

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

PRINTED: 07/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2013
NAME OF PROVIDER OR SUPPLIER AVAMERE OLYMPIC REHABILITATION OF SEQUIM		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5TH AVENUE SOUTH SEQUIM, WA 98382		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Avamere Olympic Rehabilitation of Sequim on 07/08/13, 07/09/13, 07/10/13, and 07/11/13. A sample of 38 residents was selected from a census of 81. The sample included 32 current residents and 6 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████ MSW ██████████ RN BSN ██████████ RN, BSN ██████████ RN, BSN</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services, District 3, Unit C & D P.O. Box 45819 Tumwater, Washington 98504-5819</p> <p>Telephone: 360.664.8429 Fax: 360.664.8451</p> <p><i>Jean Pierre</i> Residential Care Services</p>	F 000	<p>The filing of this plan of correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This plan of correction is filed as evidence of the facility's effort to comply with the requirements of Medicare and Medicaid participation and to continue to provide a high quality of resident care.</p>	

RECEIVED
AUG 05 2013
DSHS/ADSA/RCS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Heather J. Jones MSW
TITLE
Administrative
(X6) DATE
7/31/13

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.

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

PRINTED: 07/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2013
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER AVAMERE OLYMPIC REHABILITATION OF SEQUIM	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5TH AVENUE SOUTH SEQUIM, WA 98382
------------------------------------------------------------------------------	------------------------------------------------------------------------------------

(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 242 SS=D 483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES

The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, it was determined the facility failed to honor food preferences for 1 of 3 current sampled residents (#168) reviewed for choices. This failure placed the resident at risk for compromised nutritional status and weight loss as well as a diminished quality of life.

Findings include:

Resident #168 was admitted to the facility on [REDACTED] 13 with diagnoses to include [REDACTED] and [REDACTED]

The resident was placed on a mechanical soft diet with thickened liquids due to swallowing difficulties following a [REDACTED]

On admission documentation, Resident #168 was noted to be allergic to lactose, milk and cheese products. The resident's Dietary Preference form indicated she disliked beef, cheese and rice.

On 7/10/13 at 5:30 p.m., Resident #168 was

F 242

F242

1. Resident #168 meal card updated to reflect food preferences assessment.
2. Residents dislikes added to tray card for Dietary staff to reference resident preference while serving.
3. Dietary and dining room staff educated on the importance of honoring dislikes when serving and auditing tray prior to serving to validate that residents are receiving only items according to resident preferences.
4. Resident food preference assessments to be kept current, reviewed and updated quarterly or as needed. Random tray audits for correct preferences by Dietary Manager and Registered Dietician. Results from audits will be reviewed through facility Quality Assurance process.
5. Date of completion: 8/13/13
6. Dietary Manager & Administrator to ensure compliance.

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

PRINTED: 07/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2013
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER AVAMERE OLYMPIC REHABILITATION OF SEQUIM	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5TH AVENUE SOUTH SEQUIM, WA 98382
------------------------------------------------------------------------------	------------------------------------------------------------------------------------

(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 242 Continued From page 2
observed trying to cut her beef enchilada casserole. Approximately 8 inches of the casserole was over-baked and hard. The edges were very dry and sharp. A mound of rice was on the resident's plate. The resident reported she was unable to eat the casserole because it was too hard to cut or eat. The resident pointed to the rice and stated, "I cannot eat rice."

At 5:49 p.m., the Dietary Manager (DM) stated, "Her meal is wrong because she doesn't like rice." The DM verified beef was in the casserole and stated while the resident's preferences were listed in a book in the kitchen they were not listed on the diet slip for the kitchen staff to read.

On 7/11/13 at 9:16 a.m., Licensed Nurse (LN) D reported the resident would eat well for some meals and not for others. LN D stated the resident was eating an average of 50% of her meals.

The facility failed to respect the right of the resident regarding her significant food preferences.

F 242

F 309 SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

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.

F309
1. Resident #15 re-assessed and care plan updated to reflect location of pain, resident specific presentation of pain and appropriate interventions for pain management.
2. Care plans audited and updated as needed to reflect accurate signs and symptoms of pain interventions.

