



AGING AND LONG-TERM SUPPORT ADMINISTRATION  
**Nursing Home Survey Report**  
 STATE AND CORRESPONDING FEDERAL REQUIREMENTS

1. Page <u>1</u> of <u>1</u> Pages
2. DATES OF DATA COLLECTION 8/15/16
5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Holiday
7. LICENSE NUMBER 1439

3. NAME OF FACILITY Bothell Health Care	4. TYPE OF SURVEY <input checked="" type="checkbox"/> Full <input type="checkbox"/> Post <input type="checkbox"/> Complaint <input type="checkbox"/> Other: specify _____
6. STREET ADDRESS 707 228 <sup>th</sup> Street SW	CITY STATE ZIP CODE Bothell WA 98021

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

8.	9. WASHINGTON ADMINISTRATIVE CODES 388-97	10. CODE OF FEDERAL REGULATION 42 CFR 483.	11. FEDERAL DATA TAG NUMBER	12. REPEAT DEFICIENCY FROM SURVEY DATED	13. NEW CITATION ON POST SURVEY	14. LICENSEE'S PLANNED DATE OF CORRECTION
<input type="checkbox"/> The requirements of the following WAC's and corresponding CFR's were not met. The text of the statements of deficiencies and the licensee's plan of correction may be read on CMS form 2567, dated: _____  **Licensee must complete column 14.  <input checked="" type="checkbox"/> The following deficiencies were determined to be corrected.	-480 (1)(5)(a)(b)	.10(g)(1)	167		<input type="checkbox"/>	
	-440	.10(n)	176		<input type="checkbox"/>	
	-1060(3)(h)	.25(i)	325		<input type="checkbox"/>	
					<input type="checkbox"/>	
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					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	

15. Surveyor's Signature(s)			
SIGNATURE <i>Kathy Gold</i>	DATE 8-22-16	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

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

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

PRINTED: 07/05/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505431</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/24/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>BOTHELL HEALTH CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>707 - 228TH SOUTHWEST BOTHELL, WA 98021</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Quality Indicator Survey (QIS) Survey conducted at Bothell Health Care on 06/20/16, 06/21/16, 06/22/16, 06/23/16 and 06/24/16. The sample included 25 current residents and the records of 4 former and/or discharged residents.</p> <p>The survey was conducted by: Jacie-Janet C. Beams, R.N. Leslie Martin, BSW Theresa McCoy, R.N. Nancy Berger, R.N.</p> <p>The survey team is from: Department of Social &amp; Health Services Aging &amp; Disability Services Aging &amp; Long-Term Support Administration Residential Care Services, Region 2 Unit C 3906 172nd Street NE, Suite 100 Arlington, WA 98223</p> <p>Telephone: (360) 651-6850 Fax: (360) 651-6940</p> <p><i>Kathy Gold</i> 7-5-16 Residential Care Services Date</p>	F 000	<p><u>DISCLAIMER CLAUSE</u> PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW.</p> <p><i>rec'd by mail</i></p> <p>RECEIVED JUL 19 2016 ADSARCS Smokey Point</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *7/19/16*

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

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F 167 SS=E	<p><b>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</b></p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure survey results were readily available for review by residents and visitors. This failure denied residents the ability to be fully informed of the facility's compliance history, as afforded by their resident rights.</p> <p>Findings include:</p> <p>Observation during the initial tour of the facility on 06/20/16 at 8:30 AM., there was a sign posted, informing residents and visitors that the facility survey results were located in the family room.</p> <p>Observation of the family room revealed the facility survey results were located in a three ring binder. The three ring binder was located inside the top drawer of a tall dresser.</p> <p>In an interview on 06/24/16 at 10:47 AM, the social worker (SW) stated, she was not aware where the survey results were currently located, she stated they use to be in the lobby, she was</p>	F 167	<p><b>F-167</b> <b>Correction as it relates to the resident:</b> No residents were identified</p> <p><b>Action taken to protect residents in similar situations:</b> All residents are potentially affected.</p> <p><b>Measures taken or systems altered to ensure problem does not recur:</b> The survey results were readily accessible to all the families or residents, the cabinet drawer handles are 36.5" from the floor. Residents have been observed rolling up to the dresser in wheelchairs opening the drawer and removing the Survey Notebook reading it and replacing it back in the drawer without needing to stand or move out of the wheelchair. However, the day the surveyor notified the administrator that they did not consider the survey results to be "readily accessible" a second survey binder was placed in the lobby area on the coffee cart that same day.</p> <p><b>Person Responsible for Compliance:</b> Administrator (ADM) is responsible for ongoing compliance.</p> <p><b>Date of Compliance:</b> July 26, 2016</p>	7/26/16	

