/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>AVALON CARE CENTER AT NORTHPOINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9827 NORTH NEVADA SPOKANE, WA 99218</b>	
(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 167	Continued From page 2 on 02/09/16 at 1:26 p.m., and confirmed she did not know where the survey results were kept.	F 167		
F 279 SS=D	On 02/10/16 10:00 a.m., Staff E, Director of Nursing, stated a sign was supposed to be posted behind the receptionist, regarding the location of the survey book. He confirmed there was not a sign posted.  483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 23 residents reviewed for care plans (#227), in a sample of 36, had a	F 279	<b>F 279 §483.20 (d), §483.20 (k)(1) Develop Comprehensive Care Plans</b>  1. Resident #227 was assessed and the care plan was updated by Nurse Unit Manager on 3/2/16 to reflect the resident's current status.  2. Current residents who require enteral nutrition were assessed and their care plans were updated as applicable, by Nurse Unit Managers on 3/3/16 to reflect the resident's current status.  3. Care plan audits of residents who receive enteral nutrition will be conducted weekly by the DNS/designee to ensure the care plan reflects the resident's current status.  4. Results of the audits will be reported to the QAPI committee for a period of 3 months or until a lesser frequency is deemed appropriate.  5. Date of compliance is 3-7-2016  6. The Director of Nursing is responsible to ensure compliance.	3/7/16

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F 279	Continued From page 3 comprehensive, individualized care plan, to address her unique needs related to nutrition. This failure placed the resident at risk for unmet needs and/or inappropriate care. Findings include:  Resident #227 admitted to the facility on [REDACTED] 16, and had care needs related to medical conditions, including [REDACTED]  Review of the record revealed Resident #227 received all of her [REDACTED] (the provision of [REDACTED] into the [REDACTED]. Her nutrition care plan, printed 02/08/16, instructed staff to: allow the resident enough time to eat, encourage her to drink fluids, and to offer snacks. The care plan also indicated staff should monitor weight routinely and report significant weight changes to the doctor and dietitian, but did not specify how often "routine" weights should be done.  In an interview on 02/11/16 at 12:26 p.m., Staff N, Registered Nurse, stated the interventions including allowing time to eat, and allowing food preferences, were not appropriate for this resident. She stated the care plan addressed her [REDACTED] but indicated, "I don't really see where she has [a care plan] to address specifics of her [REDACTED]"	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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F 281	<p>Continued From page 4</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure nursing staff followed professional standards, when processing diet orders and dietary recommendations, or monitoring weights and responding to weight loss, for 5 of 7 residents (#229, 131, 227, 118, 182)-reviewed for nutrition, in a sample of 36. This failure placed residents at risk for unmet nutritional needs. Findings include:</p> <p>According to the Lippincott Manual of Nursing Practice (Lippincott, Williams &amp; Wilkins, 2013, ch.2), the standards of nursing practice include following all physician's orders.</p> <p>According to the Centers for Medicare &amp; Medicaid Services State Operations Manual (appendix pp, F325) "Current standards of practice recommend weighing the resident on admission or readmission (to establish a baseline weight), weekly for the first 4 weeks after admission and at least monthly thereafter to help identify and document trends such as insidious weight loss."</p> <p>1. Review of Resident #229's hospital discharge orders, dated [redacted] 16, revealed the resident was to continue with the current diet orders, which included a supplement drink three times a day, with each meal.</p> <p>Review of the facility's diet memo and diet orders, dated [redacted] 16, revealed the order for the supplement did not get transcribed onto the current orders for care at the facility.</p>	F 281	<p><b>F 281 §483.20 (k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b></p> <p>1. The admit order for Resident #229's supplement was processed by Unit Manager on 2/8/16 and is now in the EMAR, the resident is receiving the supplement. The Unit Manager weighed and assessed the resident, notified MD of weight change, placed resident on weekly weight monitor, and updated the care plan to reflect the resident's current status on 2/8/16. The Unit Manager weighed and assessed resident #131, notified MD of weight change, placed resident on weekly weight monitor, and updated the care plan to reflect the resident's current status on 2/11/16. The Unit Manager weighed and assessed the resident, notified MD of weight change, placed resident on weekly weight monitor, and updated the care plan to reflect the resident's current status on 2/8/16. The Unit Manager weighed and assessed resident #227, notified MD of weight change, placed resident on weekly weight monitor, and updated the care plan to reflect the resident's current status on 2/17/16. The Unit Manager weighed and assessed the resident #118, notified MD of weight change, placed resident on weekly weight monitor, and</p>	3-7-16
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F 281	<p>Continued From page 5</p> <p>On 02/08/16 at 3:32 p.m., Staff F, LN (Licensed Nurse), confirmed she processed Resident #229's admission orders and paperwork. Staff F said she did not see the order to continue with providing a nutritional supplement three times a day, with meals.</p> <p>Additionally, record review revealed on 02/02/16, there was a nutritional assessment completed by a Registered Dietician, which identified the resident had a weight loss of 2% in 7 days. In addition to other interventions, the Dietician recommended a trial of supplements for this resident (which she should have been receiving since 01/21/16).</p> <p>Review of the current treatment orders (February 2016) documented the resident was started on a supplement 02/05/16 (3 days after the Dietician made the recommendation, and approximately [REDACTED] days since it was originally ordered, upon admission to the facility).</p> <p>On 02/09/16 at 3:31 p.m., Staff I, Nurse Manager, confirmed she is responsible to follow up with the Dietician's recommendations, but did not do so in a timely manner in this instance. When asked about the processing of the dietary order from the hospital, Staff I stated they also missed the original supplement order.</p> <p>2. Resident #131 was admitted on [REDACTED] 15, with diagnoses including [REDACTED] and [REDACTED]. The resident required assistance with some activities of daily living, was able to make</p>	F 281	<p>updated the care plan to reflect the resident's current status on 2/10/16. The Unit Manager weighed and assessed the resident #182, notified MD of weight change, placed resident on weekly weight monitor, and updated the care plan to reflect the resident's current status on 2/10/16.</p> <p>2. An audit was conducted on 3/2/16 by Director of Nursing to ensure that other residents were not affected by this deficiency. RD recommendations were reviewed those that have been approved by the MD have been entered in to the EMAR to follow. All current residents were reviewed to determine the frequency of which they should be weighed per facility nutrition guidelines. During the weekly weight meeting, residents will be assessed and responses to significant weight changes are implemented.</p> <p>3. Licensed nurses including Staff F were educated by DNS on 2/12/16 to ensure that dietary orders from admit are followed. Licensed Nurses were educated by ADNS on 3/4/16 to ensure that RD recommendations are implemented timely. Dietary and Nurse Unit Managers were educated to ensure that residents are weighed and assessed following facility dietary guidelines By DNS on 2/12/16.</p> <p>4. A weekly weight meeting will be conducted by DNS/designee and</p>	

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F 281	<p>Continued From page 6</p> <p>her needs known, and received dialysis (a process to filter blood to maintain kidney function), three times a week.</p> <p>Per the facility's Dietary Guidelines Manual, dated January 2014, residents were to be weighed weekly for the first four weeks after admission. Weekly weights were also indicated for residents who had significant weight loss. Weights for dialysis residents were to come from the dialysis center.</p> <p>A Mini Nutritional Assessment, dated 11/24/15, documented the resident weighed [REDACTED] pounds (lbs.).</p> <p>Review of Resident #131's record revealed the following documented weights: 11/25/15 - [REDACTED] lbs., 11/28/15 - [REDACTED] lbs., 12/01/15 - [REDACTED] lbs.</p> <p>The next documented weight in the resident's record was [REDACTED] lbs. on 01/18/16 - seven weeks after the resident's initial weight loss had been identified. This represented an additional [REDACTED] weight loss. There was no documentation found regarding any weights obtained by the dialysis center.</p> <p>In an interview on 02/09/16 at 9:47 a.m., Staff L, Registered Dietician (RD), said she gets a report each week of residents with weight loss. She then makes recommendations, and gives those recommendations to the Unit Manager, Director of Nursing, and Administrator. The Unit Manager would then follow up on the recommendations, and provide any necessary monitoring. She confirmed the facility should have been monitoring the resident's weight more closely.</p>	F 281	<p>Dietary Manager to ensure appropriate weight monitoring is completed and responses to significant weight changes are implemented.</p> <ol style="list-style-type: none"> <li>5. Audits will be conducted weekly by DNS/designee to ensure that weights are obtained per facility nutrition guidelines, RD recommendations are entered timely, and dietary orders are followed on admit.</li> <li>6. Results of the audits will be reported to the QAPI committee for a period of 3 months or until a lesser frequency is deemed appropriate.</li> <li>7. Date of compliance is 3-7-2016</li> <li>8. The Director of Nursing is responsible to ensure compliance.</li> </ol>	

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F 281	<p>Continued From page 7</p> <p>On 02/11/16 at 8:57 a.m., Staff I, Unit Manager, said after residents were identified with significant weight loss, the Medical Director would be consulted for orders. Weights would then be done weekly. When asked about the lack of documented weights for Resident #131, between [REDACTED] 15 and [REDACTED] 5, Staff I stated she did not know what happened, and said the facility had "just missed it".</p> <p>3. Resident #227 admitted to the facility on [REDACTED] 16, had care needs related to medical conditions including malnutrition, and was fed through a [REDACTED] into her [REDACTED].</p> <p>According to the facility weight policy revised 01/14, indications requiring residents to be weighed weekly included: if they were under 100 pounds, on a [REDACTED] feeding (until they were stable), and new admissions for four weeks (or until they were stable).</p> <p>According to the computerized weight documentation for Resident #227, the facility only obtained one weight, between her admission on [REDACTED] 16, and 02/11/16. The weight was [REDACTED] lbs. on 01/27/16, showing the resident was significantly underweight. Although the resident met several criteria that would require weekly weights per the policy, she was not weighed again until staff was asked what the current weight was by the surveyor, on 02/11/16.</p> <p>A nutrition note by the RD, dated 01/26/16, documented Resident #227 was at her normal weight. In an interview on 02/09/16 at 3:26 p.m., Staff L, RD, confirmed there was not a facility weight recorded prior to that time, and stated she may have based her assessment on the hospital</p>	F 281		

