

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

PRINTED: 12/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505522	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/12/2015
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - SALMON CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 2811 NE 139TH STREET VANCOUVER, WA 98686	
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Manor Care Health Services - Salmon Creek on 12/7/15, 12/8/15, 12/9/15, 12/10/15, 12/11/15 and 12/12/15. A sample of 40 residents was selected from a census of 107. The sample included 28 current residents and the records of 12 former and/or discharged residents.</p> <p>The following complaints were investigated during the survey: 3159261, 3166551, and 3136724.</p> <p>The survey was conducted by: Tara Serrano, BA Phan Pham, RN, BSN Rebecca Kane, RN, MN Cynthia Chenot-Potter, RN, BSN Laura Fox, RN Kara Mitchell, RN</p> <p>The survey team is from: Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services, Region 3, Unit C P.O. Box 45819 Tumwater, Washington 98504-5819</p> <p>Telephone: 360 664-8420 Fax: 360 664-8451</p> <p><i>Dinda Ranco</i> 12-24-15 Residential Care Services Date</p>	F 000	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p>RECEIVED JAN 19 2016 DSHS/ADSA/RCS</p>	1/20/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE Administrator (X6) DATE 1/15/2016

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 272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p>	F 272	<p>F 272</p> <p>ManorCare Salmon Creek strives to ensure that each patient's functional capacity is accurately assessed, following the resident assessment instrument (RAI) specified by the State.</p> <p>Resident #362 no longer resides in the facility.</p> <p>Like patients have been identified; their assessments reviewed and actions taken based on findings.</p> <p>Nursing supervisors re-educated Licensed Nurses on how to develop an appropriate comprehensive assessment.</p> <p>Random audits will be completed for 3 months. Results will be presented to QA&A and action will be taken based on results.</p> <p>Compliance will be ensured by Administrative Director of Nursing; Administrator/designee by January 26, 2016</p>	1/24/16	

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F 272	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to accurately assess skin conditions, associated treatments, and effectiveness of interventions for one of six current sampled resident's (Resident #362) reviewed for pressure ulcers. This failure placed residents at risk of receiving inadequate care and services. Findings Include: Resident #362 admitted to the facility on [REDACTED] 2015 with [REDACTED] related to [REDACTED] and [REDACTED] Resident #362's Minimum Data Set (MDS), an assessment tool dated 11/13/2015, documented the resident was cognitively intact, required extensive assistance with activities of daily living (ADLS), and did not reject care. The MDS documented the resident had no pressure ulcers and 2 [REDACTED] On 12/10/2015 at 11:30 a.m., it was observed Resident #362's [REDACTED] and inner side of [REDACTED] black necrotic tissue. Director of Care Delivery (DCD M) measured the wound at 3.1 centimeters (cm) x 3 cm on the [REDACTED] and 4.5 cm x 3.6 cm on the inner [REDACTED] On 12/10/2015 at 2:39 p.m., DCD M stated, "they are pressure ulcers due to [REDACTED] he is on a standard mattress, I think he refused it." The Discharge Summary from the hospital, dated [REDACTED] 2015, documented the resident's diagnoses	F 272		4/24/16

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F 272	<p>Continued From page 3</p> <p>included [REDACTED] from a [REDACTED] and [REDACTED] of the [REDACTED] dry [REDACTED] at risk for developing infection.</p> <p>The Admission Assessment on [REDACTED] 2015, documented the resident had black tissue that appeared to be necrosis measuring 4.7 x 4 cm and a smaller area closer to [REDACTED] which measured 2 x 2 cm. The facility had no documentation at time of resident's admission to identify what type of wound the resident had.</p> <p>A Braden Scale (a pressure ulcer risk assessment tool) dated 11/11/2015, documented the resident was at low risk for skin breakdown.</p> <p>On 11/18/15 the Braden Scale documented the resident was at low risk for skin breakdown.</p> <p>The care plan, dated 11/11/15, documented interventions which included "administer treatment (to wounds) per physician orders", [REDACTED] as able" and "pressure redistributing device to bed."</p> <p>On 12/10/2015 at 11:30 a.m., resident was observed in bed and no alternating mattress was in place. The resident's heels were observed to be directly on the mattress.</p> <p>The facility was aware of the resident's wounds on his lower [REDACTED] but failed to identify them as pressure ulcers despite hospital documentation stating the areas were pressure related. This failure placed the resident at risk for inadequate interventions and further skin breakdown.</p>	F 272		1/24/16	

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F 279 F 279 SS=D	Continued From page 4 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure staff members used the results of the skin assessment to develop an individualize care plan in a timely manner to prevent the development of pressure ulcers for 1 of 25 current sampled residents (#166) reviewed for comprehensive care plan. This failure placed the resident at risk for development and/or worsening of pressure ulcer. Findings include:	F 279 F 279	F 279 ManorCare Salmon Creek does use the results of the assessment to develop, review and revise each Resident's comprehensive plan of care. Resident #166 currently resides in the facility. This Resident's care plan reviewed and ensured that appropriate assessments and interventions in place. Nursing Supervisors re-educated Licensed Nurses on how to develop an appropriate comprehensive assessment. Random audits will be completed for 3 months. Results will be presented to QA&A and action will be taken based on results. Compliance will be ensured by Administrator/ADNS, or designee, by January 26, 2016	1/26/16	