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F 167	Continued From page 2 not aware why the location changed or when it changed.  In an interview with the Administrator on 06/24/16 at 10:44 AM, when asked about the current location of the survey results, the Administrator stated the survey results binder use to be located at the nurse's station but they continuously disappeared, so they decided to move them to the family room.  The Administrator was informed the current location of the survey results were not readily accessible to all the families or residents, a resident sitting in a wheelchair would not be able to reach to open the drawer, reach in and get the survey binder out of the drawer.	F 167			
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE  An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure 1 resident (39) who was observed with a medication at the bedside, was assessed for safety of medications at bedside, including self-administration, storage,	F 176	<b>F-176</b> <b>Correction as it relates to the resident:</b> Resident #39 - Self-medication assessment has been completed and resident is appropriate for a self-med program. Care plan has been updated.	7/26/16	

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F 176	<p>Continued From page 3</p> <p>and monitoring. This failure placed the resident at risk of adverse effects from medication interactions and not taking the medication as ordered by the physician.</p> <p>Findings include:</p> <p>Resident 39 was admitted to the facility in 2013 with diagnoses to include [REDACTED]</p> <p>In an observation and interview on 06/24/16 at 10:13 AM, Resident 39 stated she had [REDACTED] ointment in a medicine cup in an empty baby wipe container. Observation revealed a medicine cup with a yellow ointment inside of an empty baby wipe container. The resident stated she usually did not tell the nurses when she was applying the medication. The resident further stated, she would just go to the bathroom and apply the medicated ointment.</p> <p>On 06/24/16 at 10:55 AM, Staff A, Residential Care Manager, Licensed Nurse (LN), was asked about the facility's policy for determining a resident's ability to self-administer medication. Staff A stated that an occupational therapy (OT) referral would be made and OT would complete an assessment of the resident for self-administration of medication.</p> <p>In an interview on 06/24/16 at 11:52 AM, Staff B, OT was asked if resident 39 had an OT evaluation and assessment for self-medication administration. Staff B stated resident 39 had recently been referred for physical therapy but had not had an OT evaluation.</p>	F 176	<p><b>Action taken to protect residents in similar situations:</b> All residents are potentially affected. Resident rooms have been audited for any unknown bedside medication. Any resident with medication at bedside have had a self-med assessment completed and care plan updated.</p> <p><b>Measures taken or systems altered to ensure problem does not recur:</b> The system and processes related to our self-med program have been reviewed and minor changes made to facilitate a thorough assessment and complete process. Self-med programs will be reviewed as needed and quarterly. Self-med assessment has been added to the quarterly review process.</p> <p><b>Plans to monitor performance to ensure solution is sustained.</b> We will continue to provide Staff education on the self-med assessment process. RCM and MDS nurse will review assessments with each MDS completed. Monthly room audits will be conducted for "meds at bed-side" to monitor that the facility self-med process has been followed. These audits will be reviewed in QA committee monthly until 100% compliance has been obtained. The QA committee will then determine a further schedule.</p> <p><b>Person Responsible for Compliance:</b> RCM is responsible and the Director of Nursing(DON) will maintain compliance.</p> <p><b>Date of Compliance:</b> July 26, 2016</p>		

