

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

1392

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505367	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/14/2013
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NAME OF PROVIDER OR SUPPLIER WILLOW SPRINGS CARE AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 4007 TIETON DRIVE YAKIMA, WA 98908
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Willow Springs Care and Rehabilitation Center on 06/10/13, 06/11/13, 06/12/13, 06/13/13, and 06/14/13. A sample of 47 residents was selected from a sample of 63. The sample included 20 current residents, the records of 5 former and/or discharged resident, and 22 supplemental residents.</p> <p>The survey was conducted by:</p> <p>██████████ RN ██████████, RN ██████████, RN ██████████, RN</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services, District 1, Unit D 3611 River Road, Suite 200 Yakima, Washington 98908</p> <p>Telephone: (509) 225-2800 Fax: (509) 574-5597</p> <p><i>Robert L. Steiner</i> 6/20/13 Residential Care Services Date 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p>	F 000	<p>ADDENDUM TO PLAN OF CORRECTION</p> <p>Submission of the 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, the Administrator 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.</p> <p>Accordingly, the Facility has prepared and submitted this Plan of Correction 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 the Title 18 and Title 19 programs. The submission of the Plan of Correction within this time frame should in no way be considered or construed as agreement with the allegations of non compliance or admissions by the facility.</p> <p style="text-align: right;">Received Yakima RCG JUN 28 2013</p>	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jamara Beumen RN</i>	TITLE <i>DRS</i>	(X6) DATE <i>6/28/13</i>
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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 241	<p>Continued From page 1</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to promote care in a manner that maintained their dignity for 3 of 21 residents (#13, 67, 149) interviewed. That lack of respect for dignity and individuality placed them at risk of lowered self esteem and/or embarrassment. Findings include:</p> <p>Resident #67. Admitted with diagnoses of a [REDACTED] and [REDACTED]. On 05/26/13 the nutritional assessment noted he was on a puree diet and did not feed himself due to his hand contracture. The current care plan directed total assistance with eating a puree diet with thickened liquids.</p> <p>On 06/10/13 at approximately 5:00 p.m., the resident was seated in a wheelchair in the dining room at a table with two other residents. Upon being served his food, the resident fed himself using a spoon but his plate was positioned approximately five inches from the table edge causing him to reach for his plate. He spilled the mashed potatoes onto the table while attempting to reach his mouth. He scooped them up off of the table and put them in his mouth.</p> <p>At approximately 5:30 p.m Staff Member H fed him his meal. She stood while completing this task, looked around the dining room, and talked</p>	F 241	<p>Resident # 67: Resident is unable to recall the evening meal on 6/10/13. He states that he is happy with everything at this time. Resident #149: Resident states that he is very happy with the staff and care at Willow Springs. He would not discuss "whatever the Surveyor stated". He stated that the staff at Willow has always treated him with dignity and respect. He has since been discharged home. Resident # 13: Resident has had facial hair removed. Care plan has been updated to include the removal of facial hair.</p> <p>Staff has been re- inserviced on skills that promotes and enhances respect and dignity. Nursing assistants have been retrained on skills that included feeding and grooming. All in-services focused on providing care for the resident while maintaining a resident's privacy when living in a communal environment.</p>	7/01/2013
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F 241	<p>Continued From page 2</p> <p>with other residents and staff at other tables. She did not communicate with the resident except to ask if he was ready for another bite or telling him to "swallow." She did not tell him what food item he was to eat prior to putting it into his mouth. Staff Member A, the Staff Development Director, asked Staff Member H if she wanted a chair, but she said "no", she was "fine" standing.</p> <p>At 5:47 p.m. Staff Member H left the resident without an explanation to him and went to another resident. She returned to Resident # 67 and asked him if he was "holding" food in his mouth; she then asked "let me see." She called over the resident to talk with a resident at another table.</p> <p>During the entire time she was assisting Resident #67 with his meal, she was not focused on him as an individual to ensure his meal was enjoyable and homelike. Also, she did not re-warm the food which had sat for at least ten minutes prior to the start of her assisting the resident.</p> <p>Further, the resident had a white substance dripping from his nose, which he had upon entering the dining room. While feeding him, Staff Member H attempted to wipe the substance off in full view of the two other residents at the table. She did not succeed in removing the substance.</p> <p>Resident #149. The 06/05/13 skin assessment documented a reddened area on the resident's bottom which was resolved. Continued monitoring of the skin was being completed weekly.</p> <p>On 06/11/13 at approximately 10:45 a.m. he</p>	F 241	<p>All residents will be assessed at time of admission of the need for grooming of facial hair. Residents requesting the removal of facial hair will now be care planned for grooming as needed.</p> <p>The Staff Development Director will continue to inservice all staff on ways to provide care so that a resident's dignity is maintained. Managers throughout the facility will conduct random audits to ensure compliance. Social Service will meet with residents to ensure that Willow Springs is providing an environment that is maintaining or enhancing their dignity and respect.</p> <p>The Quality Assurance Committee will monitor quarterly to assure compliance. Director of nursing to ensure completion. Administrator to oversee.</p>	