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

PRINTED: 07/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2013
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER AVAMERE OLYMPIC REHABILITATION OF SEQUIM	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5TH AVENUE SOUTH SEQUIM, WA 98382
------------------------------------------------------------------------------	------------------------------------------------------------------------------------

(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 309 Continued From page 3
This REQUIREMENT is not met as evidenced by:
Findings include:

Based on observation, interview and record review, it was determined the facility failed to provide necessary care and services to attain or maintain the highest level of physical, mental and psychosocial well-being by failing to consistently monitor and effectively manage pain for 1 of 3 current sampled residents (Resident #15) reviewed for pain. This failure placed the resident at risk for untreated pain and diminished quality of life.

Resident #15 was admitted to the facility on 08 with diagnoses to include [REDACTED] and [REDACTED] (a [REDACTED] which can cause [REDACTED] in the [REDACTED] and [REDACTED]).

The annual Minimum Data Set (MDS), an assessment tool, dated 5/7/13, indicated Resident #15 had difficulty communicating some words or finishing thoughts but was usually able if prompted or given time. The Brief Interview for Mental Status and the Resident Mood Interview were not completed because the resident was "rarely/never understood."

The MDS further indicated Resident #15 was non-ambulatory and required extensive assistance of two persons with bed mobility, transfers and toileting. She required extensive assistance of one person for locomotion on the unit with use of a wheelchair and was on a scheduled medication regimen for pain.

F 309
F309 Continued:
3. Staff educated on pain management, documentation and assessment of the cognitively impaired resident. Will routinely audit pain assessments and care plans quarterly and as needed.
4. Results from audits will be reviewed through facility Quality Assurance process.
5. Date of completion: 8/13/13
6. Director of Nursing to ensure compliance.

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

PRINTED: 07/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2013
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER AVAMERE OLYMPIC REHABILITATION OF SEQUIM	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5TH AVENUE SOUTH SEQUIM, WA 98382
------------------------------------------------------------------------------	------------------------------------------------------------------------------------

(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 309 Continued From page 4

F 309

Resident #15's Care Plan for pain, dated 5/7/13, indicated the resident had chronic pain related to [REDACTED] and [REDACTED]. It instructed staff to assess for pain with each interaction and ask the resident frequently if she was having pain. The Care Plan did not identify the location of Resident #15's pain or what might trigger or relieve her pain. Interventions included treatment with medication and repositioning for comfort.

The pain assessment log on Resident #15's Medication Administration Records (MARs) for June and July, 2013, on every shift, documented according to a pain scale of 0/10 (0 indicating no pain and 10 indicating the worse) pain assessment for Resident #15. The record indicated the resident had no pain (0/10) in June and July 2013 on each shift, each day between 6/1/13 and 7/10/13 except for four instances on evening shift. On 6/2/13 the resident record indicated 2/10 pain. On 6/18/13 the record indicated the resident had 2/10 pain. On 6/21/13 the record indicated the resident's pain level was 4/10, and on 6/28/13 it was assessed at 5/10).

Resident #15's MARs for June and July, 2013, documented that she received [REDACTED] 100 milligrams (mg) routinely for pain four times per day. She had an order for [REDACTED] 5-325 mg as needed for pain every six hours. Between 6/1/13 and 7/10/13, Resident #15 received [REDACTED] three times (6/21/13 at 4:50 p.m. and 6/28/13 at 5:23 p.m). On 7/10/13 at 11:55 p.m. the resident was medicated when the surveyor asked Licensed Nurse (LN) C to assess the resident.

On 7/08/13 at 3:19 p.m., Resident #15 was

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

PRINTED: 07/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2013
NAME OF PROVIDER OR SUPPLIER AVAMERE OLYMPIC REHABILITATION OF SEQUIM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5TH AVENUE SOUTH SEQUIM, WA 98382		
(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 309	<p>Continued From page 5</p> <p>observed in bed, moaning loudly, fidgeting and grabbing at her Depends near her hip, appearing agitated and restless. When the surveyor asked what she needed, Resident #15 lifted her head, reached out with her hands and said repeatedly, "Help me honey, help me."</p> <p>On 7/10/13 at 9:54 a.m., NA B stated she regularly cared for and was very familiar with Resident #15. NA B stated Resident #15 had a lot of pain and sometimes said her back hurt; other times Resident #15 would rub or hold her back and behave in an agitated manner, indicating she was in pain. NA B stated when she observed Resident #15 in pain she reported it to the nurse. "If the nurse says it's not time yet for pain medication, the aides will take Resident #15 to the bathroom or reposition her," as indicated in the resident's care plan.</p> <p>At 10:18 a.m., NAA stated she regularly cared for and was familiar with Resident #15. NAA stated, "I'm pretty sure she has a lot of pain." NAA stated that when Resident #15 was in pain, she moaned a lot and got loud and agitated, especially with transfers. "It's her back. I report it to the nurse. She checks to see if it's time for pain medication. If not, the aides try repositioning."</p> <p>At 11:40 a.m., Resident #15 was observed in bed, squirming and fidgeting, rubbing the left side of her lower back, and appeared to try to get up. She was moaning loudly, appeared restless and agitated, reaching her hand out to the surveyor. Resident #15 said, "I don't know what I want. Please help me. Don't leave me here to die. Put me in the wheelbarrow," pointing toward her</p>	F 309			