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F 279	Continued From page 5 Resident #166 was admitted to the facility on [REDACTED] 15 with diagnoses including [REDACTED] and generalized [REDACTED]. The resident Minimum Data Set an assessment tool dated 11/2/15 documented the resident was able to communicate his needs known, required assistance with his activities of daily living, transfer, and bed mobility. The resident was incontinent of bowel and at risk for development of pressure ulcers. The resident care plan to minimize skin breakdown dated 10/27/15 had interventions included encourage the resident to reposition as needed and [REDACTED] as able. The progress note dated 11/29/15 documented the resident was found with a 1.5 (centimeter) cm x 1.5 cm opened area on the resident's tailbone. The resident care plan was not updated. According to the skin alteration record dated 12/8/15 the opened area on the resident's tailbone had been resolved. On 12/10/15 at 3:10 p.m. the resident was on his back and his [REDACTED] were not [REDACTED]. The resident said he had developed a sore on his bottom from being on his back too long. The resident stated he needed help with repositioning and staff repositioned him once to twice a day. On 12/11/15 at 10:34 a.m. Director of Care Delivery (DCD) M and DCD N were asked to observe the skin on the resident's [REDACTED]. DCD N stated she observed a 5 cm x 7 cm circular shaped, red and excoriated skin area on the resident's [REDACTED].	F 279		1/24/16	

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F 279	Continued From page 6 On 12/12/15 at 8:55 a.m. the Charge Nurse said the LN who assessed the resident's skin was responsible for documenting the skin abnormalities on the skin alteration record for monitoring and initiate a care plan at the individualized level. The Charge Nurse stated the care plan would include interventions to promote healing and prevent worsening of the skin issues identified. At 9:15 a.m. the Director of Nursing Services (DNS) stated the LN or the DCD who initially identified the skin issues was responsible for developing a care plan and should be implemented as soon as possible. The DNS reviewed the resident's care plan and stated the care plan should have been updated.	F 279			
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide the necessary care and services to treat	F 314	F 314 ManorCare Salmon Creek strives to ensure that each Resident who enters the facility does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a Resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Residents #362 and #189 no longer reside in the facility.	1/26/16	

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F 314	<p>Continued From page 7</p> <p>and prevent pressure ulcers for 4 of 6 current sampled residents (#166, 52, 189 and 362) reviewed for pressure ulcers. This failed practice placed residents at risk of developing preventable pressure ulcers, the worsening of identified pressure ulcers, pain, and decreased quality of life.</p> <p>Findings include:</p> <p>1) Resident #166 was admitted to the facility on [redacted] 5 with diagnoses including [redacted] and generalized [redacted]. The resident's Minimum Data Set (MDS), an assessment tool dated 11/2/15, documented the resident was able to make his needs known, required assistance with his activities of daily living, transfers, and bed mobility. The resident was [redacted] and at risk for the development of pressure ulcers.</p> <p>The resident care plan to minimize skin breakdown, dated 10/27/15, had interventions including encourage the resident to reposition as needed and float heels as able.</p> <p>On 12/10/15 8:10 a.m., the resident was in bed covered with a bed sheet. The resident was on his back and his heels were not floated. The resident stated he slept on his back and staff had not assist reposition him on 12/10/15.</p> <p>The resident remained on his back and his heels were not floated until therapy staff assisted the resident out of bed at 9:50 a.m.</p> <p>At 3:10 p.m., the resident was on his back and his heels were not floated. The resident said he had developed a sore on his bottom from being on his</p>	F 314	<p>Residents #166 and #52 currently reside in the facility. Their care plans were reviewed to ensure that appropriate interventions were present.</p> <p>Like patients have been identified; their care plans reviewed and actions taken based on findings.</p> <p>Nursing supervisors provided re-education to Licensed Nurses on how to identify/assess risks for development of pressure ulcers and develop appropriate intervention(s).</p> <p>Nursing Supervisors will conduct random audits for 3 months. Results will be presented to QA&A and action will be taken based on results.</p> <p>Compliance will be ensured by Administrator/ADNS, or designee, by January 26, 2016</p>	1/24/16	

