

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

PRINTED: 06/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/06/2014
NAME OF PROVIDER OR SUPPLIER RAINIER REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 920 12TH AVENUE SOUTHEAST PUYALLUP, WA 98372	
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Rainier Rehabilitation on 06/02/14, 06/03/14, 06/04/14, 06/05/14, and 06/06/14. A sample of 34 residents was selected from a census of 88. The sample included 24 current residents, the records of 10 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>Marie Rose, RN, MN Michelle Darnell, BSS Sonya Conway, MSW Rae Simpson, RN, MSN Jonathan Berliner, RN, MN, CPG</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Long Term Services Administration Residential Care Services, District 3, Unit B P.O. Box 45819 MS: N27-24 Olympia, Washington, 98504-5819</p> <p>Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p><i>[Signature]</i> 6/19/14 Signature Date</p>	F 000	<p><i>This Plan of Correction is the facility's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</i></p> <p style="text-align: center;">RECEIVED JUL 07 REC'D DSHS - ADSA RCS - REGION 5</p>	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
<i>[Signature]</i>		Executive Director		6-30-14

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 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to consult with the physician or inform resident of</p>	F 157	<p>F 157 Notify of Changes (Injury/Decline/Room, Etc.)</p> <p>Resident #111 and physician were both informed of resident's current pressure ulcer status on 6/29/14 by the Registered Nurse (RN). Physician ordered to continue with current treatment plan and resident is in agreement with medical interventions.</p> <p>Current residents with pressure ulcers have been assessed for wound status by the RCM/and or designee and the physician and residents/and or responsible party were notified of condition as needed to ensure proper medical interventions are in place for pressure ulcer compliance.</p> <p>Education provided to the licensed nursing staff by the Staff Development Coordinator (SDC)/and or designee regarding the notification process to the physician and resident/and or responsible party related to change or no change in a resident's pressure ulcer status occurs as needed to ensure appropriate medical interventions are in place.</p> <p>RCM/and or designee will conduct random audits on residents with pressure ulcers to ensure that the proper notification process related to change or no change of a resident's pressure ulcer status occurs for both physician and resident/and or responsible party as required. RCM's will give findings to the Director of Nursing Services (DNS) to review.</p>		

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F 157	<p>Continued From page 2</p> <p>current condition of a pressure ulcer for 1 of 21 (#111) current sampled residents reviewed for notification of condition. This failure prevented the physician and the resident from being aware of the current condition of the pressure ulcer. This failure placed Residents #111 at risk for the potential unmet medical interventions and uninformed decisions towards pressure ulcer compliance.</p> <p>Findings include:</p> <p>Resident #111 admitted on 1 14 with diagnoses including bilateral knee pain non-surgical, osteoarthritis, 3 joint pain, difficulty walking and 3</p> <p>The resident's Minimum Data Set, an assessment tool, dated 4/24/14, indicated the resident is cognitively intact and required a two person physical assistance with bed mobility, transferring, dressing, bathing and toileting, along with one person physical assist for personal hygiene. The resident has a current unhealed Stage 3 pressure ulcer.</p> <p>The resident's care plan included encouraging frequent position change and cueing every two to three hours. Complete a pressure ulcer risk assessment weekly.</p> <p>The resident's coccyx pressure ulcer assessment included the following pressure ulcer measurements.</p> <table border="1"> <thead> <tr> <th>Date</th> <th>Length</th> <th>Width</th> <th>Depth</th> </tr> </thead> <tbody> <tr> <td>4/25/14</td> <td>0.6 cm</td> <td>0.5 cm</td> <td>0.3 cm</td> </tr> <tr> <td>5/1//14</td> <td>0.5 cm</td> <td>0.2 cm</td> <td>0.3 cm</td> </tr> <tr> <td>5/13/14</td> <td>3 cm</td> <td>1cm</td> <td>0.3 cm</td> </tr> </tbody> </table>	Date	Length	Width	Depth	4/25/14	0.6 cm	0.5 cm	0.3 cm	5/1//14	0.5 cm	0.2 cm	0.3 cm	5/13/14	3 cm	1cm	0.3 cm	F 157	<p>The DNS will bring findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 3 months and as needed thereafter.</p> <p>The QAPI Committee will review findings and will make recommendations as needed.</p> <p>The DNS will ensure compliance.</p>	7/14/14
Date	Length	Width	Depth																	
4/25/14	0.6 cm	0.5 cm	0.3 cm																	
5/1//14	0.5 cm	0.2 cm	0.3 cm																	
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F 157	<p>Continued From page 3</p> <p>5/24/14 3 cm 1 cm 0.3 cm 5/31/14 3 cm 1 cm 0.3 cm</p> <p>Included in the Interdisciplinary Team notes for 5/13/14, 5/24/14 and 5/31/14 were recommendations to continue with the current treatment for the resident's coccyx pressure ulcer.</p> <p>On 6/4/14 at 9:51 a.m., during wound care for Resident #111, Staff F stated to the resident, "It {the pressure ulcer on coccyx} looks a lot better. It's {the pressure ulcer on coccyx} getting better."</p> <p>On 6/5/14 at 9:05 a.m., Resident #111 stated, "When I came here {admitted to the facility}, it {the pressure ulcer on coccyx} was small. Two or three nurses have told me it {the pressure ulcer on coccyx} is getting better. I cannot sit in one spot all day long. At home I get up and walk around, I like to do things. They {staff} are saying it {the pressure ulcer on coccyx} is better."</p> <p>On 6/5/14 at 10:55 a.m., when asked if the physician was informed of the progression of wound healing for Resident #111's pressure ulcer, Director of Nursing Services (DNS) confirmed there was no documentation that the physician was informed of the pressure ulcer remained the same size for the last three weeks. DNS stated s/he was responsible for notifying the physician if a pressure ulcer had a lack of improvement.</p> <p>The physician's orders or progress notes did not indicate any information about continuing Resident #111's current pressure ulcer treatment. The only physician order for the pressure ulcer treatment was the initial physician's order dated 4/18/14.</p>	F 157			