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

PRINTED: 07/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2013
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER AVAMERE OLYMPIC REHABILITATION OF SEQUIM	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5TH AVENUE SOUTH SEQUIM, WA 98382
------------------------------------------------------------------------------	------------------------------------------------------------------------------------

(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 309 Continued From page 6 wheelchair.

When the surveyor put on the call light, NAA and NA B responded. Resident #15 continued moaning loudly, rubbing the left side of her lower back and calling out, saying, "Put me in the wheelbarrow." Resident #15 remained agitated and restless as NAA and NA B used the sit-to-stand lift to transfer her into her wheelchair, repeatedly saying, "She's gonna kill me, please don't let her kill me."

Once Resident #15 was in her wheelchair, NAA wheeled her out to a location near the nursing station. The resident remained agitated and continued to cry out, saying, "Take me to the window." LN C asked Resident #15 if she was in pain. Resident #15 did not answer the question but continued moaning and saying, "Take me to the window." LN C wheeled Resident #15 to a window in the hall near the dining room.

Resident #15 continued moaning loudly and at approximately 11:50 a.m., LN C stated she would get the resident some pain medication. Resident #15 received [redacted] 5-325mg at 11:55 a.m. approximately two hours after the resident was noted to exhibit signs and symptoms of pain.

At 12:30 a.m., Resident #15 was observed sitting in her wheelchair near the dining room. She was quiet, calm and appeared to be comfortable. When asked by the surveyor if she had pain, Resident #15 did not answer directly; she calmly made references to her wheelbarrow, smiled and asked the surveyor, "What's your name, honey?"

At 3:01 p.m., Resident #15 was observed

F 309

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

PRINTED: 07/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2013
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER AVAMERE OLYMPIC REHABILITATION OF SEQUIM	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5TH AVENUE SOUTH SEQUIM, WA 98382
------------------------------------------------------------------------------	------------------------------------------------------------------------------------

(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 309 Continued From page 7
sleeping in bed. She appeared restful and still.

On 7/11/13 at 9:30 a.m., LNA stated he often worked on Resident #15's hall and was very familiar with her. LNA, stated when he assessed Resident #15 for pain, he observed whether she was at her baseline, which usually presented with some mild agitation, a mild degree of restlessness, and reaching out to hold hands with staff. LNA said when Resident #15 became more restless, loud, groaning and calling out, it was an indication Resident #15 was in pain. LNA stated that Resident #15 had occasionally verbalized pain in back or her right shoulder. He stated he had not observed her outside her baseline at any time during June and July, 2013. When the surveyor described observations made of Resident #15 on 7/8/13 and 7/10/13, LNA stated they sounded like instances in which the resident was in pain. This information was not communicated in the resident's Care Plan for pain.

At 10:02 a.m., LN B stated she was very familiar with Resident #15. She had often worked with Resident #15 over several years but had not been assigned to Resident #15's hall during June or July, 2013. LN B stated that Resident #15 was very verbal and made a lot of noise such as moaning when she was in pain. LN B stated, "Both her shoulders are bone on bone. When she moves her arms wrong, when she really aches, yells or says it hurts, [REDACTED] will not be enough to treat her pain. That's when I give her [REDACTED]."

When the surveyor showed LN B the pain assessments for June and July, 2013,

F 309

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

PRINTED: 07/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2013
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER AVAMERE OLYMPIC REHABILITATION OF SEQUIM	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5TH AVENUE SOUTH SEQUIM, WA 98382
------------------------------------------------------------------------------	------------------------------------------------------------------------------------

(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 309 Continued From page 8
consistently assessing Resident #15's pain at 0/10, LN B stated, "Resident #15 is never 0/10. She always has some pain, at least 2/10." LN B stated that the nursing assistants often reported to her that Resident #15 was presenting with pain; LN B would then assess the resident herself and administer [redacted] if [redacted] was not managing the resident's pain. LN B stated Resident #15 needed to be assessed for pain throughout each shift; she said it would be rare for Resident #15 to go through an entire shift without presenting evidence of pain.