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F 241	Continued From page 3 stated "yesterday I was in the hall getting pills from the nurse. Another nurse came up behind me and pulled my pant out and looked down them." When he turned and asked her "what the hell" she was doing, she said checking the ulcer on his bottom. As a way of explanation, she told him they were just "one big family" in the nursing home. Resident #13. Review of the current care plan noted she was dependent for all grooming needs. On 06/12/13 at 12:30 p.m. the resident had visible chin hairs which were a couple of inches in length. On 06/14/13 at 9:30 a.m. the visible long gray strands of hair remained on the resident's chin. When asked if she minded having the long chin hairs, she said "yes" she did mind having them.	F 241			
F 279 SS=D	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	F 279			

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F 279	<p>Continued From page 4</p> <p>§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).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to A) identify activities, or a lack thereof, on the plan of care for 1 of 3 residents (#128) in the sample reviewed for activities; and failed to B) identify on the plan of care a potential for falls for 1 of 3 residents (#32) in the sample reviewed for falls. Findings include:</p> <p>A. Resident #128. The resident had sustained a [REDACTED] leg which required her to be non-weight bearing.</p> <p>The Activity Assessment, dated 05/07/13, noted the resident liked some games, was interested in crafts, watched some sports, liked soft and country western music and was religious. The Care Area Assessment for Activities, dated 05/09/13, noted the resident had little interest or pleasure in doing things. The resident had stated she was in the facility for rehab and planned to return to her home. She was involved in independent activities, such as watching TV, reading the daily paper, talking and visiting with family. The Care Area Summary identified that Activities was to be included on the plan of care for Resident #128.</p> <p>On 06/12/13 at approximately 3:30 p.m. the resident stated she did not wish to be out of her</p>	F 279	<p>Resident #128: Resident continues to receive the daily chronicle that has a list of daily activities in the content. The Activity Director reviewed to Daily Chronicle with the resident and showed her where to locate the daily activities. Resident now will have a full calendar posted in her room monthly. The resident has also been offered magazines, word search puzzles as per her request. Her care plan has been updated. Resident will be reminded and invited to Bingo when it is scheduled.</p> <p>All residents have been reminded that the Daily Chronicle has a list of daily activities on the back page. Residents not wishing to attend group activities will be offered things in their rooms. Full activity calendars will be posted in their rooms when requested. All residents will have a Activity Care Plan started when admitted to facility.</p>	7/01/2013

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F 279	Continued From page 5 room for activities; however, she did state she might come out for Bingo if she knew when it was scheduled. She also stated the facility did not provide her with things to do while in her room. On all days of survey, 06/10-14/13, there was no activity calendar posted in the resident's room. Review of the plan of care noted there was no problem for activities identified. On 06/12/13 at approximately 3:00 p.m., Staff Member B stated the plan of care did not identify activities even though the Care Area Summary noted it would be care planned. B. Resident #32. The Fall Risk Assessment, dated 04/26/13, noted the resident was at high risk for falls. She had fallen at home and sustained a [REDACTED]. She was very frail and was to receive physical therapy to regain some strength and return home to independent living. Review of the plan of care noted that a potential for falls due to her high risk was not identified. The resident had documented falls on 05/31/13 and 06/12/13.	F 279	.The Activity Director will meet with new admits to make sure that residents preferences in activities are being met. Care plans will be reviewed quarterly and updated as needed. Resident Council meeting minutes will be monitored during the Quality Assurance meeting to ensure that preferences and Activities are per residents' request. Activity Director will ensure compliance. Administrator to oversee. <i>Amended SOD</i> Res plan All Lic Care P falls. A All reside falls have reviewed and updated as All resident s admitted to Willow Springs with a history of falls or altered mental status will have a care plan initiated on day of admit. Restorative Director will review all new admits to ensure Care Planning is complete. Medical Records will audit all new admits to ensure completion. Director of Nursing will monitor for compliance Administrator will oversee.	7/01/2013	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323			

