

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

PRINTED: 11/19/2013
FORM APPROVED
OMB NO. 0938-0391

1361

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505246	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/04/2013
NAME OF PROVIDER OR SUPPLIER AVALON CARE CENTER - PULLMAN			STREET ADDRESS, CITY, STATE, ZIP CODE NORTHWEST 1310 DEANE PULLMAN, WA 99163	
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Avalon Care Center - Pullman on 10/29/13, 10/30/13, 10/31/13, and 11/04/13. A sample of 27 residents was selected from a census of 26. The sample included 19 current residents and the records of 8 former/discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████ R.N., B.S.N ██████████ R.N., B.S.N ██████████ R.N., B.S.N ██████████ M.S.W</p> <p>The survey team is from: Department of Social & Health Services Aging & Long-Term Support Administration Division of Residential Care Services, District 1, Unit B Rock Pointe Tower 316 West Boone Avenue, Suite 170 Spokane, Washington 99201-2351 Telephone: (509) 323-7300 Fax: (509) 329-3993</p> <p>██████████ 11/18/13 Residential Care Services Date</p>	F 000		
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES	F 166		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE ADMINISTRATOR (X6) DATE 11/27/13

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

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F 166	<p>Continued From page 1</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to resolve grievances with respect to the behavior of other residents for 4 of 4 residents reviewed for grievances (#4, 5, 15, 31) in a sample of 27. Findings include:</p> <p>Resident #31 had diagnoses including [REDACTED]. Per record review, the resident had [REDACTED] and [REDACTED] problems, required limited to extensive assistance with activities of daily living, and exhibited daily behavior of wandering in resident rooms and other areas of the facility.</p> <p>In an interview on 10/29/13 at 2:53 p.m., Resident #5 stated several residents had problems with Resident #31 wandering into their rooms. She stated Resident #31 came into her room both when she was or wasn't there and touched her belongings.</p> <p>In an interview on 10/30/13 at 2:00 p.m., Resident #15's [REDACTED] member stated Resident #31 came into her room as well and it bothered Resident #15.</p> <p>On 10/30/13 at 7:00 p.m., Resident #4 was standing in the doorway to his room yelling for help because Resident #31 had been in his room. Resident #31 was nearby in the hall crying. Initially there was no staff in sight. Then Staff #1 came from the opposite hall and wheeled Resident #31 to the nurse's station.</p>	F 166	<p><u>F-166 - A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</u></p> <p>Resident #31 encounter with resident #4, follow-up report completed and hotline call was done.</p> <p>Resident #5 – Revisit grievance with resident and family</p> <p>Resident #15 - Revisit grievance with resident and family</p> <p>Resident #4 – Resident was discharged. Facility will provide education to concerned residents regarding their options on how to deal with another resident that wanders into their room. Education on the grievance resolution process will be provided by Administrator to staff.</p> <p>Grievance and complaint trends to be monitored weekly by Social Services Director/ Designee. Trends identified will be reported to QA monthly until a lesser frequency is deemed appropriate.</p> <p>Administrator responsible to ensure compliance.</p>	12/10/13

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F 166	<p>Continued From page 2</p> <p>In an interview at 7:10 p.m., Resident #4 stated Resident #31 wheeled herself halfway into his room. Resident #4 wheeled Resident #31 to the nurse's station, returned to his room, and put a cloth barrier across the doorway. Resident #31 then wheeled herself back to his room and tried to duck under the cloth barrier. He yelled "stop" but there was no staff available.</p> <p>In an interview on 11/4/13 at 11:15 a.m., Staff #D stated he received concerns about wandering residents from residents attending the Resident Council meeting in September 2013 and responded by providing education to the residents in the October 2013 Resident Council meeting. This was noted in the 10/10/13 Resident council meeting minutes. He stated he planned to review the issue of wandering residents in the next facility Quality Assurance meeting.</p> <p>483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS</p> <p>The facility must provide for the maintenance of comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain comfortable sound levels for 4 of 8 residents who resided in the south hall of the facility (#8, 21, 26, 41) in a sample of 27. This failure placed residents at risk for loss of a quiet living environment. Findings include: During an interview with Resident #8 on 10/29/13</p>	F 166	<p><u>F-258 – The facility must provide for the maintenance of comfortable sound levels.</u></p> <p>Resident #21 has [REDACTED] Residents 8, 26, 41, DNS will discuss what noises are specific for being comfortable and whom to report to if uncomfortable noises occur. A comprehensive audit of resident care plans was performed on residents with behaviors of yelling/calling out. Interventions were implemented as appropriate. Education will be provided to the care team on dealing with residents whom yell out. DNS/Designee will conduct weekly chart audits of residents that yell out, and newly identified residents to assure care plan interventions have been implemented. Trends identified from audits will be reported to QA monthly and less frequent as appropriate. DNS to responsible to ensure compliance.</p>	12/10/13
F 258 SS=E		F 258		