LN B stated she did not think the consistent 0/10 pain assessments documented in June and July, 2013, reflected accurate or comprehensive assessments of Resident #15's pain.

F 309

F 311 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS
SS=D
A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review it was determined the facility failed to provide appropriate treatment and services to maintain or improve activities of daily living (ADLs) for 1 of 3 current sampled residents (Resident #17) reviewed for ADLs. This failure placed residents at risk of not achieving their highest practicable level of function with ADLs.

F311
F 311 1. Resident #11 re-assessed for Restorative program. Care plan updated to reflect current restorative goals.
2. Resident Restorative Programs reviewed and revised as needed. Care plans reviewed for accuracy and updated as needed.
3. The new Restorative Program Director educated on timely assessments and keeping current and accurate documentation of restorative programs, including documentation of refusals of care. The Restorative Program Director will meet routinely with Restorative Aides to communicate residents current status and review appropriateness of programs.
4. Routine audits of Restorative assessments, care plans, and documentation to ensure program is current and accurate. Results will be reviewed through facility Quality Assurance process.

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

PRINTED: 07/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2013
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER AVAMERE OLYMPIC REHABILITATION OF SEQUIM	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5TH AVENUE SOUTH SEQUIM, WA 98382
------------------------------------------------------------------------------	------------------------------------------------------------------------------------

(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 311 Continued From page 9

Findings include:

Resident #17 was originally admitted to the facility from the hospital on [REDACTED] 12 with diagnoses to include [REDACTED]s and [REDACTED] with [REDACTED]. The resident had been living at home with a family member and came to the facility for rehabilitation services for strengthening with the goal of returning home.

On 12/14/13, Resident #17 discharged to home and was readmitted on [REDACTED] 13 after declining at home. On 2/22/13, she was discharged to the hospital with a [REDACTED] and was readmitted on [REDACTED] 13. She discharged to the hospital on 3/28/13 with [REDACTED] and was readmitted on [REDACTED] 13.

The Minimum Data Set (MDS), an assessment tool, dated 4/16/13, indicated Resident #17 was alert, oriented and able to communicate her needs. She was non-ambulatory and required extensive assistance of two or more persons with bed mobility, transfers and toileting. She required extensive assistance of one person with use of a wheelchair for locomotion on the unit.

The Physical Therapy Discharge Summaries dated 12/19/12, 1/4/13, 2/27/13, 3/29/13, and 5/31/13 revealed that Resident #17 initially made progress with transfers and ambulation but after discharging to the hospital with a [REDACTED] and later with [REDACTED], the resident declined. On 12/14/13, Resident #15 was ambulating 200 feet with supervision. On 2/22/13, she ambulated 60 feet with 10% hands-on assistance. When Resident #17 was last discharged from physical

F 311

F 311 continued:

- Date of completion 8/13/13
- Director of Nursing to ensure compliance.

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

PRINTED: 07/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2013
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	----------------------------------------------

NAME OF PROVIDER OR SUPPLIER AVAMERE OLYMPIC REHABILITATION OF SEQUIM	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5TH AVENUE SOUTH SEQUIM, WA 98382
------------------------------------------------------------------------------	------------------------------------------------------------------------------------

(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 311 Continued From page 10
therapy on 5/30/13, she was non-ambulatory and required maximum assistance with 90-100% hands on for transfers.

The Restorative Nursing Referral Form, dated 5/21/13, signed by the Rehabilitation Staff (RS) and Licensed Nurse (LN) C, documented a plan for Resident #17 including daily restorative services for transfers, with transfer pole as needed, and standing at a standing frame to increase strength and range of motion (ROM) for functional mobility. It stated the resident would "stand at frame at intervals as tolerated until she can manage 10 minutes at a time."

The restorative nursing logs for May, June, and July 2013 revealed the resident received services according to the restorative plan during the MDS assessment period, between 6/23/13 and 6/29/13. Resident #17 received restorative services six times; once each day. After the MDS assessment period the resident received restorative services only three times per week instead of once daily. The services provided included standing at a standing frame and ROM to her left knee. There was no documentation of the resident refusing to participate.