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F 323	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure adequate supervision for 1 of 3 residents (#32) in the sample reviewed for falls/accidents. Failure to put appropriate interventions in place resulted in the resident falling in spite of the facility's knowledge of her history of falls. Findings include: Resident #32. The resident was admitted to the facility following a fall at home where she sustained a [REDACTED]. She required 2-person extensive assistance with all transfers and she received physical therapy to enable her to return to an independent living situation. On 04/26/13 the Fall Risk Assessment noted the resident was at high risk for potential falls. Bed and chair alarms were put in place following that assessment, however, the plan of care did not include the resident's risk for falls with appropriate interventions identified. Progress notes, dated 05/31/13 at 5:38 p.m., documented the resident was found laying on the floor next to the bed. She stated she rolled out of bed. She sustained a small skin tear to the left elbow. On the evening of 06/12/13 the resident was found sitting on the floor. Staff asked her what happened and she told them she wanted to remove the mat that was on the floor beside her bed so she could get in her wheelchair and go out of her room. A Licensed Nurse documented the "resident appeared to have attempted to get out of recliner, trying to push away the fall matt	F 323	The resident has had her care plan reviewed with interventions put in place. All Licensed Nurses were inserviced on the Care Planning process with an emphasis on falls. A full house audit has been completed. All residents who were found to be at risk for falls have had their care plans reviewed and updated as needed. All resident s admitted to Willow Springs with a history of falls or altered mental status will have a care plan initiated on day of admit. Restorative Director will review all new admits to ensure Care Planning is complete. Medical Records will audit all new admits to ensure completion. Director of Nursing will monitor for compliance Administrator will oversee.	7/01/2013	

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F 323	Continued From page 7 beside her bed and get into her wheelchair to get out of room and slid out of her recliner onto the floor." On 06/13/13 at approximately 9:55 a.m. the resident was observed sitting quietly in her recliner chair in her room with oxygen on. Her bed was a normal height (not low) and there was a mat on the floor beside her bed. The resident stated she was supposed to wait for help to get up, but she said "I don't wait because they're so slow." She said she knew how to use her call light (verified by Staff Member C), yet her call light was under the bed, out of her reach. Furthermore, in spite of a fall from the recliner chair and attempt to remove the mat on the floor, the facility did not re-evaluate the approaches, thus placing the resident at further risk for injury from falls.	F 323			
F 325 SS=D	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 nutritional problem. This REQUIREMENT is not met as evidenced by:	F 325			

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F 325	<p>Continued From page 8</p> <p>Based on observation, record review and interview, the facility failed to obtain a nutritional evaluation by a Registered Dietitian (RD) for 1 of 3 residents (#101) in the sample with pressure sores. Resident #101 had a Stage IV pressure area and was re-admitted to the facility from the hospital following [REDACTED]s (infection of the [REDACTED]m) and [REDACTED]. Failure to re-evaluate the resident's nutritional needs placed him at risk for subsequent complications. Findings include:</p> <p>Resident #101. The resident was transferred to the hospital from the nursing home in December 2012 with [REDACTED] and [REDACTED]. When he returned to the nursing facility he had a Stage IV pressure area (not a new pressure sore, rather it was present on an earlier admission). His diet was changed from a cardiac mechanical soft diet to a renal diet, which restricted his protein intake. (Protein is essential for healing of pressure sores.)</p> <p>The resident's weight had been stable and he was noted to eat 75-100% of his meals.</p> <p>The RD made a note in the resident's record, dated 01/03/13, which documented the resident was at the hospital with a [REDACTED]. He returned to the facility "with an order for renal diet. Will DC (discontinue) the IB (Instant Breakfast) with meals. Left (pressure ulcer) is healing per treatment nurse. New diet order sent to the kitchen."</p> <p>On 06/14/13 at approximately 10:05 a.m. the RD (Staff Member D) stated she had not seen the resident to do an evaluation. Normally she would</p>	F 325	<p>Resident #101: Resident was reviewed by the Registered Dietician on 1/8/13 and received a full nutritional assessment on 6/14/13 and was found to be nutritionally stable. Failure to complete full assessment was an isolated incident.</p> <p>A full house audit was completed on 6/14/13 and all residents were found to have full nutritional assessments completed by the Registered Dietician.</p> <p>Registered Dietician will continue to audit nutritional assessments. Interdisciplinary Team will audit and ensure nutritional assessments are completed in a timely fashion. Dietary Manager and DNS to oversee.</p>	7/01/2013	