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F 314	<p>Continued From page 8</p> <p>back too long. The resident stated he needed help with repositioning and staff repositioned him once to twice a day.</p> <p>On 12/11/15, from 7:10 a.m. to 9:30 a.m., the resident was on his back and his heels were not floated. The resident was sleeping intermittently until staff members assisted the resident with a bed bath at 9:35 a.m.</p> <p>At 9:35 a.m., Nursing Assistant (NA) H and a therapy staff member assisted the resident with a bed bath. The resident's tailbone had a dark and reddened skin area approximately 5 centimeter (cm) x 7 cm. The resident's skin had an excoriated area approximately 2 cm x 2 cm on his right buttock.</p> <p>At 10.34 a.m., the Director of Care Delivery (DCD) M and DCD N were asked to observe the skin on the resident's buttocks. DCD N stated she observed a 5 cm x 7 cm circular shaped, red and excoriated skin area on the resident's buttocks and tailbone.</p> <p>On 12/11/15 at 3:05 p.m., NA J stated he looked at the resident's skin when he changed the resident. NA J said he would let the LN know immediately when he identified any skin problems on the resident. NA J stated he followed the resident's care plan when he was assigned to assist the resident and the resident needed assist floating his heels and repositioning. NA J stated he repositioned the resident as needed and depended on the resident's comfort level. NA J stated the LN would inform staff in shift report when the resident had new skin problems and no skin issues had been reported.</p>	F 314		1/24/16	

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F 314	<p>Continued From page 9</p> <p>On 12/12/15 8:25 a.m. the resident was in bed. The resident's head of bed was at 45 degrees, on his back and his heels were not floated. The resident said he had been on his back and staff had not repositioned him.</p> <p>On 12/12/15 9:53 a.m. NA H stated the resident was sitting up in bed, on his back and his heels were not floated.</p> <p>According to the progress notes from 10/30/15 to 12/11/15 the resident was alert, oriented and able to communicate his needs known. The resident was pleasant and cooperative with care. The resident was incontinent of bowel and bladder and required extensive assist with bed mobility.</p> <p>The progress note dated 11/29/15 documented the resident was found with a 1.5 cm x 1.5 cm opened area on the resident's tailbone.</p> <p>According to the skin alteration record dated 12/8/15 the opened area on the resident's tailbone had been resolved.</p> <p>On 12/12/15 at 8:55 a.m. the Charge Nurse stated the NAs observed the resident's skin for abnormalities when they provided care for the residents. The Charge Nurse said the NAs would report any skin abnormalities to the LN assigned to the resident. According to the Charge Nurse the LN was supposed to assess the resident's skin immediately and document the skin abnormalities on the skin alteration record for monitoring. The Charge Nurse said the LN was supposed to document in the 24 hour communication log and notify staff in shift report. The Charge Nurse said he had not received a report on the skin problems identified on the</p>	F 314		1/24/16	

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F 314	<p>Continued From page 10</p> <p>resident on 12/11/15 and had not seen any documentation on the 24 hour shift report. The Charge Nurse said the staff member who assessed and identified the skin problems on the resident would initiate a care plan at the individualized level. The Charge Nurse stated the care plan would include interventions to promote healing and prevent worsening of the skin issues identified.</p> <p>2) Resident #52 was admitted to the facility on [REDACTED] 15 with multiple medical diagnoses which included [REDACTED] and [REDACTED].</p> <p>The resident's MDS, dated 9/5/15, documented the resident was cognitively intact, required extensive assistance with activities of daily living, was incontinent of bowel and bladder and was at risk for developing pressure ulcers.</p> <p>Resident #52's care plan, dated 8/7/15, directed staff to observe the resident's skin condition and report any abnormalities.</p> <p>A progress note, dated 12/1/15, documented, "patient has redness to coccyx."</p> <p>On 12/11/15 at 11:38 LN T conducted a skin check on Resident #52. There was a small open area noted on the resident's right buttock. LN T was not observed to measure the area on the right buttock. There was a small area of scabbing or dry skin observed on the left buttock. LN T was not observed to measure the area on the left buttock. LN T cleansed the areas with personal care wipes and applied a white barrier cream.</p>	F 314		1/26/16	

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F 314	<p>Continued From page 11</p> <p>After exiting the room, LN T stated, "That is definitely a new area since I did her skin check awhile back." LN T stated, "I can't tell you if that is a pressure ulcer. The wound team has to decide that and stage it. I will leave them an alert note."</p> <p>A progress note, dated 12/11/15 at 1:04 p.m., documented the resident had a possible pressure ulcer on the coccyx.</p> <p>On 12/12/15 at 11:04 a.m., LN F (the nurse caring for Resident #52) stated Resident #52 did not have any open areas that she was aware of. LN F stated staff put cream on her every day and turned her frequently.</p> <p>At 11:11 a.m., when asked if Resident #52 had any skin issues, DCD P stated, "not that I can think of, but let me look in the computer." After looking in the computer, DCD P stated, "Well now I am aware of it. This is the first time there is anything saying there is an open area to her coccyx." DCD P stated the resident had Z-guard (protective barrier cream) as a preventative measure. DCD P stated that typically the wound team should be notified about that so we can go and take a look at what type of treatment should be done.</p> <p>At 11:20 a.m., the physician assistant caring for Resident #52 stated she note aware of any new skin issues for the resident. The physician assistant stated facility nurses have access to her in person, as well as the ability to leave communication notes in her mailbox. The physician assisstant stated she did not receive any communication notes regarding Resident #52's open area.</p>	F 314		1/26/16	