Resident #17's Care Plan indicated that restorative nursing services for use of a standing frame were not added to the Care Plan until 7/3/13, and ROM services were not added until 7/8/13.

A review of Resident #17's nursing progress notes revealed only one "Restorative Nursing" entry since the resident's current admission on 7/13; it was written on 7/8/13 at 15:22 p.m. by

F 311

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

PRINTED: 07/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2013
NAME OF PROVIDER OR SUPPLIER AVAMERE OLYMPIC REHABILITATION OF SEQUIM		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5TH AVENUE SOUTH SEQUIM, WA 98382		
(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 311	<p>Continued From page 11 LN F.</p> <p>Multiple observations of the resident each day from 7/15/13 through 7/18/13 showed Resident #17 to be dependent on staff to propel her in her wheelchair. Resident #17 was observed several times sitting near the nursing station when staff asked her if she was ready for them to take her to her room or the dining room and the resident indicated yes.</p> <p>On 7/8/13 at 10:51 a.m., Resident #17 stated that her goal was to get strong enough to discharge home.</p> <p>On 7/10/13 at 3:17 p.m., the Rehabilitation Director (RD) stated Resident #17 had lost some degree of physical function each time she was readmitted to the facility but consistently participated in therapies, with no pattern of refusing treatment.</p> <p>On 7/11/13 at 11:16 a.m., NA C stated he had worked with Resident #17 from 5/25/13 to the present. NA C stated that Resident #17 actively participated in restorative services and had steadily improved; the resident was consistently standing for the full 10 minutes with each session. NA C stated it was not up to him to decide when to advance the interventions and licensed nursing staff had not discussed with him the possibility of advancing Resident #17's regimen to a higher level of function.</p> <p>At 10:24 a.m., LN E was unable to locate documentation of ongoing nursing assessment and review of Resident #17's restorative nursing needs and interventions. LN E stated she was</p>	F 311		

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

PRINTED: 07/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2013
NAME OF PROVIDER OR SUPPLIER AVAMERE OLYMPIC REHABILITATION OF SEQUIM		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5TH AVENUE SOUTH SEQUIM, WA 98382		
(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 311	<p>Continued From page 12</p> <p>assigned to manage the restorative nursing program approximately one month ago and was still in training for the program.</p> <p>At 12:09 p.m., LN F stated she would attempt to locate restorative nursing aide logs and all documentation of ongoing nursing assessment and review of Resident #17's restorative nursing needs and interventions from 5/21/13 to present.</p> <p>At 1:02 p.m., LN F stated she was unable to locate documents to verify ongoing nursing review and assessment of Resident #17's progress with restorative services. Nor was she able to locate documentation indicating the rationale for why Resident #17 received restorative nursing services only three times per week when the referral, dated 5/21/13, indicated services would be provided daily.</p> <p>LN F stated the facility's restorative nursing program was "in transition." LN F stated that LN E was assigned responsibility for the program after the previous restorative nursing manager left. In June, 2013, LN F was brought in to train LN E and make improvements in the program, which was an ongoing process. LN F found the previous restorative nursing program did not keep current, accurate documents or complete timely assessments to assure resident restorative programs were appropriate.</p> <p>At 2:08 p.m., the Director of Nursing Services (DNS) stated the Resident Care Managers (RCMs) were supposed to manage the restorative programs for their residents after the previous restorative program manager left. When it was determined this plan was not</p>	F 311		

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

PRINTED: 07/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2013
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER AVAMERE OLYMPIC REHABILITATION OF SEQUIM	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5TH AVENUE SOUTH SEQUIM, WA 98382
-------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------

(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 311	Continued From page 13 working, it was decided that LN E would be trained to manage the restorative program. During the transition period after the former restorative program manager left the facility, the facility failed to provide appropriate treatment and services to maintain or improve resident ADLs.	F 311		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure food was nutritive, palatable and served at safe temperatures for 13 of 34 current sampled residents (#168, 81, 147, 50, 92, 122, 62, 89, 63, 120, 154, 52 & 90) reviewed for food quality. This failure placed residents at risk for compromised nutritional status, weight loss, food-borne illness and diminished quality of life. Findings include: Dining observations were made of the independent dining room, the assisted dining room and hall trays during lunch on 7/8/13. Lunch and dinner observations were made in the	F 364	F364 1. Residents #168, 81, 147, 50, 92, 122, 62, 89, 63, 120, 154, 552 & 90 were re-assessed for dietary preferences. Dietary Manager met with residents to determine satisfaction with meal quality, presentation, and temperature; preferences updated, and progress note completed. Trays were tested and validated to be at correct temperature when served. 2. Residents listed and additional sample of residents surveyed for satisfaction. New menus implemented. Post-meal trays monitored for trends of food not eaten and reported to Dietary Manager. Dietary staff in-serviced on proper cooking techniques, presentation, consistency, temperature, and taste. Resident Food Committee initiated and meetings scheduled to discuss food complaints, compliments, requests, issues residents wish to discuss, and resident menu planning as able or desired. Beverages placed in freezer prior to meals to ensure temperature control. Food service dishes heated prior to serving to ensure hot food remained above proper temperature.	