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F 325	Continued From page 9 see a resident with a Stage IV pressure ulcer, "I do not know what happened." She stated she just did an audit four weeks ago and thought she had looked at everyone in the facility. She further stated she would normally recommend Zinc for one month to assist with healing. Although the resident had no weight loss and ate well, his diet was changed when he returned from the hospital from a cardiac diet to a renal diet and he had a Stage IV pressure area. The RD discontinued his supplement (IB) upon his return to the facility in January 2013, yet she failed to comprehensively re-evaluate the resident to ensure his nutritional needs were being met.	F 325			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329			

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F 329	<p>Continued From page 10 drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to justify the use of antipsychotic medications for 2 of 3 residents (#45,89) in the sample reviewed who were on antipsychotic medications. Failure to identify and accurately monitor/document target behaviors placed Residents #45 and #89 at risk for use of unnecessary drugs. Findings include:</p> <p>Resident #45. Multiple diagnoses included [REDACTED] with [REDACTED], [REDACTED] and [REDACTED].</p> <p>Admission physician's orders included [REDACTED] 2 milligrams (mg) twice daily and [REDACTED] 100 mg twice daily for vascular [REDACTED] and [REDACTED] mood. (Both drugs are [REDACTED] with potential significant side effects, including lethargy.)</p> <p>The facility identified target behaviors of [REDACTED], restlessness, unrealistic fears and "other behaviors". The April 2013 Behavior Monitor noted restlessness was identified one time. The May and June 2013 Behavior Monitors revealed no target behaviors were observed.</p> <p>Progress notes, dated 04/11/13, noted the resident had a fall. On 04/21/13 she refused to swallow her medications. Later that day she was</p>	F 329	<p>Resident # 45: The residents Haldol has been tapered per recommendation of the Pharmacist and will be discontinued 7/5/13. She remains per baseline with no changes. Facility will continue to monitor during her taper. A request has been sent to the Pharmacist for a full review of the residents medications.</p> <p>Resident #89: Resident continues to be seen by Comprehensive Mental Health which is following resident for her antidepressant and antipsychotic medications. Resident is back to her base line which is alert, oriented and pleasantly confused at times. She is happy and states that she feels good and likes the care that she receives at Willow Springs Care. Comprehensive Mental Health has reviewed her medications and has recommended no changes at this time.</p>	7/01/2013