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F 176	Continued From page 4  Record review of the resident's medical record included the therapy's medical record, the resident did not have an assessment for self-medication administration.  Review of the facility's policies and procedures of self-administration of medications documented, residents who self-administer medication will have a self-administer medication skill assessment conducted on a quarterly basis.  In an interview on 06/24/16 at 11:16 AM, Staff C, a LN stated she was unaware the resident had medication at the bedside or that the resident self-administered the medication.	F 176			
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: Based on interview and record review, the facility	F 325	<b>F-325</b> <b>Correction as it relates to the resident:</b> Resident #160 discharged home following completion of her treatment. Weight on discharge was within the resident's stated goal.  <b>Action taken to protect residents in similar situations:</b> All residents are considered at risk. All resident weights have been reviewed; any reweighs needed were completed and appropriate actions taken.	7/26/16	

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F 325	<p>Continued From page 5</p> <p>failed to identify weight loss in a timely manner for 1 of 3 (160) residents. This failure placed the resident at risk for continued unplanned weight loss.</p> <p>Findings include:</p> <p>Resident 160 was admitted to the facility on [REDACTED] 16 with diagnosis to include [REDACTED]. The record showed the resident lost [REDACTED] pounds in one month.</p> <p>Review of the resident's weights revealed:</p> <p>On 05/02/16, the resident weighed [REDACTED] lbs. On 05/10/16, the resident weighed [REDACTED] lbs. On 05/24/16, the resident weighed [REDACTED] lbs. On 06/07/16, the resident weighed [REDACTED] lbs.</p> <p>Review of the resident's clinical record revealed the facility had not identified Resident 160's weight loss or had put interventions in place to prevent further weight loss.</p> <p>In an interview with the Resident Care Manager (RCM) on 06/23/16 at 2:24 PM, the RCM stated, the resident should have been re-weighed and followed up with a referral to the dietician.</p> <p>In an interview with the Registered Dietician (RD) on 06/23/16 at 2:15 PM, the RD stated she had not received a referral for Resident 160. She further stated, when she came to the facility, her process was to print a report that would help her identify residents who had lost weight. The report she was working from that day was not current and did not identify Resident 160's weight loss, the RD stated she would print a current report that day.</p>	F 325	<p><b>Measures taken or systems altered to ensure problem does not recur:</b></p> <p>The Med nurses will enter resident weights in the EMR only after reviewing previous weights to establish need for a reweigh. Resident reweighs will be communicated in the 24 hour book. RCM will ensure reweigh occurred and referral to Dietician as appropriate. Health Information Manager (HIM) will distribute weekly weight reports to Nursing and the Dietician. No changes are required to this policy. However we are reinforcing this policy by educating nursing staff and the Dietician.</p> <p><b>Plans to monitor performance to ensure solution is sustained.</b></p> <p>RCM to ensure process is followed with reweigh and referral to dietician as appropriate when any significant weight change is confirmed. Weights will be reviewed weekly in the Nutrition at Risk (NAR) weekly meeting.</p> <p><b>Person Responsible for Compliance:</b> Director of Nurses (DON) is responsible.</p> <p><b>Date of Compliance: July 26, 2016</b></p>	

*[Handwritten signature]*

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5. TIME OF SURVEY  Day  Night  
 Weekend  Holiday

7. LICENSE NUMBER  
**1439**

3. NAME OF FACILITY  
**Bothell Health Care**

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

6. STREET ADDRESS  
**707 228<sup>th</sup> Street SW**

CITY  
**Bothell**

STATE  
**WA**

ZIP CODE  
**98021**

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

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						<input type="checkbox"/>	

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

SIGNATURE <i>Kathy Gold</i>	DATE 7-5-16	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

**16. Licensee or Agent**

SIGNATURE OF LICENSEE (OR AGENT) <i>Julia Omega</i>	TITLE <i>administrator</i>	DATE 7/19/16
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