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

PRINTED: 07/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2013
NAME OF PROVIDER OR SUPPLIER AVAMERE OLYMPIC REHABILITATION OF SEQUIM		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5TH AVENUE SOUTH SEQUIM, WA 98382		
(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 364	<p>Continued From page 14</p> <p>independent and assisted dining rooms on 7/10/13. Lunch observations were made in the independent and assisted dining rooms on 7/12/13.</p> <p><Food palatability></p> <p>On 7/8/13 at 11:30 a.m., Resident #62 stated, "I don't like the food, it's horrible. It's too salty. I don't like the boiled rice because it has no flavor."</p> <p>At 2:45 p.m., Resident #90 stated, "I don't think the food here is good. Sometimes it will look o.k. but it doesn't taste good. It's bland. I use my own condiments to add some flavor."</p> <p>At 4:31 p.m., Resident #81 stated, "We need more fresh fruit and vegetables."</p> <p>The Dietary Manager (DM) provided the menu for the week of 7/8/13 through 7/14/13. The lunch menu for 7/8/13 indicated beef tips with gravy, garlic and onion mashed potatoes, mixed vegetables and pumpkin bread were to be served.</p> <p>On 07/08/13, the lunch meal was observed to be brown gravy with a few bits of meat over mashed potatoes. The frozen vegetables were observed to be mushy and overcooked.</p> <p>On 7/9/13 at 9:33 a.m., Resident #52 stated, "The food is bland and unappealing."</p> <p>At 9:49 a.m., Resident #147 reported he received "ground up food" which was unappealing and had little flavor.</p>	F 364	<p>F364 continued:</p> <p>3. Caring Partner rounds updated to add questions for residents about Food preferences being honored and meal satisfaction. Dining Room Monitor Audit forms updated to add observations of food items enjoyed or not eaten, as well as observation of overall resident satisfaction and comments/discussions about meal.</p> <p>Staff educated on importance of timely service of meals to ensure food served at proper temperature.</p> <p>Beverages will be served directly to residents in the dining room at time of the meal service.</p> <p>4. Results from residents surveys, committee feedback, caring partner rounds & meal monitors, including routine monitoring of food and beverage temperatures at time of cooking, serving, and delivering of trays to validate proper temperature at points of service. Results will be reviewed through facility Quality Assurance Process.</p> <p>5. Date of completion 8/13/13</p> <p>6. Dietary Manager & Administrator to ensure compliance.</p>	

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

PRINTED: 07/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2013
NAME OF PROVIDER OR SUPPLIER AVAMERE OLYMPIC REHABILITATION OF SEQUIM		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5TH AVENUE SOUTH SEQUIM, WA 98382		
(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 364	<p>Continued From page 15</p> <p>At 10:22 a.m., Resident #168 reported she did not like the food.</p> <p>At 12:00 p.m., Resident #154 stated, "I don't like the food, especially lunch and dinner. Breakfast is o.k. most of the time."</p> <p>The lunch menu for 7/10/13 indicated cranberry turkey breast, new potatoes, winter vegetable mix and angel food cake were to be served.</p> <p>On 07/10/13, the lunch meal was observed to be boiled white potatoes cut into chunks. There was no sauce or seasonings observed on the potatoes. The frozen vegetables were observed to be mushy and colorless, and overcooked.</p> <p>The dinner menu for 7/10/13 indicated beef enchiladas, Spanish rice, tossed salad, and peach cobbler were to be served.</p> <p>On 07/10/13, the dinner meal's enchiladas were observed to be dried, hard, overcooked tortillas. The rice was pink in color and sticky. The salad consisted of approximately one-fourth to one-third cup of lettuce. There were no other vegetables observed in the salad.</p> <p>At 5:30 p.m., Resident #168 was observed trying to cut her enchilada casserole. Approximately 8 inches of the casserole was over-baked and hard. The edges were very dry and sharp. A mound of rice was on the resident's plate and her lettuce salad had been blended into very small, wet pieces. The resident reported she was unable to eat the casserole because it was too hard to cut or eat. The resident pointed to her salad and stated, "I can't eat that."</p>	F 364		