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F 329	<p>Continued From page 11</p> <p>"upset...being combative with" nursing assistants, "wouldn't take evening medications and sat on her bed crying."</p> <p>On 05/10/13 progress notes documented the resident was "tearful and stating that she wants to go home. Earlier this a.m. she was combative with staff which is not her baseline." A urinalysis was done to rule out infection. Later that evening the resident refused her medications and care. She was reassured and stayed in her room. On 05/15/13 an antibiotic was initiated to treat a [REDACTED]</p> <p>Not until 06/05/13 did the facility request a gradual dosage reduction from the physician due to the resident being "very lethargic" and staff felt it was related to the [REDACTED] (per progress note on 06/05/13).</p> <p>Interview with the Staff Member E, the Social Services Director, on 06/12/13 at approximately 10:45 a.m. revealed the resident had "really bad" behaviors, such as hitting and refusing everything. However, review of the behavior monitors did not provide documented evidence that she had "really bad" behaviors.</p> <p>On 06/12/13 during the day the resident was observed quietly sitting in her wheelchair with her head down, a fall alarm attached to her clothing and the wheelchair. On 06/13/13 throughout the day the resident was quiet in her wheelchair with no observed "bad" behaviors.</p> <p>The plan of care identified a behavior problem related to vascular dementia with a goal for fewer episodes or no behaviors. Staff was to attempt to</p>	F 329	<p>All residents upon admission will have medications reviewed to ensure that all are necessary. A full house audit was completed to ensure all residents receiving antidepressants and antipsychotics medications had behavior monitoring in place to ensure effectiveness of the medication. All tapers have been completed per policy. All Licensed Nurses have been inserviced on behavior documentation as well as the Psychotic Medication Policy.</p> <p>Willow Springs has started a Psychotropic Medication meeting. This meeting will include an interdisciplinary team that will include the Director of Nursing, Social Services Director, Resident Case Managers and the Staff Development Director. The goal of this meeting is to ensure that all residents receiving antidepressants and antipsychotic medications will be monitored and tapered per policy guidelines. The team will also monitor documentation and inservice staff as needed.</p> <p>Social Services Director will continue to monitor and report updates in the quarterly Quality Assurance meeting.</p> <p>Director of Nursing to oversee.</p>	

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F 329	<p>Continued From page 12</p> <p>determine the underlying cause of any behaviors. There was no documented evidence provided that staff attempted to determine why the resident refused her medications or was combative with staff (04/21/13) until 05/10/13 (one month after admission) when a urinalysis was done to rule out urinary tract infection. In addition, the Behavior Monitor was not accurate and did not include the combative behaviors identified in the progress notes on 4/21 and 5/10/13.</p> <p>During interview with Staff Member E, the Social Services Director, on 06/12/13 at 3:00 p.m. she stated she was not familiar with "a bunch of the meds" so she would talk with the Case Manager to discuss whether the drugs should be discussed with the physician.</p> <p>The facility failed to address the use of two antipsychotic medications in a timely manner in spite of no behaviors documented on the monitoring forms. Although the resident exhibited no catastrophic behaviors, but rather occasionally refused medications, the facility did not attempt gradual dosage reductions until two months after she was admitted. In addition, the target behaviors were not specific and did not justify the use of the two antipsychotic medications.</p> <p>Resident #89. Admitted in 2011 and receiving care from a mental health agency. Diagnoses included [REDACTED], "[REDACTED]s," [REDACTED] and [REDACTED]. Physician orders included routine [REDACTED]t, [REDACTED] and the [REDACTED], 0.5 mg. (Side effects include: insomnia, anxiety, agitation, suicidal</p>	F 329			

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F 329	<p>Continued From page 13 ideation, drowsiness, and upper respiratory infection.)</p> <p>When interviewed on 06/12/13, the resident was calm but confused. Further confusion was also noted on 6/13/13.</p> <p>The current care plan identified behavior problems of suicidal ideations, crying, frustration, tearfulness, agitation, yelling at staff, seeing and hearing things, pinching and refusing meals. The plan noted the psychotropic drug use related to Risperidone for depression and anxiety.</p> <p>The resident's mental health agency noted an appointment with the resident on 04/30/13. The documentation identified she was fairly stable and the plan was to lower [REDACTED] to 0.25mg twice a day "to see if she really needs this and if she can remain stable." The listed diagnoses were [REDACTED] and persistent mental disorder.</p> <p>Behavioral monitoring sheets from 01/2013 through 06/13/13 contained target behaviors related to her mood and [REDACTED], including tearfulness and yelling at staff.</p> <p>The behavioral monitoring sheets revealed she exhibited no behaviors during the months of February 01, 2013 through June 13, 2013. Further, incomplete documentation occurred between February 01, 2013 through June 12, 2013.</p> <p>During January, 2013, behaviors were documented during night shift on 01/07/13 with agitation, yelling at staff, and tearfulness exhibited</p>	F 329		