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F 314	<p>Continued From page 12</p> <p>Facility staff failed to notify the provider and institute timely treatment for Resident #52's newly identified open area. Staff caring for the resident on 12/12/15 (the day after the open area was identified) were unaware the resident had an open area. This placed Resident #52 at risk for worsening skin impairment. Resident admitted to the facility on [REDACTED] 2015 with [REDACTED] related [REDACTED] and [REDACTED]</p> <p>3) Resident #362 's Minimum Data Set (MDS), an assessment tool dated 11/13/2015, documented the resident was cognitively intact, required extensive assistance with activities of daily living (ADLS), and did not reject care. The MDS documented the resident had no unhealed pressure ulcers and 2 vascular ulcers. A Braden Scale (a pressure ulcer risk assessment tool) dated 11/11/2015, documented the resident was at low risk for skin breakdown.</p> <p>On 11/18/15 the Braden Scale documented the resident was at low risk for skin breakdown.</p> <p>On 11/10/2015 orders documented that the treatment for the resident 's wounds were an alternating pressure mattress, float heels while in bed every shift, mineral oil to Bilateral lower extremities twice a day and evening shift, and paint [REDACTED] wounds with betadine daily every dayshift.</p> <p>Observation on 12/10/2015 11:30 a.m. of the Resident 's [REDACTED] and inner side [REDACTED] black necrotic tissue, resident very protective of wounds, Director of Care Delivery (DCD) M measured 3.1 cm x 3 cm [REDACTED]</p>	F 314		1/20/16	

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F 314	<p>Continued From page 13 and 4.5 cm x 3.6 cm on [REDACTED]</p> <p>On 12/10/2015 2:39:43 PM DCD M stated, "they are pressure ulcers due to [REDACTED] he is on a standard mattress; I think he refused it."</p> <p>The care plan, dated 11/11/15, documented interventions which included "administer treatment (to wounds) per physician orders, float heels as able and pressure redistributing device to bed."</p> <p>On 11/10/2015 a nutrition assessment was documented resident's weight at [REDACTED] pounds, resident is on an [REDACTED] Formula [REDACTED] 1.2 at 85 mls/hr and Registered Dietician (RD) documented that his [REDACTED] are covering all of his needs.</p> <p>On 11/10/15, a physician's order documented the facility should put an alternating pressure mattress on the resident's bed.</p> <p>On 12/10/2015 at 11:30 a.m., resident was observed in bed and no alternating mattress was in place. The resident's heels were observed to be directly on the mattress.</p> <p>On 12/10/15 at 2:39 p.m., DCD M stated "the resident is on standard mattress."</p> <p>On 11/7/2015 the skin alteration record documented the resident's right side proximal wound measured 2 cm x 2 cm with slough, moist yellow or gray necrotic tissue, with no drainage and surrounding tissue had a normal appearance.</p>	F 314		1/26/16

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F 314	<p>Continued From page 14</p> <p>On 12/8/2015 the skin alteration record documented the resident 's wound was 2.5 x 3 with eschar with no drainage and surrounding skin was reddened.</p> <p>On 11/7/2015 the skin alteration record documented that the resident 's [REDACTED] wound measured 4.8 cm x 4 cm with eschar, thick, hard, leathery, black necrotic tissue with no drainage and the surrounding tissues was reddened and dry.</p> <p>On 12/8/2015 the skin alteration record documented the resident 's [REDACTED] wound measured 5.2 cm x 4 cm with eschar thick, hard, leather, black necrotic tissue, with no drainage and surrounding tissues were normal in appearance.</p> <p>The facility's failure to identify wounds as pressure ulcers, implement and/or follow interventions that were ordered and consistent with resident's identified needs, resident goals and recognized standards of practice resulted in resident 's pressure ulcers to worsen and places the resident at increased risk for further skin breakdown.</p> <p>4) Resident (#189) was admitted to the facility on [REDACTED] 15 with diagnoses to include [REDACTED] and [REDACTED]. The care plan initiated on 11/16/15 for urinary incontinence had an intervention for nursing to provide incontinent care as needed and to report changes in skin integrity found during daily care. An MDS (an assessment tool) done on 11/19/15 reflected the resident was at moderate risk of developing a pressure ulcer. It</p>	F 314		1/26/16