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F 281	<p>Continued From page 8 weight, which may be incorrect.</p> <p>In an interview on 02/10/16 at 3:49 p.m., Staff H, Unit Manager, stated newly admitted residents should be weighed within 24 hours of admission. She confirmed the only weight recorded for Resident #227 was on [REDACTED] 16, almost 2 weeks after she admitted. When asked the appropriate length of time between weights for Resident #227, Staff H stated she should be weighed weekly.</p> <p>4. Review of the weight record for Resident #118 revealed significant weight loss, from [REDACTED] lbs. on 12/07/15, to [REDACTED] lbs. on 12/28/15, and a further decrease to [REDACTED] lbs. on 01/08/16. The weight record, printed on 02/08/16, showed no weights recorded after 01/11/16. No notes in the record were found, to indicate the initial weight loss on 12/28/15 was identified, or that new interventions were put in place in a timely manner for Resident #118.</p> <p>In an interview on 02/11/16 at 8:50 a.m., Staff I, Unit Manager, confirmed there were no notes indicating the weight decrease on 12/28/15 was identified, or that facility staff followed up on the issue prior to 01/08/16.</p> <p>5. Resident #182 admitted to the facility on [REDACTED] 15, and was first weighed in the facility, per review of the record, on 09/18/15 - nearly [REDACTED] weeks after admission. The facility did not weigh the resident weekly during her first 4 weeks in the facility, or follow up in a timely manner to documented weight loss on 09/18/15 or 12/02/15.</p> <p>In an interview on 02/11/16 at 8:42 a.m., Staff I indicated she was not aware of any reason</p>	F 281		

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F 281	Continued From page 9 Resident #182 would not have weekly weights upon admission.  In an interview on 02/09/16 at 3:21 p.m., Staff L, RD, confirmed Resident #182's weight loss was first brought to her attention on [REDACTED] 5.  Failure to follow physician orders for nutritional supplements, monitor weights as frequently as resident conditions warranted, and respond timely to significant weight loss, did not meet professional standards for nutrition management.  (See F325 for more information).	F 281	<b>F 282 §483.20 (k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b>  1. The Unit Manager on 2/8/16 obtained weights for Resident #131, assessed the resident, placed resident on weekly weight monitoring, and updated the care plan to reflect the resident's current status.  2. An audit was conducted on all current dialysis residents by Nurse Unit Managers on 3/3/16 to ensure that the residents are being weighed and assessed per the care plan. No other residents were identified as being affected by this deficiency.  3. Licensed Nurses were educated by SDC on 3/4/16 to ensure that dialysis communication forms (including a space for dialysis facility to fill out pre and post dialysis weights) are sent to dialysis, filled out and returned to facility.  4. Audits will be conducted weekly by the DNS/designee to ensure that residents on dialysis have weights and are assessed.  5. Results of the audits will be reported to the QAPI committee for a period of 3 months or until a lesser frequency is deemed appropriate.  6. Date of compliance is 3-7-2016.  7. The Director of Nursing is responsible to ensure compliance.	
F 282 SS=D	<b>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b>  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement care plan interventions related to nutrition, for 1 of 7 residents (#131) reviewed for weight loss, in a sample of 36. Failure to monitor Resident #131's weights weekly resulted in continued significant weight loss for the resident. Findings include:  Resident #131 was admitted on [REDACTED] 15 with diagnoses including [REDACTED] and [REDACTED]. The resident received dialysis (a process to filter blood to maintain kidney function) three times a week.	F 282		

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F 282	<p>Continued From page 10</p> <p>An undated care plan related to nutrition and hydration included the interventions: to monitor the resident's weight routinely, and report significant weight changes to the physician and dietician. An undated care plan for activities of daily living included an intervention to obtain weights weekly.</p> <p>Per the facility's Dietary Guidelines Manual, dated January 2014, residents were to be weighed weekly for the first four weeks after admission. Weekly weights were also indicated for residents who had significant weight loss. Weights for dialysis residents were to come from the dialysis center.</p> <p>Review of Resident #131's record revealed the following documented weights: 11/25/15 - [REDACTED] pounds (lbs.), 11/28/15 - [REDACTED] lbs., 12/01/15 - [REDACTED] lbs.</p> <p>The next documented weight in the resident's record was [REDACTED] lbs. on 01/18/16 - [REDACTED] weeks after the resident's initial weight loss had been identified. This represented an additional 25% weight loss. There was no documentation found regarding any weights obtained by the dialysis center, as indicated in the facility's guidelines.</p> <p>In an interview on 02/10/16 at 10:37 a.m., Staff I, Unit Manager, explained the dialysis center generally took the resident's weight, but the facility had been having a difficult time communicating with the center. She provided the surveyor with a weight report from the dialysis center received on 02/08/16. Based on the post dialysis weights, the resident had an actual weight loss of [REDACTED] pounds (30%) from the time of</p>	F 282		
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F 282	Continued From page 11 admission, and 02/02/15.  In a follow-up interview on 02/11/16 at 8:57 a.m., when asked about the lack of documented weekly weights for Resident #131, between [REDACTED] 15 and 01/18/16, Staff I said she did not know what happened, and that the facility had "just missed it".  (See F-325 for more information)	F 282	<b>F 285 5483.20 (m), 483.20 (e) PASSR REQUIREMENTS FOR MI &amp; MR</b>  1. Resident # 119 was assessed by PASRR evaluator on 11/4/15. 2. Current residents were assessed by Social Services Director on 2/29/16 for the need of a level 2 PASSR. An audit was conducted by Social Services Director on 2/29/16 to ensure current resident's PASRRs were complete, accurate, and appropriate follow up has been completed. 3. All admission inquiries will be reviewed by the Social Services Director/designee to ensure that anyone requiring a level 2 PASRR evaluation has the evaluation completed prior to admission to the facility. 4. Audit to ensure resident PASRR compliance will be completed weekly, by Social Services Director/designee. Results of the audits will be reported to the QAPI committee for a period of 3 months or until a lesser frequency is deemed appropriate. 5. Date of compliance is 3-7-2016. 6. The Nursing Home Administrator is responsible to ensure compliance.	3/7/16
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR  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.  A nursing facility must not admit, on or after January 1, 1989, any new residents with: (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; (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 (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (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--	F 285		

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NAME OF PROVIDER OR SUPPLIER  <b>AVALON CARE CENTER AT NORTHPOINTE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>9827 NORTH NEVADA SPOKANE, WA 99218</b>
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F 285	<p>Continued From page 12</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>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) Level 2 referrals and evaluations were completed timely, for 1 of 5 residents (# 119), reviewed for PASRR, in a sample of 36. This failure placed the resident at risk for a decline in condition, and for not receiving care and services needed in the most appropriate setting. Findings include:</p> <p>Resident #119 was admitted to the facility from a hospital on [REDACTED] 15, with diagnoses including [REDACTED]</p> <p>Review of the resident's record revealed a PASRR Level 1 completed by the hospital on [REDACTED] 15, which indicated the resident needed a Level 2 evaluation for [REDACTED]</p>	F 285		
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F 285	Continued From page 13 Level 2 evaluations are done to determine the appropriateness of a nursing home placement, and to determine additional services the resident may require.  Review of Resident #119's Level 2 Initial Psychiatric Evaluation Summary documented a referral for the evaluation was made on 11/01/15 ( █ days after admission). The evaluation was completed on 11/04/15 ( █ days after admission), rather than prior to admission, as required. Recommendations were made for mental health services, as well as specific nursing interventions, which the facility was to provide for the resident.  In an interview on 02/10/16 at 1:35 p.m., Staff G, Social Services Director, confirmed the resident's Level 2 evaluation was not completed prior to admission to the facility.	F 285	<b>F 309 \$483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  1. Resident #131 was not affected by this deficiency. Dialysis communications forms are being completed and sent to the dialysis center with the resident. Forms are being completed and returned by the dialysis center. 2. An audit was conducted by Nurse Unit Managers on 3/3/16 to ensure other current residents were not affected by this deficiency. No other residents were identified. 3. Licensed Nurses were educated by Staff Development Coordinator on 3/3/16 to ensure that dialysis communication forms are being completed and sent to the dialysis center with the resident and that the forms are being completed and returned by the dialysis center. 4. Audits will be conducted daily by Medical Records/designee to ensure dialysis communication forms have been sent to the dialysis center and returned from the dialysis center. 5. Results of the audits will be reported to the QAPI committee for a period of 3 months or until a lesser frequency is deemed appropriate. 6. Date of compliance is 3-7-2016. 7. The Director of Nursing is responsible to ensure compliance.	3-7-16	
F 309 SS=D	<b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure consistent communication with the center providing dialysis for 1 of 1 residents (#131), reviewed for dialysis care, in a sample of 36. Failure to ensure post dialysis status,	F 309			

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F 309	<p>Continued From page 14</p> <p>including weight, was received from the dialysis center, put the resident at risk for unidentified and untreated changes in condition, and/or complications related to having dialysis. Findings include:</p> <p>Resident #131 was admitted with [REDACTED] and received dialysis (a process to filter blood to maintain kidney function) three times a week.</p> <p>Per review of the facility's policy, a Kidney Dialysis Information Form was to be used to communicate information between the facility and the dialysis center. The form was to be filled out by the facility, with a brief summary of the resident's health status, and sent with the resident when she left the facility to have dialysis. The dialysis center was to then complete the form, which included the resident's weight, blood pressure, medications given, and any changes to be noted, and return the form with the resident.</p> <p>In an interview on 02/09/16 at 9:18 a.m., Staff I, Unit Manager, explained dialysis information forms were filled out by the dialysis center, and returned with the resident, or faxed back to the facility. The forms were then scanned into the resident's electronic record.</p> <p>Resident #131's medical record was thoroughly reviewed at the time of the survey; it did not contain any dialysis information forms.</p> <p>On 02/09/16 at 9:47 a.m., Staff L, Registered Dietician, stated the facility had not been getting reports from the dialysis center, as they had in the past.</p>	F 309			

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F 309	Continued From page 15 On 02/11/16 at 8:57 a.m., Staff I confirmed the facility had been having difficulty communicating with the dialysis center.  Dialysis information reports for Resident #131 were requested from the facility. None were provided.	F 309	<b>F 312 §483.25 (a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</b>  1. Resident #220 was provided ADL care including dressing with clean clothes, was assessed and the care plan was updated to reflect resident's current status by the Unit Manager on 2/12/16. Resident #14 was showered on 2/16/16, the care plan was updated by the Unit Manager on 3/3/16 to reflect the resident's current status. Resident #50 received nail care by the shower aide on 2/19/16. The resident was assessed and the care plan was updated to reflect the resident's current status by the Unit Manager on 3/4/16. Resident #97 received nail care by Unit Manager on 2/9/16. Resident was assessed and the care plan was updated to reflect the resident's current status by Unit Manager on 3/4/16.  2. Current residents who require ADL assistance with emphasis on showers, dressing, and nail care, were assessed by Unit Managers on 2/12/16 and their care plans were updated as applicable by Unit Mangers on 3/4/16 to reflect the resident's current status.  3. Dignity and Grooming Audits will be conducted weekly by Director of Nursing/designee to ensure that dependent residents receive adequate	3-7-16
F 312 SS=E	<b>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</b>  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.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide assistance with dressing, bathing, and/or nail care for 4 of 10 residents (#220,14, 97,50), reviewed for activities of daily living, in a sample of 36. This failure placed the residents at risk for diminished self worth and unmet care needs.  1. Resident #220 admitted to the facility on [REDACTED] 15, with diagnoses including post surgical [REDACTED]  Per review of the facility's comprehensive asses'sment dated 01/11/16, the resident was cognitively impaired, had [REDACTED] to reason or confrontation with actual fact), and had not exhibited refusal of care behaviors. The assessment documented the resident required 1 person physical assistance	F 312		