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

PRINTED: 07/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2013
NAME OF PROVIDER OR SUPPLIER AVAMERE OLYMPIC REHABILITATION OF SEQUIM		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5TH AVENUE SOUTH SEQUIM, WA 98382		
(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 364	<p>Continued From page 16</p> <p>The resident's meal slip indicated she was to have a mechanical soft diet as she had difficulty swallowing.</p> <p>At 5:49 p.m., the DM verified the resident was to receive a mechanical soft diet and she would be unable to eat the casserole that was served to her. The DM reported the kitchen staff were to monitor the food as it was being plated to ensure the residents received the ordered diet.</p> <p>The DM reported that the enchilada casserole was considered a mechanical soft food if it was prepared properly with the sauce covering the tortilla to keep it moist. The DM stated, "A resident should only have to chew each bite 10-12 times on a mechanical soft diet. What she was given is unacceptable."</p> <p>During the dinner meal on 07/10/13, the following resident observations and statements were made:</p> <p>Resident #62 was observed attempting to cut the hard pieces of the casserole. The resident stated, "I can't eat it if I can't even cut it." The resident pointed to the bowl of pureed lettuce and stated, "That's horrible. I won't eat that. And the rice is awful. There isn't any flavor. It seems all we ever get is rice."</p> <p>Resident #89 stated, "I refuse to eat this. It's terrible."</p> <p>Resident # 50 stated, "All we ever get is rice, rice, rice. Rice for every meal and it has no taste. I refuse to eat it any more. We never have fresh</p>	F 364		

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

PRINTED: 07/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2013
NAME OF PROVIDER OR SUPPLIER AVAMERE OLYMPIC REHABILITATION OF SEQUIM			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5TH AVENUE SOUTH SEQUIM, WA 98382		
(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 364	Continued From page 17 fruit or vegetables. It's melon season. You would think we could have fresh melon. The only vegetables we get are canned or frozen. Oh, I guess we get lettuce sometimes." Resident # 63 stated, "Every meal is rice. It would be nice if we had potatoes or noodles sometimes. I would like some fruit that isn't canned. I can't remember the last time we had fresh fruit. And I refuse to eat that pureed lettuce." Resident # 120 stated, "I don't like the food. We have bland rice all the time. We don't have fresh fruit or vegetables." Resident # 122 stated, "They gave me lettuce that went through a blender. How do they expect me to eat that? I haven't had fresh fruit or veggies since I've been here. My family brings me fresh fruit. And I keep soy sauce to flavor the rice." Resident # 92's son-in-law reported he comes several nights per week to eat dinner with her. He reported he has not seen any fresh fruit served to her. Following the 07/10/13 dinner meal, 12 of 22 plates in the independent dining room were observed to have more than 80% of the rice left on the plates after the residents finished dinner. The dinner menu for 7/8/13 to 7/14/13 indicated rice would be served 4 of 7 days. A sample tray containing the 07/10/13 dinner meal was tasted by the DM and the surveyor. The DM reported the meal was "bland." The DM	F 364			

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

PRINTED: 07/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2013
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER AVAMERE OLYMPIC REHABILITATION OF SEQUIM	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5TH AVENUE SOUTH SEQUIM, WA 98382
-------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------

(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 364 Continued From page 18
reported the menus and recipes came directly from the corporate office and she was expected to follow them. The DM stated she would prefer more freedom to design meals specifically for resident tastes and preferences.

<Food temperatures>

Per United States Food and Drug Administration Food Code 2009, cold food must "be at a temperature of 41 degrees Fahrenheit or below when received." Cooked foods should be received hot and must "be at a temperature of 135 degrees F or above."

On 7/10/13 a test tray containing the evening's regular and pureed meal, including beverages, was sampled for temperatures.

At 6:00 p.m., the following temperatures were taken by the DM, using a facility thermometer. There was an approximate 10 minute lapse from the time the tray returned to the kitchen and the time the temperatures were taken.