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F 314	<p>Continued From page 15</p> <p>also reflected the resident was incontinent of bowel and bladder several times a week and required extensive assistance with all activities of daily living.</p> <p>The resident had weekly Braden Scale (a tool used to assess resident 's risk of developing a pressure ulcer-The higher the score, the lower probability of developing a pressure ulcer. A score of 23 means there is no risk for developing a pressure ulcer while the lowest possible score of 6 points represents the severest risk for developing a pressure ulcer) assessments done. The Braden Scale assessment score scale:</p> <p>Very High Risk: Total Score 9 or less High Risk: Total Score 10-12 Moderate Risk: Total Score 13-14 Mild Risk: Total Score 15-18 No Risk: Total Score 19-23</p> <p>Assessments done: 11/15/15 resident assessed to be low risk for developing pressure ulcer (Braden Scale) at score of 22 11/19/15 resident assessed to be low risk for developing pressure ulcer at score of 20 11/26/15 resident assessed to be low risk at score of 16 (increased risk, but still low) 12/03/15 resident assessed to be moderate risk at score of 14</p> <p>A weekly skin assessment was completed and documented on 12/03/15 at 1:22 p.m. there were no skin issues.</p> <p>Documentation on 12/03/15 at 9:56 p.m. indicated the resident 's wife had discovered the alteration in skin when she was helping the resident in the bathroom. The nursing assessment at that time indicated there was a " skin tear " around the resident 's coccyx and with further assessment it was documented as a</p>	F 314		1/26/16
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F 314	Continued From page 16 pressure-related wound in the gluteal crease that measured 1.8x0.8x0.1 cm, with the wound bed at 100% beefy red granulation tissue. On 12/11/15 at 4:12 p.m. interview with the DNS regarding the skin check that had been done earlier the same day the pressure ulcer was found. The DNS stated " It may have been a quick check for as long as he would allow (due to behavior issues). He may not have allowed staff to look as close as we like to." There was no documentation to indicate the resident would not allow skin assessment to be completed. Incidentally, resident also had an unplanned weight loss of approximately 10%; which has increased the risk of developing a pressure ulcer. Resident appeared to be quite thin, with rib bones noticeable . There was no care plan problem or interventions to prevent developing a pressure ulcer in a resident who had a significant weight loss, required extensive assistance with all ADL ' s and was incontinent of bowel and bladder frequently throughout the day and night. The facility ' s failure to implement and/or follow interventions that were consistent with resident ' s identified needs, resident goals and recognized standards of practice resulted in resident developing an avoidable pressure-related ulcer.	F 314		1/26/16
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 17 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined staff failed to lock the Hoyer (mechanical) lift during a transfer for 1 of 1 randomly observed resident (#464) reviewed for accident supervision and assistive devices. This failure had the potential for the resident to sustain avoidable injuries during the transfer. Findings include: Resident #464's was admitted to the facility on [REDACTED] 15 with diagnoses including [REDACTED]. The resident's Minimum Data Set assessment dated 11/26/15 identified the resident had cognitive impairment, required extensive assistance from staff for his activities of daily living and two staff assistance during transfers with the use of a Hoyer lift. On 12/10/15 at 11:35 a.m. Nursing Assistant (NA) K and NA L used the Hoyer lift and assisted the resident to transfer from the resident's wheelchair into his bed. The NAs did not lock the Hoyer lift when they raised the resident from his wheelchair and when they lowered the resident onto his bed. At 11:55 a.m. the resident was not able to provide additional information related to the safety measures staff had implemented during transfers. At 12:00 p.m. NA L stated she had been trained to lock the Hoyer when lifting the resident from the wheelchair and when lowering the resident. NA L stated the staff member operated the Hoyer lift was responsible for locking the brakes.	F 323	F 323 ManorCare Salmon Creek strives to 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. Resident #464 no longer resides in the facility. Manufacturer's guidelines for the mechanical lift used to transfer Resident #464 requires that the wheels not be locked during transfer.	1/24/16	

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F 323	Continued From page 18 On 12/11/15 at 10:35 a.m. the Director of Care Delivery M stated staff members had been trained to lock the Hoyer lift when they raise and lower the resident. At 3:20 p.m. Licensed Nurse (LN) R stated staff had been trained to lock the Hoyer lift when they transfer the residents to prevent injuries. LN R said she made random observation and observed staff transfers to ensure proper procedures were being followed.	F 323		1/24/16
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 it was determined that the facility failed to ensure 1 of 3 current sampled residents (#189) reviewed for nutrition and/or weight loss maintained or attained acceptable nutritional status and/or did not experience significant unintentional body weight loss. This failure resulted in an unintentional	F 325	F 325 ManorCare Salmon Creek strives to ensure that each Resident who enters the facility maintains acceptable parameter of nutritional status, such as body weight and protein levels, unless the Resident's clinical condition demonstrates that this is not possible; and receives a therapeutic diet when there is a nutritional problem. Resident #189 no longer resides in the facility. Like patients have been identified; their care plans reviewed and actions taken based on findings. Licensed Nurses and RD were re-educated to facility weight guidelines, including assessment and appropriate intervention(s), and appropriate/timely physician notification.	