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F 258	Continued From page 3 between 1:45 p.m. and 2:15 p.m., Resident #21 was overheard intermittently calling out and singing loudly. During this time, there was no staff overheard interacting with the resident. Resident #8 stated that the noise generally did not bother her, and she used ear plugs if it did. During observation between 2:15 p.m. and 2:30 p.m., the resident continued to call out loudly enough to be overheard by staff at the nurse's station. No staff responded to the resident. In an interview on 10/30/13 at 9:00 a.m., Resident #41 stated she was bothered by Resident #21 calling out but she understood he was ill. In an interview on 10/30/2013 at 1:03 p.m., Resident #26's family member stated the resident preferred to have his door shut at night because Resident #21 called out at night, affecting his sleep. In an interview on 11/4/13 at 11:15 a.m., Staff #D stated he previously addressed concerns about other residents who called out at night. He stated concerns about Resident #21 were new and would be addressed in the next Quality Assurance meeting.	F 258			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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	F 312			

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F 312	<p>Continued From page 4</p> <p>review it was determined the facility failed to provide necessary care and services in regards to oral hygiene for 1 of 3 (#26) residents in a sample of 27. Findings include:</p> <p>Resident #26 had his natural teeth and required assistance with oral care. The resident had declined significantly since his admission in [REDACTED] of 2012. The resident spent most of his time in bed and needed assistance for daily activities and care.</p> <p>Per the most recent care plan, it stated the resident needed set up assistance with oral hygiene as needed and required physical assistance at times.</p> <p>During observation on 10/30/13 at 7:30 p.m., the resident had a thick substance in his mouth and on his teeth.</p> <p>On 10/31/13 at 2:19 p.m., Staff #C stated each resident received oral care during morning care and at night before they go to bed. Staff #C also stated the residents should receive oral care as needed when something is in their teeth and confirmed Resident #26 had a change in condition and needed more assistance.</p> <p>During an interview on 11/4/13 at 10:30 a.m., the resident stated he had not received any assistance with oral care that day and he wanted to get his teeth brushed.</p> <p>On 11/4/13 at 11:13 a.m., Staff #E stated that oral care was provided every morning but they had not provided oral care for Resident #26 today. Staff #E stated the resident "was totally dependent for oral care" and "he used to assist a little but now he is shaky and can't grip".</p> <p>On 11/4/13 at 12:00 p.m., Staff #F and the surveyor observed the resident's mouth. At this time the resident's tongue was swollen, red and had grated marks on the tongue. The resident</p>	F 312	<p><u>F-312 – 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.</u></p> <p>Resident #26 care plan has been reviewed and updated appropriately to reflect current level of care. A comprehensive audit of residents for what level of care is required to complete oral care, will be completed and care plans will be updated appropriately to reflect current level of care.</p> <p>Education on oral care will be provided to care giving staff. DNS/designee will conduct random weekly rounds for oral care completion.</p> <p>Trends identified from audits will be reported to QA monthly and less frequently as deemed appropriate. DNS responsible to ensure compliance.</p>	12/10/13

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F 312	Continued From page 5 stated that "the top of my tongue is sore." The resident also had a film of thick substance on his teeth and gums along with observations of substances being moved around in the resident's mouth with his tongue. Staff #F confirmed the resident's tongue was red and swollen with food left in his mouth. Staff #F stated the residents were supposed to have oral care twice a day. The facility was aware the resident needed total assist with oral hygiene but did not ensure it was consistently being provided. This placed the resident at risk for further decline in oral condition.	F 312		
F 325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(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</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to identify weight [REDACTED] in a timely manner for 1 of 3 (#10) residents in a sample of 27. This failure placed the resident at risk for unplanned weight [REDACTED]. Findings include:</p>	F 325	<p><u>F-325 - Based on a residents comprehensive assessment, the facility must ensure that a resident - Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the residents clinical condition demonstrates that this is not possible and</u></p> <p><u>- Receives therapeutic diet when there is a nutritional problem</u></p> <p>Resident #10 has been identified as at Risk for weight [REDACTED] and care plan has been updated accordingly. A review is conducted on all residents either weekly or monthly depending on individual need. IDT meeting held weekly to evaluate and make recommendations. Dietician and Physician notified as appropriate. Education to LN staff on nutrition, weights and dietary needs. DNS/Designee and DM will audit charts, weights and care plans with weekly IDT meeting. Trends and new at risk clients will be reported to QA monthly until a lesser frequency is deemed appropriate. DNS responsible to ensure compliance.</p>	12/10/13