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F 312	<p>Continued From page 16 with dressing.</p> <p>Multiple observations were made of Resident #220 during the survey period (02/04/16, 02/05/16, 02/08/16, 02/09/16 &amp; 02/10/16). It was noted the resident was wearing the same soiled clothing, arm protectors and socks, during each observation.</p> <p>In an interview on 02/09/16 at 9:45 a.m., Staff A, Unit Manager, confirmed the resident required assistance with activities of daily living, and reported the resident often refused care. Staff A further stated direct care staff were to report refusals of care to nursing staff, who were expected to document refusals and alternate approaches/attempts in the resident's record.</p> <p>A review of the nursing notes revealed there was no documented pattern of the resident refusing assistance with dressing.</p> <p>In a follow-up interview on 02/11/16 at 9:24 a.m., Staff A reported he was able to assist the resident to change his shirt the evening of 02/10/16, after much encouragement.</p> <p>2. Per record review, Resident #14 admitted to the facility in [REDACTED] 12, and required extensive assistance with her activities of daily living, including bathing.</p> <p>In an initial interview on 02/05/16 at 1:08 p.m., Resident #14 stated she would like to have more showers. She stated she gets showers "sometimes twice a week, sometimes once a week, sometimes not at all."</p> <p>Review of the computerized and hand-written</p>	F 312	<p>ADL cares with emphasis on showers, dressing, and nail care.</p> <p>4. Results of the audits will be reported to the QAPI committee for a period of 3 months or until a lesser frequency is deemed appropriate.</p> <p>5. Date of compliance is 3-7-2016.</p> <p>6. The Director of Nursing is responsible to ensure compliance.</p>		

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F 312	<p>Continued From page 17</p> <p>shower records, dated 12/01/15 to 02/08/16, as well as documentation provided by the facility on 02/16/16, revealed Resident #14 received one shower per week during that time period (rather than her scheduled two). In addition, between 12/12/15 to 12/31/15, no showers were documented as given - a period of 19 days. The record showed Resident #14 refused one shower, on 12/22/15, but did not indicate the reason for the refusal, or any follow-up arrangements to re-schedule the shower for the resident.</p> <p>In a follow-up interview on 02/10/16 at 2:38 p.m., Resident #14 stated she liked to shower in the evenings, and reiterated that she would like to have her two scheduled showers per week.</p> <p>In an interview on 02/10/16 at 3:56 p.m., Staff H, Unit Manager, stated showers were scheduled to be given twice a week, and if a shower is not given, it should be documented, and reported to the nurse, so any trends could be tracked.</p> <p>3. Resident #50 admitted to the facility with diagnoses including [REDACTED] in [REDACTED]. The resident required assistance with all activities of daily living.</p> <p>During multiple observations on 02/04/16 and 02/05/16, the resident had long fingernails, with a brown substance beneath them.</p> <p>In an interview on 02/09/16 at 10:26 a.m., Staff H, Unit Manager, stated nail care was included in bathing care, and should have been completed during resident showers.</p> <p>The facility's shower book was reviewed. It was</p>	F 312		
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F 312	<p>Continued From page 18</p> <p>documented the resident was scheduled for, and had received, 2 showers per week. Nail care was not completed during bathing, as evidenced by observations of the resident's nails remaining long and dirty.</p> <p>During a follow-up observation on 02/10/16 at 3:45 p.m., the resident's fingernails continued to be long and dirty, despite staff being notified of the concern the previous day.</p> <p>4. Resident #97 admitted to the facility on [REDACTED] 3, with diagnoses including [REDACTED]</p> <p>A review of the facility's comprehensive assessment, dated 11/10/15, documented the resident had a severely impaired memory, and required physical assistance to complete bathing and personal hygiene tasks. Further review noted the resident had not exhibited rejection of care behaviors.</p> <p>Per review of the resident's current care plan, staff were directed to give the resident a bath twice a week.</p> <p>In an observation on 02/04/16 at 2:58 p.m., the resident had long fingernails, with a brown substance caked under them. Multiple observations on 02/08/16 revealed the resident continued to have long, dirty fingernails.</p> <p>On 02/09/16 at 10:18 a.m., Staff M, shower aide, escorted this surveyor into the resident's room, and assessed the resident's fingernails. Staff M confirmed the resident's nails were dirty and long, and acknowledged this should have been addressed during the resident's last shower.</p>	F 312		
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F 312	Continued From page 19 Staff M reviewed the facility's shower book with the surveyor, and confirmed the resident's last shower was documented as given on 02/01/16. Staff M was unable to identify the reason Resident #97 did not receive another shower between 02/01/16 and 02/09/16.  In an interview on 02/09/16 at 10:26 a.m., Staff H, Unit Manager, confirmed bathing care would include nail care. Staff H said if the resident had refused bathing, it would have been noted in the shower book.  A follow-up review of the shower book was completed. There was no documentation that indicated the resident had refused bathing during the month of February 2016.  During a follow-up observation on 02/10/16 at 2:38 p.m., the resident's fingernails continued to be long and dirty, despite discussing care concerns with staff the previous day.	F 312	<b>F 315 §483.25 (d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</b>  1. Resident #220 was assessed and the care plan was updated to reflect the resident's current status by the Unit Manager on 3/3/16. 2. Residents with indwelling catheters were assessed by Nurse Unit Managers on 3/3/16 and care plans were updated as applicable to reflect the resident's current status. 3. A weekly audit will be conducted by DNS/designee to ensure residents with catheters are being provided assistance with emptying and positioning of the catheter bag. 4. Results of the audits will be reported to the QAPI committee for a period of 3 months or until a lesser frequency is deemed appropriate. 5. Date of compliance is 3-7-2016. 6. The Director of Nursing is responsible to ensure compliance.	3-7-16
F 315 SS=D	<b>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</b>  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced	F 315		

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F 315	<p>Continued From page 20</p> <p>by: Based on observation, interview, and record review, the facility failed to provide care and services to manage an indwelling catheter, to minimize the potential for infection, for 1 of 3 residents (#220), reviewed for urinary catheter use, in a sample of 36. Findings include:</p> <p>Resident #220 admitted to the facility on [REDACTED] 15, with diagnoses including post surgical [REDACTED]</p> <p>Per review of the facility assessment dated 01/11/16, the resident was cognitively impaired, [REDACTED] and required extensive assistance with toileting.</p> <p>A review of the resident's medical records documented he had a history of self-catheterization (a procedure performed to empty the bladder, by passing a catheter - a flexible tube - through the urethra into the bladder) at home, but was no longer able to do so safely. As a result, an indwelling catheter was placed during a recent hospital stay.</p> <p>During multiple observations of the resident between 02/04/16 and 02/11/16, it was noted the resident's catheter bag was hung high on the side of his wheelchair. Current standards of practice dictate catheter bags should be hung below the level of the bladder, to prevent backflow of urine, and potential complications (including urinary tract infections).</p> <p>During an observation on 02/08/16 at 4:50 p.m., the resident emptied his catheter bag, by disconnecting the catheter bag from the tubing.</p>	F 315		
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F 315	Continued From page 21 The resident did not wash his hands, was not wearing gloves, and did not sanitize the catheter tubing or bag.  A review of the resident's 12/28/15 care plan revealed there was no plan in place for the resident to empty his own catheter bag, nor had the resident been assessed for his ability to safely do so.  In an interview on 02/09/16 at 9:45 a.m., Staff A, Unit Manager, confirmed the resident was emptying his own catheter bag, and acknowledged the absence of a related care plan. Staff A also confirmed the resident's catheter bag was hung inappropriately, stating "we normally place catheter bags underneath the wheelchair." Staff A stated he would consult with the facility's physician regarding the safety of this practice.  In a follow-up interview on 02/09/16 at 3:18 p.m., Staff E, Director of Nursing, stated if the resident wished to empty his own catheter bag, an assessment should have been completed, to determine if the resident was capable of completing the task, utilizing acceptable infection control practices.	F 315			
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a	F 325			

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F 325	Continued From page 22 nutritional problem.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to monitor weights, and implement and/or re-evaluate interventions related to weight loss, for 5 of 7 residents (#118, 131, 182, 227, 229) reviewed for nutrition, in a sample of 36. This failure resulted in harm for Resident #131, who lost an additional [REDACTED] in 7 weeks, after being identified with significant weight loss, and Resident # 229, who had a [REDACTED] weight loss in 11 days. Findings include:  1. Resident #131 was admitted on [REDACTED] 15, with diagnoses including [REDACTED] and [REDACTED]. The resident required assistance with some activities of daily living, was able to make her needs known, and received dialysis (a process to filter blood to maintain kidney function) three times a week.  Per the facility's Dietary Guidelines Manual, dated January 2014, residents were to be weighed weekly for the first four weeks after admission. Weekly weights were also indicated for residents who had significant weight loss. Weights for dialysis residents were to come from the dialysis center.  A Mini Nutritional Assessment dated 11/24/15 documented the resident weighed [REDACTED] pounds (lbs.).  An undated care plan, related to nutrition and	F 325	<b>F 325 §483.25 (i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</b>  1. The admit order for Resident #229's supplement was processed by Unit Manager on [REDACTED] 16 and is now in the EMAR, the resident is receiving the supplement. The Unit Manager weighed and assessed the resident, notified MD of weight change, placed resident on weekly weight monitor, and updated the care plan to reflect the resident's current status on 2/8/16. The Unit Manager weighed and assessed resident #131, notified MD of weight change, placed resident on weekly weight monitor, and updated the care plan to reflect the resident's current status on 2/11/16. The Unit Manager weighed and assessed the resident, notified MD of weight change, placed resident on weekly weight monitor, and updated the care plan to reflect the resident's current status on 2/17/16. The Unit Manager weighed and assessed the resident #118, notified MD of weight change, placed resident on weekly weight monitor, and updated the care plan to reflect the		3-7-16