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F 325	<p>Continued From page 19</p> <p>weight loss of 10% in less than 1 month for resident #189. The facility failed to take timely interventions to ensure the Resident was offered his individualized food preferences to stimulate intake.</p> <p>Findings include:</p> <p>Resident #189 was admitted to the facility on [REDACTED] 2015 with multiple diagnoses to include [REDACTED] and [REDACTED]. The Minimum Data Set, an assessment tool dated 11/19/2015, noted the resident had cognitive impairment and required supervision (this includes cueing) for meals. The Care Area Assessment (CAA) for nutrition was triggered and a care plan for this was initiated.</p> <p>Resident's admit weight on [REDACTED] 15 documented by the facility was [REDACTED] lbs (which, according to a dietician's assessment dated 11/23/15, was near his typical weight of [REDACTED] lbs). On 11/15/15 resident weight was documented as [REDACTED] lbs, then on 11/19/15 [REDACTED] lbs, and then on 12/3/15 the weight was documented as [REDACTED] lbs, a loss of 10% in less than 30 days.</p> <p>A weekly weight was due again on 12/10/15, but it is documented the resident refused to be weighed. There is no documentation that other alternatives, such as re-approaching resident later or any other attempts were made to obtain a current weight.</p> <p>On 12/11/2015 at 2:05 p.m., the Registered Dietitian (RD) was interviewed in regard to how residents with weight loss are assessed. RD stated "If it's expected, such as in this case (in reference resident #189), he came to us on a</p>	F 325	<p>Nursing Supervisors will conduct random audits for 3 months. Results will be presented to QA&A and action will be taken based on results.</p> <p>Compliance will be ensured by Administrator/ADNS, or designee, by January 26, 2016.</p>	1/24/16

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F 325	<p>Continued From page 20</p> <p>██████ diet which is ██████ because he was ██████ but we changed him to a No Added Salt diet recently." In regard to the snacks that were discontinued because he was refusing them routinely, RD states "I changed it to offering instead of routinely sending them. The staff have access to patient food that is stocked on the units including, fruit, pretzels, sandwiches, ice cream, pudding, and things like that." When asked what she would expect a resident who has dementia to have as a type of snack, she indicated "something they could feed themselves with supervision like a sandwich".</p> <p>Record review of resident's physical assessments since admit had no indication of edema (swelling of body parts due to excess fluid), and resident was not receiving a diuretic. Resident was receiving a ██████ which has a common side effect of loss of appetite.</p> <p>The nutritional care plan initiated on 11/23/15 includes the intervention "Review weights and notify physician and responsible party of significant weight change." There is no documentation noted that physician or responsible party were notified.</p> <p>Residents with impaired nutrition are at risk for developing pressure ulcers. On 12/03/2015 this resident was discovered to have developed a stage 2 pressure ulcer on his coccyx.</p> <p>The facility failed to notify the physician and failed to ensure Resident and family were consulted regarding favorite food to individualize Resident's diet in attempt to slow his rapid weight loss and implement other interventions that may have helped resident maintain weight resulted in the</p>	F 325		1/24/16	

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F 325	Continued From page 21	F 325			
F 371 SS=D	<p>resident having a significant weight loss.</p> <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: Based on observation and interview, it was determined the facility failed to ensure staff practiced proper hand hygiene to prevent potential food borne illness exposure and cross-contamination of germs when passing trays to residents in 1 of 2 dining rooms and residents eating in their room for 1 of 5 halls. This placed residents at risk of obtaining a food-borne illness.</p> <p>Findings include: <Hall Tray Pass></p> <p>On 12/7/15 at 5:48 p.m., Nursing Assistant (NA) O removed a dinner tray from the delivery cart and placed the tray on her shoulder as she walked down the hall to room 202. NA O's long hair was loosely tied back into a ponytail. NA O's hair touched the resident's food tray as it was being carried on her shoulder.</p>	F 371	<p>F 371 ManorCare Salmon Creek does distribute and serve food under sanitary conditions</p> <p>Resident #74 currently resides in the facility. Staff involved with Resident's meal delivery were educated to appropriate tray delivery and how to handle glassware and utensils.</p> <p>Interdisciplinary staff were then re-educated on how to appropriately deliver trays and handle glassware and utensils.</p> <p>Random audits will be completed for 3 months. Results will be presented to QA&A and action will be taken based on results.</p> <p>Compliance will be ensured by Administrator/ADNS, or designee, by January 26, 2016</p>	1/24/16	

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F 371	<p>Continued From page 22</p> <p>At 5:50 p.m., NA O carried a food tray on her shoulder to room 210. Her hair touched the resident's water glass multiple times as the tray was being carried into the room.</p> <p>At 5:53 p.m., NA O delivered a tray to Resident #74. NA O applied gloves, assisted Resident #74 up in bed with the help of NA P. NA O was not observed to remove her gloves or wash hands and proceeded to handle the resident's silverware and cut up the meal. NA O did not wash her hands or use hand sanitizer when exiting the room.</p> <p>Then at 5:58 p.m., immediately after exiting the room of Resident #74, NA O entered the room of Resident #197 and did not wash her hands or use hand sanitizer. NA O took several cups from Resident #197's tray, exited the resident's room and went into the nourishment room.</p> <p>At 5:59 p.m., NA O reentered Resident #197's room, did not wash or sanitize her hands, put on gloves and then assisted the resident to eat.</p> <p><Willamette Dining Room Observation></p> <p>On 12/12/15 at 10:29 a.m., Director of Care Deliver (DCD) O stated that staff are expected to wash hands or use hand sanitizer between passing trays if they touch anything in the residents' rooms or provide any care. DCD O stated staff should not carry food trays on their shoulders when delivering them and agreed that it was concerning the NA O's hair was touching the residents' food trays during delivery.</p>	F 371		1/26/16	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441			