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F 329	<p>Continued From page 14</p> <p>by the resident. Behaviors were also documented during day shift on 01/29/13 with the description of a crying and tearful resident. Interventions were provided as directed and were successful with the behaviors being alleviated. It was also noted the resident received an antibiotic in January due to [REDACTED] (an infection could be a possible cause of the increased behaviors).</p> <p>Further, a chest x-ray taken on 04/12/13 noted she had probable [REDACTED] with potential [REDACTED]; an antibiotic was ordered on 06/03/13 for a diagnosis of [REDACTED]</p> <p>Progress notes, dated 05/21/13, by licensed nurses documented the resident was tearful two or three times, but the resident did not know why. The resident had episodes of tearfulness and feelings of uselessness over the past week. The mental health agency was called by Staff Member L and the [REDACTED] was increased to the original dose.</p> <p>When interviewed on 06/14/13 at approximately 8:00 a.m., the charge nurse, Staff Member L stated she had requested the increase of the [REDACTED] stating she had observed the resident becoming tearful (although there were no behaviors documented on the behavior monitoring sheets or the progress notes). She stated the staff were just not documenting correctly.</p> <p>When interviewed on 06/13/13 at 12:00 p.m., the Licensed Nurse, Staff Member N, stated he had not observed any behaviors by the resident and he often visited with her.</p>	F 329		

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F 329	<p>Continued From page 15</p> <p>When interviewed on 06/13/13 at 11:00 a.m., Staff Member M stated the charge nurse had called the mental health agency to inform them the resident was tearful and asked about increasing [REDACTED] back to 0.5 mg. Staff Member M did not know why mental health had not evaluated the resident's [REDACTED] as a possible cause but said she would obtain documentation from mental health as to their rationale for increasing the [REDACTED] c. (The documentation received from the mental health agency, dated 05/23/13, noted Staff Member L requested [REDACTED] be increased back to the original dosage.)</p> <p>Without accurate monitoring of target behaviors and attempts to determine the cause of her tearfulness and feelings of uselessness (also symptoms of depression or as an outcome of illness) there was no justification for increasing the dose of the antipsychotic.</p>	F 329		
F 364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to serve meals that were palatable related to complaints of cold food and overcooked vegetables. Failure to serve properly cooked food caused the taste and/or</p>	F 364		

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F 364	Continued From page 16 flavor of the food to be less than satisfactory for the residents' enjoyment of their meals. Findings include: Eight of 21 residents interviewed had complaints related to food quality and temperature. Comments included: food quality was lacking; food was cold when received from the hall trays; not palatable; food was overcooked—especially vegetables, particularly broccoli. On 06/10/13 the supper menu included a cheese omelet with maple sausage, hashbrowns and a melon cup. The items were served at the proper temperature. The omelet had been frozen and had little cheese in the middle, with no flavor and a rubbery texture. On 6/12/13, at noon, a test tray was requested related to concerns expressed during resident interviews about overcooked vegetables and cold food. The tray received was the last tray on the hall cart. The meal served was beef stroganoff over steamed rice, broccoli, dinner roll and chocolate pudding, included was a small cup of milk and a cup of coffee. The broccoli was overcooked and mushy, not palatable.	F 364	The Nursing Home completed a full house audit on meal palatability and temperatures. Dietary Staff will now batch cook all vegetables, especially those more sensitive to cooking methods used. Dietary Manager conducted an inservice regarding proper food cooking techniques. Dietary staff will continue inservice training to meet requirements. Dietary Manager will continue to audit each meal at least once weekly prior to meal service to ensure continued compliance. Dietary Manager will also conduct random resident satisfaction surveys to ensure meal palatability. Dietary Manager will ensure compliance by at least once weekly audits of meal palatability. Administrator and/or DNS to oversee.	7/01/2013	
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	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure refrigerated foods were properly labelled and/or dated. Without identification of a date when the food item was opened, the foods may not be discarded within three days to avoid potential food-borne illness. Findings include: On 06/10/13 during the initial kitchen observation, the walk-in refrigerator contained the following items: A container of spiced apple rings for the evening meal - no label or date A stainless steel container of macaroni salad, not dated or labelled A bag of ready-to-eat salad with a tear in the bag, not labelled/dated A bag of cheese slices with one end open, not dated when opened A one-gallon container of Italian dressing, not dated when opened Part of a chocolate cream pie, not dated when opened A one-gallon container of Worcestershire sauce, not dated A container of tuna salad, not dated A bag of whipping cream, opened and not dated A plastic container of yeast (as stated by the Dietary Supervisor, Staff Member F), without an identifying label or date	F 371			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	The Nursing Home completed a full house audit on all items stored in all areas of the main and serving kitchens for proper labeling and dating. Dietary staff will now ensure all items that are opened and stored for reuse will have a label and date on them. Dietary Manager conducted an inservice regarding proper labeling and dating procedures. Dietary staff will continue inservice training to meet requirements. Dietary Manager will continue to audit items stored for reuse at least once weekly to ensure proper food handling procedures. Dietary Manager will ensure compliance by at least once weekly audits of storage areas. Administrator and/or DNS to oversee.	7/01/2013	