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F 325	<p>Continued From page 23</p> <p>hydration, included the interventions: to monitor the resident's weight routinely, and report significant weight changes to the physician and dietician. An undated care plan for activities of daily living included an intervention to obtain weights weekly. An undated care plan for dialysis included interventions to monitor the resident for fluid volume deficit and/or excess.</p> <p>Review of Resident #131's record revealed the following documented weights: 11/25/15 - [REDACTED] lbs., 11/28/15 - [REDACTED] lbs., 12/01/15 - [REDACTED] lbs.</p> <p>A progress note from Staff L, Registered Dietician (RD), dated 12/01/15, indicated the resident had a 5% weight loss, which was identified as significant. The weights used to determine this loss were not documented in the note. Staff L's goal for the resident was weight maintenance, and she recommended large portions to help the resident meet nutritional needs in regards to dialysis. The order was written on the same day.</p> <p>A nutrition progress note dated 01/12/16, indicated the resident had lost approximately 3 more pounds. The weights used to determine this loss were not in the note. There had been no other weights documented in the record since 12/01/15.</p> <p>The next documented weight in the resident's record was [REDACTED] lbs. on 01/18/16 - seven weeks after the resident's initial weight loss had been identified. This represented an additional 25% weight loss. There was no documentation found regarding any weights obtained by the dialysis center.</p> <p>A progress note dated 01/25/16 revealed Staff J,</p>	F 325	<p>resident's current status on 2/10/16. The Unit Manager weighed and assessed the resident #182, notified MD of weight change, placed resident on weekly weight monitor, and updated the care plan to reflect the resident's current status on 2/10/16.</p> <p>2. An audit was conducted on 3/2/16 by Director of Nursing to ensure that other residents were not affected by this deficiency. RD recommendations were reviewed those that have been approved by the MD have been entered in to the EMAR to follow. All current residents were reviewed to determine the frequency of which they should be weighed per facility nutrition guidelines. During the weekly weight meeting, residents will be assessed and responses to significant weight changes are implemented.</p> <p>3. Licensed nurses including Staff F were educated by DNS on 2/12/16 to ensure that dietary orders from admit are followed. Licensed Nurses were educated by ADNS on 3/4/16 to ensure that RD recommendations are implemented timely. Dietary and Nurse Unit Managers were educated to ensure that residents are weighed and assessed following facility dietary guidelines By DNS on 2/12/16.</p> <p>4. A weekly weight meeting will be conducted by DNS/designee and Dietary Manager to ensure appropriate</p>		

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F 325	<p>Continued From page 24</p> <p>Dietary Manager, believed the facility's weights from November and December 2015 were inaccurate, and contacted the dialysis center to obtain a current weight. Per the dialysis center, the resident weighed [REDACTED] lbs. as of 01/22/16. There was no indication the facility confirmed whether or not the November and December 2015 weights were accurate or inaccurate, by contacting and obtaining weights from the dialysis center, until 01/22/16.</p> <p>A nursing progress note on 02/02/16 revealed the resident's physician had been notified of the weight loss. An order for double protein portions, to increase intake and protein levels was obtained. Neither the amount of weight loss, nor the resident's current weight, were documented in the note to the physician.</p> <p>In an interview on 02/09/16 at 9:47 a.m., Staff L, the RD, said she routinely gets a weekly report, identifying residents with weight loss. She then makes recommendations, and gives them to the Unit Manager, Director of Nursing, and Administrator. It is the Unit Manager who then follows up on the recommendations, and ensures any additional monitoring. She confirmed the facility should have been monitoring Resident #131's weight more closely.</p> <p>On 02/10/16 at 10:37 a.m., Staff I, Unit Manager, stated the resident had significant edema (accumulation of excess fluid in body tissues), when first admitted, and had been receiving [REDACTED] (a medication that promotes fluid loss). She explained the dialysis center generally took the resident's weight pre/post dialysis, but the facility had been having a difficult time communicating with the center.</p>	F 325	<p>weight monitoring is completed and responses to significant weight changes are implemented.</p> <ol style="list-style-type: none"> <li>5. Audits will be conducted weekly by DNS/designee to ensure that weights are obtained per facility nutrition guidelines, RD recommendations are entered timely, and dietary orders are followed on admit.</li> <li>6. Results of the audits will be reported to the QAPI committee for a period of 3 months or until a lesser frequency is deemed appropriate.</li> <li>7. Date of compliance is 3-7-2016</li> <li>8. The Director of Nursing is responsible to ensure compliance.</li> </ol>	

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F 325	<p>Continued From page 25</p> <p>Review of the resident's edema monitor from 11/17/15 through 1/31/16 documented edema in the resident's lower extremities, ranging from none to 1+ (slight). In addition, a Physician's Progress Note, dated 12/16/15, indicated the resident had no edema. There was no care plan or assessment, found in the record, regarding expected and/or planned weight loss, due to treatment for edema.</p> <p>Upon questioning by the surveyor, facility staff provided a weight report from the dialysis center, which they received on 02/08/16. The report confirmed the weights the facility had for November and December 2015 were accurate. Per the dialysis weights, Resident #131 had a weight loss of [REDACTED] pounds (30%), from the date of admission through 02/02/15, when the physician was notified.</p> <p>On 02/11/16 at 8:57 a.m., Staff I said after residents were identified with significant weight loss, the Medical Director would be consulted for orders. Weights would then be done weekly. When asked about the lack of documented weights for Resident #131 between 12/01/15 and 01/18/15, Staff I stated she did not know what happened, and the facility had "just missed it".</p> <p>2. Resident #229 admitted on [REDACTED] 15, with diagnoses of [REDACTED] and a [REDACTED] to the [REDACTED]. Review of Resident #229's hospital discharge orders, dated [REDACTED] 16, revealed the resident was to continue with the current diet orders, which included a supplement drink three times a day, with each meal.</p>	F 325			

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F 325	<p>Continued From page 26</p> <p>Review of the facility's diet memo and diet orders, dated 01/21/16, revealed the order for the supplement did not get transcribed onto the current orders for care at the facility.</p> <p>On 02/08/16 at 3:32 p.m., Staff F, LN (Licensed Nurse), confirmed she processed Resident #229's admission orders and paperwork. Staff F said she did not see the order to continue with providing a nutritional supplement three times a day, with meals.</p> <p>Additionally, record review revealed on 02/02/16, there was a nutritional assessment completed by a Registered Dietitian, which identified the resident had a weight loss of 2% in 7 days. In addition to other interventions, the Dietitian recommended a trial of supplements for this resident (which she should have been receiving since 01/21/16).</p> <p>Review of the current treatment orders (February 2016) documented the resident was started on a supplement [REDACTED] 16 (3 days after the Dietitian made the recommendation, and approximately 14 days since it was originally ordered upon admission to the facility).</p> <p>On 02/09/16 at 3:31 p.m., Staff I, Nurse Manager, confirmed she does the follow up with the Dietitian's recommendations, but did not do so in a timely manner in this instance. When asked about the processing of the dietary order from the hospital, Staff I stated they also missed</p>	F 325			

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F 325	<p>Continued From page 27 the original supplement order.</p> <p>Review of the facility's weight monitoring record revealed that on [REDACTED] 16, the resident weighed [REDACTED] lbs. On 01/25/16 the resident weighed [REDACTED] lbs. (a 5 pound weight loss in 4 days), on 02/01/16 [REDACTED] lbs. (a 15 pound weight loss in 7 days), and on 02/08/16, the resident's most recent weight was [REDACTED] lbs.</p> <p>The comprehensive assessment dated 01/28/16 referenced the resident's weight on admission of [REDACTED] pounds. This assessment did not identify the resident had a weight loss of 5 pounds on 01/25/16, when she weighed [REDACTED] lbs. (which was a 5% weight loss in 4 days).</p> <p>The 01/21/16 nutrition plan of care included interventions such as: allowing the resident enough time to eat her meals, and to feed or cue the resident to eat as needed. Staff were to monitor the resident's food intake, and inform the doctor and dietician of significant changes in intake. In addition, staff were to monitor the resident's weight routinely and report significant weight changes to the doctor and dietitian.</p> <p>On 02/08/16 at 12:35 p.m., Staff G, Director of Social Services, was observed delivering Resident #229 her lunch tray, and left the room. The resident was in bed, her eyes were closed, her lunch tray was on the bedside table, and the main dish was left covered.</p>	F 325			

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F 325	<p>Continued From page 28</p> <p>At 12:42 p.m., the resident was still in bed, her eyes were closed, and her lunch tray was untouched. At 1:02 p.m., the resident was still in bed with her eyes closed, her lunch was untouched. At 1:14 p.m., Staff S, nursing assistant, checked on the resident to see how she was doing with her lunch.</p> <p>Review of the meal intake monitor provided by Staff I, Unit Manager, on 02/08/16 revealed the resident ate 50% of her lunch earlier that day. In addition, there was documentation of the resident's meal intake for only 11 out of the 17 days the resident was in the facility.</p> <p>On 02/08/16 at 3:02 p.m., Staff J, Dietary Manager, stated she enters resident weights into the electronic record. Staff J confirmed she monitors resident weights, and notifies the RD and the Unit Manager if there was a concern about weight changes.</p> <p>Review of the progress notes for the resident revealed on 02/01/16 Staff I, Unit Manager, documented the resident's physician was notified of a weight loss, from [redacted] lbs. on admission, to [redacted] lbs. on 01/25/16. There was no indication the physician was notified of the further weight decline, to [redacted] lbs. on 02/01/16.</p> <p>Additional record review revealed on 02/02/16 there was a nutritional assessment completed by a Registered Dietitian (RD). This assessment was based off the resident's weight of [redacted] lbs. on 01/25/16, rather than the most recent weight [redacted]</p>	F 325		

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F 325	<p>Continued From page 29</p> <p>lbs., as of 02/01/16. It was identified on this assessment that the resident had a weight change of 2% in 7 days, which was inaccurate. The nutrition goal at that time was to maintain the resident's weight, and to add nutritionally enhanced meals, try smaller portions, and to start a trial of supplements.</p> <p>On 02/09/16 at 10:27 a.m., Staff L, a RD, stated she was at the facility once a week, and sometimes it would be 14 days before she could do an initial nutritional assessment on a newly admitted resident (the resident was admitted on [REDACTED] 16, and the RD assessed the resident on 02/02/16). Staff L said she was not aware of the resident's weight change on 02/01/16.</p> <p>On 02/09/16 at 3:31 p.m., Staff I, Unit Manager, stated she was not aware of the resident's weight change from 01/25/16-02/01/16. Staff I confirmed there was a problem with the process, because the weight information should have been communicated to her and the RD sooner. In addition, Staff I said she expects staff to consistently monitor meal intake for residents who have that as part of their care plan (and are at high risk for weight loss).</p> <p>The facility failed to provide nutritional supplements timely as ordered, monitor weights and food intake as ordered, and assess significant weight loss timely.</p> <p>3. Resident #227 admitted to the facility on [REDACTED] 16, and had care needs related to medical</p>	F 325			