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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - SALMON CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 2811 NE 139TH STREET VANCOUVER, WA 98686		
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F 441	Continued From page 23 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions 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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F 441 ManorCare Salmon Creek maintains 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 Residents #464, 424 and #447 no longer reside in the facility. Resident #52 currently resides in the facility. Staff involved with Resident's care were educated to appropriate infection control and hand hygiene practices, including practices specific to catheter care. Interdisciplinary staff were re-educated on appropriate infection control and hand hygiene practices. Nursing staff were also re-educated to appropriate catheter care protocols. Random audits will be completed for 3 months. Results will be presented to QA&A and action will be taken based on results. Compliance will be ensured by Administrator/ADNS, or designee, by January 26, 2016	1/24/16	

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

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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - SALMON CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 2811 NE 139TH STREET VANCOUVER, WA 98686
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F 441	<p>Continued From page 24</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, it was determined the facility failed to ensure staff members followed proper infection control practices to prevent the spread of infections during dressing changes and personal care. These failures placed the residents at risk for contracting infection and/or delaying wound healing.</p> <p>Findings include:</p> <p>1) On 12/10/15 at 11:35 a.m. Nursing Assistant (NA) K and NA L were observed assisted Resident #464 with his incontinent care.</p> <p>NA K wiped the resident's peri area and assisted the resident repositioned to his left side.</p> <p>NA L wiped the resident's buttocks and assisted the resident repositioned to his right side.</p> <p>NA K and NA L assisted the resident put on a clean brief and pants. The NAs touched the resident's shoulders, arms and legs when the NAs repositioned the resident and put on his clothes. NA K and NA L wore the same pair of gloves during the entire process.</p> <p>At 12:00 p.m. NA L said she was supposed to change her gloves when she finished wiping the resident. NA L said she had been in-serviced on gloves change.</p> <p>2) On 12/10/15 at 3:30 p.m. NA M and NA N were observed assisted Resident #424 with his incontinent care.</p>	F 441		1/24/14
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F 441	<p>Continued From page 25</p> <p>NA N wiped the resident's peri area and assisted the resident repositioned to his right side. NA N placed a clean draw sheet, an incontinent pad and a brief under the resident. NA N assisted the resident repositioned to his left side. NA N touched the resident's shoulders, arms and knees. NA N lifted the resident's head and adjusted the resident's pillow. NA N handed the resident a box of tissue and adjusted the resident's oxygen tubing. NA N assisted the resident put on a gown and put on a clean bed sheet. NA N wore the same pair of gloves.</p> <p>At 3:42 p.m. NA N said had been instructed to change gloves after provided personal care.</p> <p>3) On 12/11/15 at 9:35 a.m. NA H and a therapy staff member were observed given the resident a bed bath.</p> <p>NA H wiped the resident personal area with a towel. NA H used the contaminated part of the towel and wiped the catheter tubing. NA H used another towel and wiped the resident's personal area. NA H wiped the tip of the penis and the catheter tubing with the contaminated towel. NA H held the catheter tubing at the tip of the penis with her right contaminated gloved hand and wiped the rest of the catheter tubing with her left gloved hand.</p> <p>NA H wiped the resident's buttocks, grabbed a clean towel and dried the resident's buttocks. NA H adjusted the resident's pillow and assisted the resident rolled to his right side. NA H did not change gloves after the gloves had been contaminated.</p> <p>4) On 12/10/15 at 11:03 a.m., LN S was observed</p>	F 441		1/24/16	

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F 441	<p>Continued From page 26</p> <p>changing a wound dressing on Resident #318's calf. LN S used a piece of gauze and saline to clean the resident's wound in an up and down motion.</p> <p>Using an up and down motion, as opposed to a circular inside to outside motion, to clean the wound had the potential to contaminate the wound.</p> <p>On 12/11/15 at 3:40 p.m., Director of Care Delivery [DCD] O stated, "the process for cleaning a wound is in a circular motion inside to outside. You don't want to drag germs into the wound."</p> <p>5) On 12/11/2015 at 11:38 a.m., LN T changed Resident #52's brief, cleansed the peri-area using personal care wipes and applied a barrier cream to the resident's buttocks. LN did not remove his gloves or wash his hands and then adjusted the resident's pillows and blankets, boosted the resident up in bed, and repositioned the resident on her right side.</p> <p>At 3:40 p.m., DCD O stated the expectation is for staff to wash hand and change gloves when they are going from dirty to clean. DCD O stated, "for example when changing a brief and then assisting with other care, staff should wash their hands or use hand-sanitizer."</p> <p>6) On 12/08/2015 at 10:06 a.m., when a dressing change on resident #447 it was observed that LN Q did not change gloves between removing soiled dressing, cleansing wound, getting pen out of pocket, and placing new dressing; LN then changed gloves, took out packing of 2nd wound and proceeded to cleanse wound and apply new</p>	F 441		1/24/16	