Chicken rice soup -124.5 degrees Fahrenheit (F)
Spanish rice - 130.5 degrees F
Apple juice - 58.4 degrees F
Apple sauce - 61.8 degrees F
Tossed salad - 63.6 degrees F
Pureed green salad - 60.9 degrees F
Milk - 50.9 degrees
Peach cobbler made with canned peaches - 67.3 degrees.

At 6:40 p.m., the DM verified the temperatures were not within the safe range.

F 364

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

PRINTED: 07/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2013
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER AVAMERE OLYMPIC REHABILITATION OF SEQUIM	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5TH AVENUE SOUTH SEQUIM, WA 98382
-------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------

(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 364	<p>Continued From page 19</p> <p>On 07/11/13 a second test tray was sampled for temperature during the lunch meal. A regular meal and a pureed meal were tested. The following temperatures were taken by the DM, using a facility thermometer:</p> <p>Pureed entrée - 113 degrees F Pureed salad - 67.8 degrees F Beef and pasta entrée - 116 degrees F Lettuce salad - 61.9 degrees F Juice - 61.8 degrees F Spice cake - 66.0 degrees F.</p> <p>At 12:57 p.m., the DM stated, "The food is hot when it leaves the steam table but I question our system at this point. The foods shouldn't be served at these temperatures." The DM confirmed foods must be served below 41 degrees F or above 135 degrees F.</p>	F 364		
F 371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 371	<p>F371</p> <ol style="list-style-type: none"> 1. Unlabeled food items were discarded. 2. Visual inspection of refrigerators validated items labeled per regulation. 3. Dietary staff in-serviced on proper labeling and storage techniques. Dietary staff in-serviced on Policy and Procedure on dishwasher temperature monitoring, including when, how and where to log temps and when to report to maintenance. 3. Dietary manager to complete routine audits of food storage to validate appropriate techniques practiced. Random audits of dishwasher temperatures and proper documentation. 4. Results will be reviewed through facility Quality Assurance process. 5. Date of completion: 8/13/13 6. Dietary Manager to ensure completion. 	

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

PRINTED: 07/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2013
NAME OF PROVIDER OR SUPPLIER AVAMERE OLYMPIC REHABILITATION OF SEQUIM		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5TH AVENUE SOUTH SEQUIM, WA 98382		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	<p>Continued From page 20</p> <p>Based on observation, interview and record review it was determined the facility failed to store, prepare and serve food under sanitary conditions. This failure created the potential for foodborne illness for all residents receiving food prepared by the dietary department.</p> <p>Findings include:</p> <p><Food Storage></p> <p>On 7/8/13 at 8:40 a.m., during rounds with the Dietary Manager (DM), several open containers of salad dressings and condiments, including large bulk containers and smaller serving containers, were observed in the refrigerator labeled #2. There was no indication of when the items were opened. When asked, the DM stated the facility policy was to label all food items with the date they were opened.</p> <p><Sanitization of dishes and utensils></p> <p>On 7/8/13 at 8:45 a.m., the DM stated the facility used a high temperature mechanical dishwasher process for sanitizing dishes and utensils: the wash cycle must be at least 150 degrees Fahrenheit (F) and the rinse cycle must be at least 180 degrees F. Dishwashing staff were instructed to report temperatures outside those parameters to the DM.</p> <p>The July 2013 Dishwasher Temperature Log posted on the outside of the dishwasher indicated that from 7/1/13 through 7/4/13 the temperatures at dinner were below 150 degrees F for the wash cycle and below 180 degrees F for the rinse cycle</p>	F 371		

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

PRINTED: 07/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505327	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2013
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER AVAMERE OLYMPIC REHABILITATION OF SEQUIM	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 5TH AVENUE SOUTH SEQUIM, WA 98382
-------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

F 371 Continued From page 21
(the wash cycle was between 140 and 145; the rinse cycle was between 160 and 165). The DM stated dishwashing staff should have reported the low temperatures but did not. The DM said the staff person who logged the low temperatures may have taken the temperatures during the first dishwasher "run" for that meal but it took three runs for the dishwasher temperatures to rise to the proper level.

Kitchen Staff (KS), who was operating the dishwashing machine, stated he could tell the temperatures during the first run were below the proper level "because the dishes don't dry as fast." The DM stated the facility policy was to run the dishwasher empty for two runs before putting dishes in the dishwasher; staff should not be putting dishes in the dishwasher on the first run.

<Food Service>

See F364 - Food Temperatures

F 371