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F 325	<p>Continued From page 30 conditions including [REDACTED]</p> <p>Review of the record revealed Resident #227 received all of her nutrition from [REDACTED] however, her care plan of 02/08/16 instructed staff to allow the resident enough time to eat, encourage her to drink fluids, and to offer snacks. The care plan also directed staff to monitor weights routinely, and report significant weight changes to the doctor and dietitian, but did not specify how often "routine" weights should be done.</p> <p>In an interview on 02/11/16 at 12:26 p.m., Staff N, Registered Nurse, stated the interventions including allowing time to eat, and allowing food preferences were not appropriate for this resident. She stated the care plan addressed her [REDACTED] under skin integrity, but said, "I don't really see where she has [a care plan] to address specifics of her [REDACTED] and] nutrition."</p> <p>According to the facility Dietary Guidelines Manual, revised 01/14, indications requiring residents to be weighed weekly included: if they were under 100 pounds, on a [REDACTED] (until they were stable), and new admissions for four weeks (or until they were stable).</p> <p>According to the computerized weight documentation for Resident #227, the facility only obtained one weight between her admission on [REDACTED] 16, and 02/11/16. The weight was [REDACTED] bs. on 01/27/16, showing the resident was significantly underweight. Although the resident met several criteria that would require weekly weights per the policy, she was not weighed again until staff was asked what the current weight was by the surveyor on 02/11/16.</p>	F 325		

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F 325	<p>Continued From page 31</p> <p>A nutrition note by Staff L, the RD dated 01/26/16 reported Resident #227 was at her normal weight. In an interview on 02/09/16 at 3:26 p.m., Staff L confirmed there was not a facility weight recorded prior to that time, and stated she may have based her assessment on the hospital weight, which may be incorrect.</p> <p>In an interview on 02/10/16 at 3:49 p.m., Staff H, Unit Manager, stated newly admitted residents should be weighed within 24 hours of admission. She confirmed the only weight recorded for Resident #227 was on 01/27/16, almost [redacted] weeks after she admitted. When asked the appropriate length of time between weights for Resident #227, Staff H indicated the resident should be weighed weekly.</p> <p>4. Resident #118 admitted to the facility in [redacted] 2014, and had diagnoses including [redacted]</p> <p>Observation during the survey period, including on 02/08/16 at 6:16 p.m. and 02/09/16 at 9:13 a.m. revealed Resident #118 required cueing and occasional physical assistance with meals.</p> <p>Review of the weight record for Resident #118 revealed significant weight loss, from [redacted] lbs. on 12/07/15, to [redacted] lbs. on 12/28/15 (a 7% loss), and then a further decrease to [redacted] lbs. on 01/08/16, and [redacted] lbs. on 01/11/16 (a total loss of 11%). The weight record printed 02/08/16 showed no weights recorded after 01/11/16. No notes in the record were found to show the weight loss on 12/28/15 was identified, or that new interventions were put in place in a timely manner</p>	F 325			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505496</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/11/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>AVALON CARE CENTER AT NORTHPOINTE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>9827 NORTH NEVADA SPOKANE, WA 99218</b>
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F 325	<p>Continued From page 32 for Resident #118.</p> <p>In an interview on 02/09/16 at 3:24 p.m., Staff L stated she followed Resident #118 monthly. She said she reviewed weights early in the morning weekly, when she was in the facility, and sometimes the weights were entered into the computer after she had finished her review so she did not see them.</p> <p>In an interview on 02/11/16 at 8:50 a.m., Staff I, Unit Manager, confirmed there were no notes indicating the weight decrease on 12/28/15 was identified, or that staff followed up on the issue until 01/08/16.</p> <p>5. Resident #182 admitted to the facility on [REDACTED] 15, and had diagnoses including [REDACTED]</p> <p>According to the facility Dietary Guidelines Manual, weekly weights should be obtained for new admissions until they were stable, and "If the change (loss or gain) is 2% or more on weekly weights; then a narrative note needs to be completed ... the main information that needs to be documented is why the change..."</p> <p>Review of the weights for Resident #182 revealed she was [REDACTED] lbs. on admission [REDACTED] 15), and decreased to [REDACTED] lbs. on 09/18/15, a change of 3.8 %, with no weekly weights in between. The first note in the record, which mentioned her weight, was on 10/08/15, and did not address the weight loss.</p> <p>In an interview on 02/11/16 at 8:42 a.m., Staff I indicated she was not aware of any reason Resident #182 would not have weekly weights</p>	F 325		
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F 325	Continued From page 33 upon admission.  A progress note on 10/27/15 by Staff J indicated the weight recorded on [REDACTED] 15 was from the hospital "so not sure we have a loss." This would indicate the resident was first weighed in the facility almost [REDACTED] weeks after admission.  Per the record, Resident #182 experienced another weight loss, from [REDACTED] lbs. on 11/09/15, to [REDACTED] lbs. on 12/02/15, a 5.2% change. A nutrition note dated 12/07/15 referenced the [REDACTED] pound weight, but did not identify the weight loss on 12/02/15. Per the notes, the doctor was notified of a weight loss on 12/14/15, [REDACTED] days after the fact. In an interview on 02/11/16 at 8:40 a.m., Staff I confirmed no follow-up was documented related to Resident #182's weight loss between 12/02/15 and 12/14/15.  Further review of the record revealed the RD saw the resident for the first time on 12/21/15, although she had an initial weight loss on 09/18/15, and another decrease on 12/02/15. In an interview on 02/09/16 at 3:21p.m., Staff L confirmed Resident #182's nutritional concerns and weight loss were first brought to her attention on 12/21/15.	F 325			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371			

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F 371	<p>Continued From page 34</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure proper food cooling was followed for foods that were pre-cooked and re-heated, health shakes were dated when thawed, foods were dated when refrigerated and disposed of per schedule, and ready-to-eat foods were not contaminated by dirty gloves. This failure placed all residents who ate in the facility at risk for foodborne illness. Findings include:</p> <p><b>1. COOLING METHODS</b></p> <p>According to the United States Department of Agriculture (<a href="http://www.fsis.usda.gov">http://www.fsis.usda.gov</a>), "bacteria grow most rapidly in the range of temperatures between 40 [degrees]F and 140 [degrees]F...This range of temperatures is often called the "Danger Zone."" The USDA additionally noted food must be cooled quickly, as improper cooling of cooked foods is a common cause of foodborne illness.</p> <p>According to the State Food Code, approved methods for cooling potentially hazardous foods include placing foods in a shallow pan (no more than 2 inches deep) for continuous cooling in a refrigerated environment, or taking the temperature of cooling foods to ensure it is down to 70 degrees F within 2 hours, and to 41 degrees or less within a total of six hours.</p> <p>Observation of the kitchen's walk-in refrigerator on 02/04/16 at 8:46 a.m. with Staff J, Dietary</p>	F 371	<p><b>F 371 §483.35 (i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</b></p> <ol style="list-style-type: none"> <li>No residents were identified as being affected by this deficiency.</li> <li>All staff including Staff M were educated by Nursing Home Administrator on 2/18/16 to ensure food is handled with clean gloves. Staff U was educated by Staff Development Coordinator on 3/4/16 to ensure that cups were not handled with bare hands on the drinking surface of the cups. Staff were educated by Dietary Manager on 2/22/16 to ensure that pre-cooked and re-heated foods are properly cooled, health shakes are dated when thawed, foods are dated when refrigerated and disposed of per schedule, and ready to eat foods are not contaminated by dirty gloves.</li> <li>Audits will be conducted by Dietary Manager 2 times weekly to ensure that pre-cooked and re-heated foods are properly cooled, health shakes are dated when thawed, foods are dated when refrigerated and disposed of per schedule, and ready to eat foods are not contaminated by dirty gloves. Medical Records will conduct weekly audits on new admits to ensure that dietary supplements ordered by discharging physician are transcribed into the EMAR and followed.</li> </ol>	3-7-16

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F 371	<p>Continued From page 35</p> <p>Manager, revealed roast beef, parmesan noodles, hamburger patties and chicken pieces stacked in individual containers that were between 4-6 inches in height. All of the foods were dated 02/03/16. At 8:50 a.m., the parmesan noodles were 46.4 degrees Fahrenheit (F). Staff J indicated the food was not in the proper temperature range, and discarded it. In an interview on 02/04/16 at 8:46 a.m., Staff J stated for foods that are monitored during cooling, temperatures were taken every 2 hours. She stated the cooling process was not used for foods that were previously cooked and heated, only raw foods.</p> <p>Review of the cooling log provided by Staff J on 02/04/16 at 9:02 a.m. revealed instructions for staff to "cool hot food to 70 F in 2 hours, and to 40 F by 4 hours." Staff J stated she did not have cooling logs for the foods in the refrigerator to show they were cooled within the required time frames.</p> <p><b>2. FOOD LABELING AND DISPOSAL SCHEDULE</b></p> <p>Observation of the East Unit Kitchenette on 02/04/16 at 9:35 a.m., and the West Unit Kitchenette on 02/04/16 at 9:48 a.m. revealed signs on the refrigerators which stated, "everything in this refrigerator must have a date on it. Food older than 3 days must be thrown away." Inside the West Unit refrigerator were two food containers with resident names on them, but no dates. In an interview on 02/04/16 at 9:55 a.m., Staff I, Unit Manager, stated all shifts were responsible to check the dates on food, and the undated food should be discarded.</p>	F 371	<p>4. Results of the audits will be reported to the QAPI committee for a period of 3 months or until a lesser frequency is deemed appropriate.</p> <p>5. Date of compliance is 3-7-2016.</p> <p>6. The Nursing Home Administrator is responsible to ensure compliance.</p>		