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F 325	<p>Continued From page 6</p> <p>Resident #10 was admitted to the facility on [REDACTED]/13. Per record review, the resident needed set up assistance with meals.</p> <p>Per record review, on 6/18/13 the resident weighed [REDACTED] pounds. On 7/1/13 the resident weighed [REDACTED] pounds for a total [REDACTED] of [REDACTED] pounds ([REDACTED] of her body weight) in 15 days.</p> <p>On 7/17/13 the resident's weight was documented at [REDACTED] pounds or a total [REDACTED] of [REDACTED] ([REDACTED] of her body weight) in a month.</p> <p>Per record review, the initial nutritional assessment was dated 7/3/13. It identified the resident as having no weight [REDACTED] (even though it was documented that the resident weighed [REDACTED] pounds on 7/1/13 which was a [REDACTED] pound loss.), no decrease in food intake, and was not at risk for unplanned weight [REDACTED]. There was no documentation of the resident's usual body weight.</p> <p>The resident had a significant unplanned weight [REDACTED], however, the facility did not identify the [REDACTED] or evaluate the potential causes to prevent further weight [REDACTED] until 7/31/13. On 8/6/13, the dietician recommended interventions to include an enhanced diet to provided additional calories and protein, weekly weights, and to ensure resident's food preferences were being met.</p> <p>Per record review, the resident's weight stabilized between [REDACTED] and [REDACTED] pounds during September and October 2013.</p> <p>In an interview on 11/4/13 at 1:20 p.m., Staff #A stated the resident was a "picky eater." She stated that the resident usually ate about 50% of her food. The resident would let staff know if there was something else she wanted to eat but often times wouldn't eat that either.</p> <p>On 11/4/13 at 1:45 p.m., Staff #B stated that she monitored resident weights weekly. She and</p>	F 325			

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F 441	<p>Continued From page 8</p> <p>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, it was determined the facility failed to provide a designated sink for safe hand washing for both the residents and staff during and following meal time. Findings include:</p> <p>During the initial tour on 10/29/13, there was a hand washing sink observed adjacent to the dining room. When the hot water handle was turned on, no water came out.</p> <p>On 11/4/13 at 1:30 P.M., Staff #J stated a hot water tank was installed in 2001 and then disconnected in 2003. It was then removed in 2013. Staff #J confirmed there was no hot water plumbed into the sink outside the main dining room.</p> <p>During an interview on 11/4/13 at 1:45 p.m., Staff #E stated they use the sink with cold water to wash their hands on the way into the dining room. Some of the staff used the sink in the staff break room where the soap was milder and the water was warm.</p> <p>The failure to ensure appropriate hand washing techniques before and after handling foods placed residents at high risk of cross contamination and spread of infection.</p>	F 441			

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F 463 SS=E	<p>483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH</p> <p>The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to accommodate needs related to a residents call light not functioning for 1 out of 27 (#26) sample residents. This failure reduced the ability for the resident to request assistance when needed in the resident's room. Findings include:</p> <p>Resident #26, per record review, needed extensive assistance with bed mobility, activities of daily living (ADL) and transfers. The resident spent most of his time in bed. He was able to make his needs known and was able to use the call light appropriately when in reach.</p> <p>Per observation on 10/30/13 at 7:19 p.m., the resident's call light cord was not connected to the wall outlet and was coiled up on the bed side stand out of reach. There was no emergency call sounding at the nurse's station to alert staff that the call light was not connected.</p> <p>During observation of medication pass with Staff #H at 7:30 p.m., the call light was not connected and no emergency light was sounding. Staff #H reconnected the call light to the wall and stated he did not know why the emergency call system did not activate when the call light was pulled out of the wall. He stated he would report the call light system problem to Staff #D, the administrator.</p>	F 463	<p><u>F-463 – The nurse station must be equipped to receive resident calls through a communication system from resident rooms and toilet and bathing facilities.</u></p> <p>Resident #26 call light outlet was immediately put back in the receptacle and instance was reported to administrator at 7:30pm. The receptacle was immediately tightened by Administrator and the next morning was replaced by maintenance director.</p> <p>Call light system was tested on 11/21/13.</p> <p>Call light system will be updated to ensure all call light receptacles will alert the call light system when a call light comes out of the receptacle. Training on the call light standards and use will be provided to staff.</p> <p>Administrator/Designee to monitor call light system and call light response weekly.</p> <p>Trends identified will be reported to QA monthly until a lesser frequency deemed appropriate.</p> <p>Administrator to ensure compliance.</p>	12/18/13	

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F 463	<p>Continued From page 10</p> <p>During the exit meeting on 11/4/13 at 3:05 p.m., Staff #D stated the call light system was 40 years old and 1/2 of the building lights (south hall) did not activate when a call light was pulled out of a wall outlet. This was why no alarm was going off when Resident #26's call light was not plugged into the appropriate outlet.</p> <p>The facility failed to provide the resident with the means to call for assistance when needed due to the call light not being functional.</p>	F 463		