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F 441	<p>Continued From page 27</p> <p>dressing with same gloves used to remove old dressing. Before removing contaminated gloves, LN touched all unused dressing items with contaminated gloves and put them back on shelf in resident's room. When asked how often and when gloves are typically changed during wound care LN stated, "I usually change them before and after wound care."</p> <p>On 12/08/2015 at 10:15 a.m., NA G was observed using/wearing only one glove (on left) hand while putting a new brief on a resident who had just had a dressing change done and had bloody drainage on gown and bed linens. When asked how NA can manage resident care with one glove on, NA stated "I didn't touch anything with that hand and just rolled the glove up (when taking it off)", though it was noted that NA G did use both hands to provide care to resident.</p> <p>7) On 12/08/2015 at 2:33 p.m., it was observed that NA U had no gloves on when she entered a resident's room who was on isolation precautions due to c-diff. When asked why she was coming into the room without gloves on, she stated "I usually do, but I just was coming by and saw her light on." NA had an isolation gown on during this time.</p> <p>8) On 12/10/2015 at 2:50 p.m., it was observed LN was about to start applying a WoundVac to resident (#447). The following observations were made while 2 LN's applied the WoundVac:</p> <p>At 2:53 p.m., there was no hand-washing after entering room by LN V before putting on gloves; and no hand-washing by LN Q before putting on gloves.</p> <p>At 2:58 p.m., LN V changed gloves but did not do</p>	F 441		1/26/16	

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F 441	<p>Continued From page 28 hand hygiene.</p> <p>At 3:00 p.m., LN Q took scissors out of pocket, cut side of resident soiled brief for removal, then put them back into pocket.</p> <p>At 3:01 p.m., LN V removed old dressing; she changed gloves but did not perform hand-hygiene.</p> <p>At 3:09 p.m., LN V left room and upon returning to room did not perform hand hygiene before putting gloves on.</p> <p>At 3:11 p.m., LN Q used scissors out of pocket to cut string from green, long sleeved shirt and put them back into pocket.</p> <p>At 3:12 p.m., LN Q used scissors out of pocket to cut foam used with/for WoundVac.</p> <p>At 3:18 p.m., LN Q reached into pocket for skin prep with contaminated gloves on.</p> <p>At 3:32 p.m., LN Q put scissors put back into pocket with no observation of cleaning/sanitizing.</p> <p>At 3:35 p.m., LN Q was asked what staff was taught about hand-hygiene and glove application and removal. LN replied, "Staff is supposed to wash their hands before putting gloves on and after taking them off each time." When asked about what was taught about cleaning/sanitizing equipment (such as bandage scissors) LN stated "We use the wipes to wipe down things between residents."</p>	F 441		1/24/16



Aging and Adult Services Administration
NURSING HOME SURVEY REPORT
 State and Corresponding Federal Requirements

1. Page 1 of 1 Pages
2. DATES OF DATA COLLECTION 12/7/15, 12/8/15, 12/9/15, 12/10/15, 12/11/15, 12/12/15
5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input checked="" type="checkbox"/> Weekend <input type="checkbox"/> Holiday
7. LICENSE NUMBER 505522

3. NAME OF FACILITY Manorcare Health Services - Salmon Creek	4. TYPE OF SURVEY <input checked="" type="checkbox"/> Full <input type="checkbox"/> Post <input checked="" type="checkbox"/> Complaint <input type="checkbox"/> Other (<i>Specify</i>)
6. ADDRESS 2811 NE 139 th St	STREET CITY STATE ZIP Vancouver WA 98686

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

8.	9. WASHINGTON ADMINISTRATIVE CODES 388-97	10. CODE OF FEDERAL REGULATION 42 CFR 483.	11. FEDERAL DATA TAG NUMBER	12. REPEAT DEFICIENCY FROM SURVEY DATED	13. NEW CITATION ON POST SURVEY	•• 14. LICENSEE'S PLANNED DATE OF CORRECTION
<input checked="" type="checkbox"/> The requirements of the following WAC's and corresponding CFR's were not met. The text of the statements of deficiencies and the licensee's plan of correction may be read on CMS form 2567, date: •• Licensee must complete column 14 <input type="checkbox"/> The following deficiencies were determined to be corrected.	-1000(1)(b)	20(b)(1)	F-272		<input type="checkbox"/>	1/26/16
	-1020(1)(2)(a)(b)	20(d)	F-279		<input type="checkbox"/>	1/24/16
	-1060(3)(b)	25(c)	F-314		<input type="checkbox"/>	1/26/16
	-1060(3)(g)	25(h)	F-323 *		<input type="checkbox"/>	1/24/16 *
	-1060(3)(h)	25(i)	F-325		<input type="checkbox"/>	1/26/16
	-1100(3) and 2980	35(i)	F-371		<input type="checkbox"/>	1/24/16
	-1320(1)(a)	65	F-441		<input type="checkbox"/>	1/26/16
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	

13. SURVEYOR'S SIGNATURE(S)			
SIGNATURE <i>Christ Potter, RN</i>	DATE 12/24/15	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE
14. LICENSEE OR AGENT			
SIGNATURE OF LICENSEE (OR AGENT) <i>Moy</i>	TITLE Administrator	DATE 1/15/16	