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F 371	Continued From page 36 Further observation on 02/04/16 at 10:00 a.m., with Staff J, revealed the bottom compartments of the refrigerator contained unopened sugar free and regular health shakes. Some felt frozen, and others were thawed. The health shake labels instructed "thaw under refrigeration, use within 14 days of thawing." Health shake packages on both the East and West Units were not dated. In an interview on 02/04/16 at 10:01 a.m., Staff J stated the drawers should have the date the health shakes were placed in the refrigerator, and verified the date was not there.  2. FOOD/ DISH HANDLING During observations on 02/04/16 at 12:37 p.m., 12:40 p.m., and 12:45 p.m., Staff M, Nursing Assistant, was assisting to serve meals in the West Dining Room. She was wearing disposable gloves, and touched meal tickets, which had been on resident tables, and then touched breadsticks directly with her gloves before serving them to residents.  In an interview on 02/04/16 at 3:45 p.m., Staff E, Director of Nursing, stated staff could use clean gloves that had not touched anything else to handle foods served to residents, otherwise they should use a barrier.  In an observation of the East hall tray service on 02/04/16 at 12:07 p.m., Staff U, Nursing Assistant, handled plastic cups with her bare hands on the drinking surface of the cups, when serving beverages to several residents.	F 371			
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS  The facility must assist residents in obtaining	F 411			

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F 411	Continued From page 37 routine and 24-hour emergency dental care.  A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide dental services for 1 of 3 Medicare residents (#231), of 4 total residents reviewed for dental concerns, in a sample of 36. This failed practice placed the resident at risk for weight loss, due to chewing problems. Findings include:  Resident #231, admitted on [REDACTED] 16, was identified by the facility as having missing teeth and chewing problems.  A nursing admission note on [REDACTED] 16, stated Resident #231 had his own teeth, and they were in poor condition.  The nursing care plan of 01/22/16, showed Resident #231 was on a mechanically altered diet, and had an intervention that stated "Schedule dental eval (evaluation), arrange for follow up care as indicated".	F 411	<b>F 411 §483.55 (a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS</b>  1. Resident #231 was discharged from facility. 2. An audit was conducted by Unit Mangers on 3/4/16 of current Medicare residents to ensure that those identified as having poor dentition were offered assistance with obtaining dental services. 3. Licensed nurses will assess residents oral status weekly. Education was provided to Licensed Nurses By Social Services Director on 3/4/16 related to communication of dental needs to Social Services so that dental services referrals can be arranged for residents if applicable. 4. Audits will be conducted by Social Services Director/designee weekly to ensure that assessments are completed and Social Services are notified of need for dental service referral. 5. Results of the audits will be reported to the QAPI committee for a period of 3 months or until a lesser frequency is deemed appropriate. 6. Date of compliance is 3-7-2016. 7. The Nursing Home Administrator is responsible to ensure compliance.	3-7-16	

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F 411	Continued From page 38 During an interview on 02/04/16 at 3:45 p.m., Resident #231 was observed to have several missing teeth. The resident confirmed he had difficulty chewing some foods, and stated staff did not talk to him about dental services.  On 02/10/16 at 2:40 p.m., Staff H, Unit Manager, stated Resident #231 was identified upon admission as having a dental concern, and confirmed dental services were not arranged for him.	F 411	<b>F 412 §483.55 (b) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS</b>  1. Resident #206 was assessed and the care plan was updated to reflect the resident's current status. Social services are in the process of arranging dental services for this resident. 2. An audit was conducted by Unit Mangers on 3/4/16 of current Medicaid residents to ensure that those identified as having poor dentition were offered assistance with obtaining dental services. 3. Licensed nurses will assess residents oral status weekly. Education was provided to Licensed Nurses By Social Services Director on 3/4/16 related to communication of dental needs to Social Services so that dental services referrals can be arranged for residents if applicable. 4. Audits will be conducted by Social Services Director/designee weekly to ensure that assessments are completed and Social Services are notified of need for dental service referral. 5. Results of the audits will be reported to the QAPI committee for a period of 3 months or until a lesser frequency is deemed appropriate. 6. Date of compliance is 3-7-2016. 7. The Nursing Home Administrator is responsible to ensure compliance.	3-7-16
F 412 SS=D	<b>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</b>  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.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide dental services for 1 of 1 Medicaid residents (#206), of 4 total residents reviewed for dental concerns, in a sample of 36. This failure placed the resident at risk for further dental decay and weight loss. Findings include:  Resident #206, admitted on [REDACTED] 15, had a history of dental decay.	F 412		

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F 412	Continued From page 39  A review of Resident #206's admission comprehensive assessment, showed the resident had obvious or likely cavities, and/or broken natural teeth.  After sixty days at the facility, per Resident #206's weight record, he experienced a twenty three pound weight loss.  The nursing care plan showed Resident #206 was on a mechanically altered diet, and had an intervention that stated "Schedule dental eval (evaluation), arrange for follow up care as indicated".  During an interview on 02/05/16 at 9:21 a.m., Resident #206 was observed to have some missing and decayed teeth. The resident stated he was not aware he could see the dentist, and said staff did not talk to him about dental services.  On 02/10/16 at 2:40 p.m., Staff H, Unit Manager, stated Resident #206 was identified upon admission as having dental decay, and confirmed dental services had not been arranged.	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.	F 431			

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F 431	<p>Continued From page 40</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 and interview, the facility failed to ensure 1 of 5 medication carts were kept locked, supervised, and inaccessible to residents. This failure increased the risk of residents having unsupervised access to medications. Findings include:</p> <p>On 02/10/16 at 3:20 p.m., the medication cart on the north unit was observed unlocked and unsupervised. The licensed staff who was using</p>	F 431	<p><b>F 431 §483.60 (b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</b></p> <ol style="list-style-type: none"> <li>1. No residents were affected by this deficiency.</li> <li>2. Staff K was educated by Director of Nursing on 2/11/16 to ensure that all drugs and biologicals are stored in locked compartments. Licensed nurses were educated by DNS on 2/11/16 to ensure that all drugs and biologicals are stored in locked compartments.</li> <li>3. Audits will be conducted 2 times weekly by DNS/designee to ensure that all drugs and biologicals are stored in locked compartments.</li> <li>4. Results of the audits will be reported to the QAPI committee for a period of 3 months or until a lesser frequency is deemed appropriate.</li> <li>5. Date of compliance is 3-7-2016.</li> <li>6. The Director of Nursing is responsible to ensure compliance.</li> </ol>	3-7-16

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F 431	Continued From page 41 the cart was in another resident's room during this time. About 5 minutes later, Staff K, Licensed Nurse, returned to the medication cart. When asked whether or not the medication cart had been locked when she was not there, Staff K said it was not.  On 02/11/16 at 12:24 p.m., Staff E, Director of Nursing Services, confirmed medication carts should be locked when nursing staff were not present.	F 431	<b>F 441 §483.65 INFECTION CONTROL, PREVENT SPREAD, LINENES</b>  1. Resident #201 was discharged from facility. Resident #235 was assessed by the Unit Manager on 2/12/16 and was not affected by this deficiency. The Unit Manager assessed resident #220, updated the care plan to reflect the resident's current status, and provided education to the resident on 3/3/16.  2. An audit was conducted by Staff Development Coordinator on 3/4/16 to ensure that safe infection control practices are consistently maintained, to prevent potential cross contamination during medication administration, wound care and catheter care.  3. Licensed Nurses including Staff V and Staff W, were educated by Staff Development Coordinator on or before 3/4/16 to ensure safe infection control practices are maintained to prevent potential cross contamination during medication administration, wound care.  4. Audits will be conducted by Director of Nursing/designee two times weekly to ensure safe infection control practices are consistently maintained, to prevent potential cross contamination during medication administration, wound care and catheter care.  5. Results of the audits will be reported to the QAPI committee for a period of	3-7-16
F 441 SS=D	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  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	F 441		

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NAME OF PROVIDER OR SUPPLIER  AVALON CARE CENTER AT NORTHPOINTE		STREET ADDRESS, CITY, STATE, ZIP CODE 9827 NORTH NEVADA SPOKANE, WA 99218		
(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 441	<p>Continued From page 42</p> <p>from direct contact with residents or their food, if 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 and interview, the facility failed to ensure safe infection control practices were consistently maintained, to prevent potential cross contamination during medication administration, wound care, and catheter care. Findings include:</p> <p><b>MEDICATION ADMINISTRATION</b> During an observation on 02/09/16 at 9:20 a.m., Staff V, LPN, administered medication to Resident #201 through the resident's [REDACTED]. Staff V donned gloves and began to administer medication into the resident's [REDACTED] via an open syringe. Staff V then picked up her cell phone, and the communication board belonging to the resident, and continued administering medications through the resident's [REDACTED]. Staff V did not wash her hands or change her gloves after touching the potentially contaminated items.</p> <p><b>WOUND CARE</b> On 02/05/16 at 1:50 p.m., Staff W, LPN, was</p>	F 441	<p>3 months or until a lesser frequency is deemed appropriate.</p> <p>6. Date of compliance is 3-7-2016.</p> <p>7. The Director of Nursing is responsible to ensure compliance.</p>	

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

PRINTED: 02/26/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505496</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/11/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>AVALON CARE CENTER AT NORTHPOINTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>9827 NORTH NEVADA SPOKANE, WA 99218</b>		
(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 441	<p>Continued From page 43</p> <p>observed completing a dressing change during wound care for Resident #235. Staff W washed her hands and put gloves on. Staff W then touched her own clothing, and continued with the resident's dressing change. Staff W did not wash her hands or change her gloves after touching potentially contaminated items prior to continuing with wound care.</p> <p><b>CATHETER CARE</b> During an observation on 02/08/16 at 4:50 p.m., Resident #220 went into his bathroom and emptied his catheter bag, by disconnecting the bag from the catheter tubing. The resident did not wash his hands, was not wearing gloves, and did not sanitize the catheter tubing or drain plug during this observation.</p> <p>In an interview on 02/09/16 at 3:18 p.m., Staff E, Director of Nursing, confirmed the observations documented above were not acceptable infection control practices. Staff E further stated when administering medications through a [REDACTED] if staff let go of the [REDACTED] to handle something else, they should have changed their gloves before continuing to administer medications. In addition, Staff E stated Resident #235 should have been assessed and care planned to empty his own catheter bag, to ensure he could do so in a sanitary and safe manner.</p>	F 441			



AGING AND DISABILITY SERVICES ADMINISTRATION  
**Nursing Home Survey Report**  
 STATE AND CORRESPONDING FEDERAL REQUIREMENTS

1. Page <u>1</u> of <u>2</u> Pages
2. DATES OF DATA COLLECTION 02/04/16-02/05/16, 02/08/16-02/11/16
5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Holiday
7. LICENSE NUMBER 1358

3. NAME OF FACILITY Avalon Care Center - Northpointe	4. TYPE OF SURVEY <input checked="" type="checkbox"/> Full <input type="checkbox"/> Post <input checked="" type="checkbox"/> Complaint <input type="checkbox"/> Other: specify _____
6. STREET ADDRESS 9827 N. Nevada	CITY STATE ZIP CODE Spokane WA 99218

NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.