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F 441	<p>Continued From page 18</p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <ol style="list-style-type: none"> (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. <p>(b) Preventing Spread of Infection</p> <ol style="list-style-type: none"> (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. <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</p>	F 441		

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F 441	<p>Continued From page 19</p> <p>by: Based on observation, interview and record review, the facility failed to maintain an infection control program designed to provide a safe, sanitary environment for each resident according to CFR 483.65 (b)(3). To prevent cross-contamination, the facility failed to implement hand hygiene practices for 13 residents observed during dining (#'s 23, 32, 35, 39, 48, 56, 65, 67, 68, 69, 160, 166, 172) and failure to maintain good infection control practices for 7 residents observed during medication pass (#'s 10, 53, 56, 59, 169, 171, 172). Failure to maintain good infection prevention practices placed all residents at risk of harm from infection. Findings include:</p> <p>DINING</p> <p>Observations on 06/10/13 at approximately 4:40 p.m. revealed that Staff Member J, a Nursing Assistant, was touching/adjusting the bottom of her long pant legs as she waited in the dining room for the meal delivery cart to be filled with residents' in-room dinner trays. No hand wash was performed prior to Staff Member J beginning meal tray deliveries. Directly after leaving the dining room, Staff Member J delivered a dinner tray to Resident #65.</p> <p>At approximately 4:48 p.m. on 06/10/13, Staff Member J was again waiting in the dining room for the meal delivery cart to be refilled. Staff Member J tickled Resident #68 under her chin. No hand wash was performed prior to resuming meal tray deliveries. While walking down the hallway, Staff Member J reached out and touched the clothing protector on an unidentified resident</p>	F 441	<p>All residents continue to be cared for in a safe and sanitary environment. Infection Control Rate continues to be at baseline.</p> <p>All staff has been inserviced on the importance of infection control with an emphasis on:</p> <p>Hand washing after completing resident care.</p> <p>Not touching other items such as clothing when completing task such as meal and medication pass.</p> <p>Using paper trays only once during a medication pass and use of a barrier when setting an item down in a room.</p>	7/01/2013	

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F 441	<p>Continued From page 20</p> <p>who was seated in her wheelchair across from the nurses' station. There was no follow-up hand wash. Staff Member J then delivered a meal tray to Resident #56 and she assisted the resident to reposition. No hand wash was performed prior to delivering a meal tray to Resident #48.</p> <p>On 06/10/13 at approximately 4:55 p.m. Staff Member K, a NAAssistant, was rubbing her hands on her face as she waited in the dining room for the tray cart to be refilled. Without performing a hand wash, Staff Member K took the cart and delivered dinner trays to Resident #69, Resident #172, Resident #160, and Resident #35. Staff Member K entered an unidentified female resident's room and assisted her with her clothing protector placement. Staff Member K was then observed at approximately 5:02 p.m. scratching her forehead while returning to the dining room to pick up more clothing protectors. Staff Member K picked up the clothing protectors in the dining room and then continued passing trays to other residents: Resident #23 and Resident #166.</p> <p>Staff Member H was observed assisting three residents, Resident #67, #32 and #39 with the evening meal from 5:30 p.m. through 5:45 p.m.. At the onset of the assistance, she was observed to wash her hands. She assisted Resident #67 to eat. He had a white substance in the left side of his nose. While feeding him, with bare hands, she attempted to wipe the substance off with a napkin in full view of the two other residents at the table. She did not succeed in removing the substance. When completed, she crumpled the napkin up and placed it under the corner of the table's centerpiece. Prior to continuing to assist</p>	F 441	<p>The Infection Control Nurse will complete random audits and continued education to ensure ongoing infection control measures are being utilized.</p> <p>Quality Assurance will reviewed compliance quarterly.</p> <p>DON will ensure continued compliance</p>	

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505367	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/14/2013
NAME OF PROVIDER OR SUPPLIER WILLOW SPRINGS CARE AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 4007 TIETON DRIVE YAKIMA, WA 98908		
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F 441	<p>Continued From page 21</p> <p>Resident #67 with eating, she did not wash her hands. She wiped his eyes with the corner of his clothing protector. She then went to Resident #39 and turned her plate around with bare hands. She assisted Resident #32 with wiping her face, then returned to assist Resident #67. She was not observed to wash her hands after assisting with tasks that placed her in potential contact with bodily fluids before assisting others, therefore increasing the possibility of spread of infection.</p> <p>MEDICATION PASS</p> <p>On 06/11/13 at approximately 3:22 p.m., Staff Member I, a Licensed Nurse (LN), carried a paper tray containing medications into Resident #10's room, placed the paper tray directly on the over-bed table without a barrier, placed it on the counter surface next to the sink while she washed her hands, and then placed the paper tray on top of her medication cart. On 06/11/13 at approximately 3:30 p.m. Staff Member I took the same paper tray into Resident #172's room and placed it on her over-bed table without a barrier and returned it to the top of her medication cart (for re-use).</p> <p>On 6/11/13 at approximately 3:50 p.m., Staff Member I took another paper tray containing a glucometer (machine used to check blood sugar) and alcohol wipes into Resident #169's room. After doing a blood sugar check, Staff Member I returned the soiled glucometer to the paper tray and placed it on top of the unused packages of alcohol wipes. At the medication cart Staff Member I removed the soiled glucometer, wiped it with a sanitizing wipe, and returned it on top of the unused wipes in the paper tray (that had</p>	F 441		

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F 441	<p>Continued From page 22 previously been in contact with the soiled glucometer).</p> <p>On 6/11/13 at approximately 3:58 p.m., Staff Member I entered Resident #171's room with the paper tray containing the glucometer and wipes. Similarly, the LN placed the paper tray on the resident's over-bed table. The soiled glucometer was placed on top of the unused packaged wipes, taken to the medication cart for sanitizing, and then returned to the paper tray on top of the packaged wipes previously in contact with the soiled glucometer. The resident's insulin was also administered at approximately 4:00 p.m. The LN placed the soiled syringe in her pocket, left the room and discarded the syringe in her medication cart container. However, the LN failed to wash her hands prior to preparing medications, checking the chart for an order, and administering oral medications to Resident #59 on 6/11/13 at approximately 4:15 p.m.</p> <p>On 06/10/13 during the mid-afternoon medication pass between 3:00 and 3:30 p.m., the Licensed Nurse (Staff Member G) was preparing medications for Resident #53. The medication cup containing medications was put into a paper tray, taken to the resident's room and set on the resident's overbed table without a barrier. After the resident took her medications, the Licensed</p>	F 441		
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F 441	<p>Continued From page 23</p> <p>Nurse (LN) took the tray and placed it on the sink counter without a barrier while she washed her hands. She then took the paper tray and put it on the medication cart to re-use for the next resident.</p> <p>The LN then prepared medications for Resident #56, putting them into a medication cup and then into the same paper tray used for the previous resident. She placed the tray on the overbed table without a barrier. She removed a medicated pain patch from the resident and put it into the tray along with the empty medication cup and plastic wrappers from the patch and placed the tray adjacent to the sink on top of a box of gloves and under the paper towel dispenser. She washed her hands appropriately, retrieved paper towels which were directly above the tray, dried her hands, picked up the paper tray and shook the water out that had fallen into it from her dripping hands and took it back to the medication cart to re-use for the next resident's medications.</p>	F 441			