8.	9. WASHINGTON ADMINISTRATIVE CODES 388-97	10. CODE OF FEDERAL REGULATION 42 CFR 483.	11. FEDERAL DATA TAG NUMBER	12. REPEAT DEFICIENCY FROM SURVEY DATED	13. NEW CITATION ON POST SURVEY	14. LICENSEE'S PLANNED DATE OF CORRECTION
<input checked="" type="checkbox"/> The requirements of the following WAC's and corresponding CFR's were not met. The text of the statements of deficiencies and the licensee's plan of correction may be read on CMS form 2567, dated: <u>02/11/16</u>  **Licensee must complete column 14.  <input type="checkbox"/> The following deficiencies were determined to be corrected.	-0480	10(g)(1)	F-167		<input type="checkbox"/>	3-7-16
	-1020(1),(2)(a)(b)	20(k)	F-279		<input type="checkbox"/>	3-7-16
	-1620(2)(b)(i)(ii), (6)(b)(i)	20(k)(3)(i)	F-281		<input type="checkbox"/>	3-7-16
	-1620	20(k)(3)(ii)	F-282		<input type="checkbox"/>	3-7-16
	-1975	20(m)	F-285		<input type="checkbox"/>	3-7-16
	-1900(5)(a-d)	25	F-309		<input type="checkbox"/>	3-7-16
	-1060(2)(b)	25(a)(3)	F-312	01/09/15	<input type="checkbox"/>	3-7-16
	-1060(3)(c)	25(d)(1)(2)	F-315		<input type="checkbox"/>	3-7-16
	-1060(3)(h)	25(i)(1)	F-325		<input type="checkbox"/>	3-7-16
	-1100(3) & -2980	35(i)(2)	F-371	01/09/15	<input type="checkbox"/>	3-7-16
-1060(2)(c), (3)(j)(vii)	55(a)(1)-(4)	F-411		<input type="checkbox"/>	3-7-16	
					<input type="checkbox"/>	

RECEIVED  
 MAR 10 2016  
 DSHS ADSA RCS  
 SPOKANE WA

15. SURVEYOR'S SIGNATURE(S)			
SIGNATURE <i>Cindy Caville for Hai Nguyen</i>	DATE 2/26/16	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

16. LICENSEE OR AGENT		
SIGNATURE OF LICENSEE (OR AGENT) <i>Mary Deen</i>	TITLE Administrator	DATE 3-7-16



AGING AND DISABILITY SERVICES ADMINISTRATION  
**Nursing Home Survey Report**  
 STATE AND CORRESPONDING FEDERAL REQUIREMENTS

1. Page 2 of 2 Pages

2. DATES OF DATA COLLECTION  
 02/04/16-02/05/16, 02/08/16-02/11/16

5. TIME OF SURVEY  Day  Night  
 Weekend  Holiday

7. LICENSE NUMBER  
 1358

3. NAME OF FACILITY  
 Avalon Care Center - Northpointe

4. TYPE OF SURVEY  
 Full  Post  Complaint  Other: specify \_\_\_\_\_

6. STREET ADDRESS  
 9827 N. Nevada

CITY STATE ZIP CODE  
 Spokane WA 99218

NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.

8.	9. WASHINGTON ADMINISTRATIVE CODES 388-97	10. CODE OF FEDERAL REGULATION 42 CFR 483.	11. FEDERAL DATA TAG NUMBER	12. REPEAT DEFICIENCY FROM SURVEY DATED	13. NEW CITATION ON POST SURVEY	14. LICENSEE'S PLANNED DATE OF CORRECTION	
<input checked="" type="checkbox"/> The requirements of the following WAC's and corresponding CFR's were not met. The text of the statements of deficiencies and the licensee's plan of correction may be read on CMS form 2567, dated: <u>02/11/16</u> .  **Licensee must complete column 14.  <input type="checkbox"/> The following deficiencies were determined to be corrected.	-1060(2)(c), (3)(i)(vii)	55(b)(1)-(3)	F-412		<input type="checkbox"/>	3-7-16	
	-1300(2) & -2340	60(e)	F-431		<input type="checkbox"/>	3-7-16	
	-1320(1)(a)(c)	65(a)(1)-(3), (b)(3)	F-441		<input type="checkbox"/>	3-7-16	
						<input type="checkbox"/>	
						<input type="checkbox"/>	
						<input type="checkbox"/>	
						<input type="checkbox"/>	
						<input type="checkbox"/>	
						<input type="checkbox"/>	
						<input type="checkbox"/>	

15. SURVEYOR'S SIGNATURE(S)

SIGNATURE <i>H. Nguyen</i>	DATE 2-23-16	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

16. LICENSEE OR AGENT

SIGNATURE OF LICENSEE (OR AGENT) <i>Mary Deem</i>	TITLE Administrator	DATE 3-7-16
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AGING AND DISABILITY SERVICES ADMINISTRATION

**Nursing Home Survey Report**  
STATE REQUIREMENTS

1. Page 1 of 2 Pages
2. DATES OF DATA COLLECTION 02/04-05/16, 02/08-11/16
5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Holiday
7. LICENSE NUMBER 1358

3. NAME OF FACILITY Avalon Care Center at Northpointe	4. TYPE OF SURVEY <input checked="" type="checkbox"/> Full <input type="checkbox"/> Post <input type="checkbox"/> Complaint <input type="checkbox"/> Other: specify _____
6. STREET ADDRESS 9827 N. Nevada St.	CITY STATE ZIP CODE Spokane WA 99218

**NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.**

8. <input checked="" type="checkbox"/> The requirements of the following Washington Administrative Code (WAC) were not met:  WAC 388-97-0580(1)(b)  <input type="checkbox"/> The following deficiencies were determined to be corrected.	9. REPEAT DEFICIENCY FROM SURVEY DATED	11. LICENSEE'S PLAN OF CORRECTION WAC 338-97-0580(1)(b)  1. Resident #206 has not voiced further concerns related to the room move.  2. An audit was conducted on 3/4/16 by Social Service Director/designee to ensure that other current residents have not been affected by this deficiency.  3. Residents will be notified of potential room changes and/or roommate changes 3 days prior to the change when applicable according to guidelines.  4. Audits will be conducted by Nursing Home Administrator/designee weekly to ensure that residents are notified of room changes and/or roommate changes according to guidelines.  5. Results of the audits will be reported to the QAPI committee for a period of 3 months or until a lesser frequency is deemed appropriate.  6. Date of compliance is 3-7-2016.  7. The Nursing Home Administrator is responsible to ensure compliance.	12. LICENSEE'S PLANNED DATE OF CORRECTION 3-7-16
	10. NEW CITATION ON POST SURVEY <input type="checkbox"/> Yes <input type="checkbox"/> No		
DEFICIENCY WAC 388-97-0580 (1)(b) Roommates/rooms. (1) A resident has the right to: (b) Receive three days notice of change in room or roommate except: (i) For room changes: The move is at the resident's request; and (ii) For room or roommate changes: A longer or shorter notice is required to protect the health or safety of the resident or another resident; or an admission to the facility is necessary, and the resident is informed in advance. The nursing home must recognize that the change may be traumatic for the resident and take steps to lessen the trauma. This requirement was not met as evidenced by:  Based on interview and record review, the facility failed to ensure 1 of 3 residents reviewed for a room change (#206) received notification 3 days before he was asked to move. This failure caused Resident #206 frustration, and placed him at risk for diminished quality of life. Findings include:			

13. SURVEYOR'S SIGNATURE(S)			
SIGNATURE <i>Hannah Adams</i>	DATE 02/17/16	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

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MAR 10 2016

14. LICENSEE OR AGENT		
SIGNATURE OF LICENSEE (OR AGENT) <i>Mary Deen</i>	TITLE Administrator	DATE 3-7-16



AGING AND DISABILITY SERVICES ADMINISTRATION

**Nursing Home Survey Report**  
STATE REQUIREMENTS

1. Page 2 of 2 Pages
2. DATES OF DATA COLLECTION 02/04-05/16, 02/08-11/16
5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Holiday
7. LICENSE NUMBER 1358

3. NAME OF FACILITY Avalon Care Center at Northpointe	4. TYPE OF SURVEY <input checked="" type="checkbox"/> Full <input type="checkbox"/> Post <input type="checkbox"/> Complaint <input type="checkbox"/> Other: specify _____
6. STREET ADDRESS 9827 N. Nevada St.	CITY STATE ZIP CODE Spokane WA 99218

**NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.**

8. <input checked="" type="checkbox"/> The requirements of the following Washington Administrative Code (WAC) were not met:  WAC 388-97-0580(1)(b)  <input type="checkbox"/> The following deficiencies were determined to be corrected.	9. REPEAT DEFICIENCY FROM SURVEY DATED	11. LICENSEE'S PLAN OF CORRECTION	12. LICENSEE'S PLANNED DATE OF CORRECTION 3-7-16
	10. NEW CITATION ON POST SURVEY <input type="checkbox"/> Yes <input type="checkbox"/> No		
<p><b>DEFICIENCY</b> In an initial interview on 02/05/16 at 9:22 a.m., Resident #206 reported he had been moved to a different room while in the facility, and that he did not receive notice.</p> <p>Review of the record revealed the following progress note dated 01/06/16: "Resident will be moving... this afternoon as he is no longer under a medicare stay, and will possibly be here... for several more weeks. Resident made aware, and expressed frustration, but agreed to move..." The note indicated the resident was only notified the day of the move.</p> <p>In an interview on 02/11/16 at 10:32 a.m., Staff G, Social Services Director, was asked for any additional information regarding any other considerations regarding Resident #206's reasons for a room change. None was provided.</p>			

13. SURVEYOR'S SIGNATURE(S)			
SIGNATURE <i>Harold Adams</i>	DATE 02/17/16	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

14. LICENSEE OR AGENT		
SIGNATURE OF LICENSEE (OR AGENT) <i>Mary Deen</i>	TITLE Administrator	DATE 3-7-16



AGING AND LONG-TERM SUPPORT ADMINISTRATION

**Nursing Home Survey Report**  
STATE REQUIREMENTS

1. Page 1 of 2 Pages
2. DATES OF DATA COLLECTION 02/04-05/16, 02/08-11/16
5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Holiday
7. LICENSE NUMBER 1358

3. NAME OF FACILITY Avalon Care Center- Northpointe	4. TYPE OF SURVEY <input checked="" type="checkbox"/> Full <input type="checkbox"/> Post <input type="checkbox"/> Complaint <input type="checkbox"/> Other: specify
6. STREET ADDRESS 9827 N. Nevada	CITY STATE ZIP CODE Spokane WA 99218

**NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.**

8. <input checked="" type="checkbox"/> The requirements of the following Washington Administrative Code (WAC) were not met:  388-97-1800  <input type="checkbox"/> The following deficiencies were determined to be corrected.	9. REPEAT DEFICIENCY FROM SURVEY DATED	11. LICENSEE'S PLAN OF CORRECTION WAC 338-97-1800  1. No residents were affected by this deficiency. A background check was completed on Staff F by Human Resources in January of 2016.  2. An audit was conducted by Human Resources on 2/19/16 to ensure current employees, volunteers and students have current valid criminal background checks.  3. The facility will have valid criminal background check for any individual employed directly or by contract, volunteers or students upon hire and every two years.  4. Audits will be conducted by Human Resources monthly to ensure that valid criminal background checks are completed for new hires and every 2 year rechecks.  5. Results of the audits will be reported to the QAPI committee for a period of 3 months or until a lesser frequency is deemed appropriate.  6. Date of compliance is 3-7-2016.	12. LICENSEE'S PLANNED DATE OF CORRECTION 3-7-16
	10. NEW CITATION ON POST SURVEY <input type="checkbox"/> Yes <input type="checkbox"/> No		
DEFICIENCY WAC 388-97-1800 requires but not is not limited to: The nursing home must have a valid criminal history background check for any individual employed, directly or by contract, or any individual accepted as a volunteer or student who may have unsupervised access to any resident; and a background check must be repeated every two years.  This requirement was not met as evidenced by:  Based on interview and record review, the facility failed to ensure that 1 of 7 personnel (Staff S) reviewed for background checks, had the required background check completed for 2014.			

13. Surveyor's Signature(s)			
SIGNATURE <i>Angel Butts</i>	DATE 02/22/2016	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

14. Licensee or Agent		
SIGNATURE OF LICENSEE (OR AGENT) <i>Macey Druce</i>	TITLE Administrator	DATE 3-7-16



# Nursing Home Survey Report

## STATE REQUIREMENTS

1. Page <u>2</u> of <u>2</u> Pages
2. DATES OF DATA COLLECTION 02/04-05/16, 02/08-11/16
5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Holiday
7. LICENSE NUMBER 1358

3. NAME OF FACILITY Avalon Care Center- Northpointe	4. TYPE OF SURVEY <input checked="" type="checkbox"/> Full <input type="checkbox"/> Post <input type="checkbox"/> Complaint <input type="checkbox"/> Other: specify
6. STREET ADDRESS 9827 N. Nevada	CITY STATE ZIP CODE Spokane WA 99218

**NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.**

8. <input checked="" type="checkbox"/> The requirements of the following Washington Administrative Code (WAC) were not met:  388-97-1800  <input type="checkbox"/> The following deficiencies were determined to be corrected.	9. REPEAT DEFICIENCY FROM SURVEY DATED	11. LICENSEE'S PLAN OF CORRECTION	12. LICENSEE'S PLANNED DATE OF CORRECTION 3-7-16
	10. NEW CITATION ON POST SURVEY <input type="checkbox"/> Yes <input type="checkbox"/> No		
DEFICIENCY A review of staff records indicated that there was no evidence Staff S had a background check completed between October of 2012 and January of 2016.  During an interview with Staff Coordinator/Staff T on 02/11/16 at approximately 10:00 a.m., Staff T confirmed that if there was no record of a background check in the files provided to surveyor for review, it could safely be assumed that there was not one done.			

### 13. Surveyor's Signature(s)

SIGNATURE <i>Angel Butta</i>	DATE 02/22/2016	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

### 14. Licensee or Agent

SIGNATURE OF LICENSEE (OR AGENT) <i>Mary Deen</i>	TITLE <i>Administrator</i>	DATE 3-7-16
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# Nursing Home Survey Report

## STATE REQUIREMENTS

1. Page <u>1</u> of <u>3</u> Pages
2. DATES OF DATA COLLECTION 02/04-05/16, 02/08-11/16
5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Holiday
7. LICENSE NUMBER 1358

3. NAME OF FACILITY Avalon Care Center- Northpointe	4. TYPE OF SURVEY <input checked="" type="checkbox"/> Full <input type="checkbox"/> Post <input type="checkbox"/> Complaint <input type="checkbox"/> Other: specify
6. STREET ADDRESS 9827 N. Nevada	CITY STATE ZIP CODE Spokane WA 99218

**NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.**

8. <input checked="" type="checkbox"/> The requirements of the following Washington Administrative Code (WAC) were not met:  388-97-1380  <input type="checkbox"/> The following deficiencies were determined to be corrected.	9. REPEAT DEFICIENCY FROM SURVEY DATED	11. LICENSEE'S PLAN OF CORRECTION WAC 338-97-1380	12. LICENSEE'S PLANNED DATE OF CORRECTION 3-7-16
	10. NEW CITATION ON POST SURVEY <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>1. No residents were affected by this deficiency. Staff Q, R and X are no longer employed at the facility. Staff S had a TB test done on 1/4/16.</p> <p>2. An audit was conducted by the Staff Development Coordinator on 3/4/16 to ensure current employees have had TB testing completed within 3 days of employment and annually.</p> <p>3. Audits will be conducted by Human Resources weekly to ensure that personnel and residents have TB testing within 3 days of hire for employment or admission and will be retested annually.</p> <p>4. Staff R and X are no longer employed at the facility. Staff Q and S have had a TB test.</p> <p>5. Audits will be conducted by HR/designee monthly to ensure compliance with TB testing guidelines.</p> <p>6. Results of the audits will be reported to the QAPI committee for a period of 3</p>	

**DEFICIENCY**  
**WAC 388-97-1380 Tuberculosis (TB)-Testing required (1) The nursing home must develop and implement a system to ensure that facility personnel and residents have tuberculosis testing within three days of employment or admission; (2) and that facility personnel are tested annually.**

These requirements were not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that 4 of 9 staff (Q,R,S, X) reviewed for tuberculosis (TB) testing, had testing within 3 days of employment and/or failed to ensure that these staff were tested or assessed for signs and symptoms annually according to individual staff requirements. This failure placed residents at risk of exposure to a communicable illness, due to inadequate screening. Findings included:

**13. Surveyor's Signature(s)**

SIGNATURE <i>Angel Patton</i>	DATE 02/22/2016	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

**14. Licensee or Agent**

SIGNATURE OF LICENSEE (OR AGENT) <i>Mary Deen</i>	TITLE Administrator	DATE 3-7-16
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AGING AND LONG-TERM SUPPORT ADMINISTRATION  
**Nursing Home Survey Report**  
 STATE REQUIREMENTS

1. Page 2 of 3 Pages
2. DATES OF DATA COLLECTION 02/04-05/16, 02/08-11/16
5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Holiday
7. LICENSE NUMBER 1358

3. NAME OF FACILITY Avalon Care Center- Northpointe	4. TYPE OF SURVEY <input checked="" type="checkbox"/> Full <input type="checkbox"/> Post <input type="checkbox"/> Complaint <input type="checkbox"/> Other: specify
6. STREET ADDRESS 9827 N. Nevada	CITY STATE ZIP CODE Spokane WA 99218

**NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.**

8. <input checked="" type="checkbox"/> The requirements of the following Washington Administrative Code (WAC) were not met:  388-97-1380  <input type="checkbox"/> The following deficiencies were determined to be corrected.	9. REPEAT DEFICIENCY FROM SURVEY DATED	11. LICENSEE'S PLAN OF CORRECTION  months or until a lesser frequency is deemed appropriate.  7. Date of compliance is 3-7-2016.  8. The Nursing Home Administrator is responsible to ensure compliance.	12. LICENSEE'S PLANNED DATE OF CORRECTION  3-7-16
	10. NEW CITATION ON POST SURVEY <input type="checkbox"/> Yes <input type="checkbox"/> No		
DEFICIENCY The facility's tuberculin test policy and procedure, as provided to surveyor states in part that "newly hired personnel will be tested using the two-step method," and "will (testing) be repeated annually for residents and staff using the one-step method." The policy also notes that residents/staff with previously positive test results should be questioned/assessed annually for signs and symptoms, unless otherwise specified by regulations.  In an interview with Staffing Coordinator/Staff T on 02/10/16, at approximately 10:15 a.m., Staff T had a list of four staff members that were past due for their TB tests. Staff T confirmed that this list was accurate and that there was no additional information that the facility could provide.			

13. Surveyor's Signature(s)			
SIGNATURE <i>Angel Batta</i>	DATE 02/22/2016	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

14. Licensee or Agent		
SIGNATURE OF LICENSEE (OR AGENT) <i>Mary Deen</i>	TITLE <i>Administrator</i>	DATE 3-7-16



AGING AND LONG-TERM SUPPORT ADMINISTRATION

**Nursing Home Survey Report**

STATE REQUIREMENTS

1. Page <u>3</u> of <u>3</u> Pages
2. DATES OF DATA COLLECTION 02/04-05/16, 02/08-11/16
5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Holiday
7. LICENSE NUMBER 1358

3. NAME OF FACILITY Avalon Care Center- Northpointe	4. TYPE OF SURVEY <input checked="" type="checkbox"/> Full <input type="checkbox"/> Post <input type="checkbox"/> Complaint <input type="checkbox"/> Other: specify
6. STREET ADDRESS 9827 N. Nevada	CITY STATE ZIP CODE Spokane WA 99218

**NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.**

8. <input checked="" type="checkbox"/> The requirements of the following Washington Administrative Code (WAC) were not met:  388-97-1380  <input type="checkbox"/> The following deficiencies were determined to be corrected.	9. REPEAT DEFICIENCY FROM SURVEY DATED	11. LICENSEE'S PLAN OF CORRECTION	12. LICENSEE'S PLANNED DATE OF CORRECTION 3-7-16
	10. NEW CITATION ON POST SURVEY <input type="checkbox"/> Yes <input type="checkbox"/> No		
DEFICIENCY A review of these 4 staff and 5 others sampled, indicated that Staff S was missing TB testing/assessment for 2013 & 2015; Staff Q, for 2012, 2013, & 2015; Staff R, for 2015; and Staff X for 2013 & 2015.  A review of payroll records for Staff Q, Staff R, Staff S, and Staff X indicated that these staff had access to residents during the timeframes in which TB testing was not done as required.			

13. Surveyor's Signature(s)			
SIGNATURE <i>Angie Butler</i>	DATE 02/22/2016	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE
14. Licensee or Agent			
SIGNATURE OF LICENSEE (OR AGENT) <i>Mary Durr</i>	TITLE Administrator	DATE 3-7-16	