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F 157	Continued From page 4	F 157		
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 Comprehensive Assessments</p> <p>Resident #57 was discharged from the facility on 1/14.</p> <p>Oral assessments have been conducted on current residents by the Resident Care Manager/and or designee to ensure residents with broken/missing teeth or oral dental pain have been assessed and offered services as needed.</p> <p>Education provided by the Director of Nursing Services/and or designee to the Minimum Data Set licensed nursing staff on ensuring accurate dental assessments have been completed.</p> <p>Education provided by the Staff Development Coordinator/and or designee to the licensed nursing staff to ensure that resident with broken/missing teeth or oral dental pain have been assessed and offered dental service. Also, to ensure notification to the Social Services department of residents dental service needs.</p> <p>The Director of Nursing Services (DNS)/and or designee will conduct random audits to ensure accuracy of dental assessment and that appropriate referrals have been initiated and documented.</p> <p>The DNS will bring audit findings to QAPI Committee monthly for 3 months and as needed thereafter.</p> <p>The QAPI Committee will review findings and make recommendations as needed.</p>	

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F 272	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to comprehensively assess 1 of 21 residents (#57) reviewed for care and services. This failure placed the resident at risk of experiencing unidentified mouth pain.</p> <p>Findings include:</p> <p>Resident #57 was readmitted to the facility on 1/13 with diagnoses including 3</p> <p>The resident's Minimum Data Set (MDS), an assessment tool, dated 05/12/14 indicated the resident was cognitively intact and required extensive assistance with activities of daily living. The resident's MDS failed to document the resident had missing/broken teeth.</p> <p>On 06/03/14 at 9:14 a.m., Resident #57 was observed with missing/broken teeth. The resident stated, "My teeth are rapidly deteriorating and I have not seen a dentist in years." The resident pointed to his upper and lower jaw and stated he had pain in his mouth.</p> <p>On 06/05/14 at 4:55 p.m., the Administrator stated Resident #57 had not been assessed by the dentist.</p> <p>Failure to accurately assess the resident's dental</p>	F 272	<p>The DNS will ensure compliance.</p> <p>7/14/14</p>

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F 272	Continued From page 6 condition placed the resident at risk of experiencing mouth pain and a delay in care.	F 272	F 281 Services Provided Meet Professional Standards.		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure that medications were administered according to standards of practice for 1 of 3 (#184) current sampled residents reviewed for medication administration. This failure placed residents at risk of potential complications associated with improper technique of medication administration. Findings include: On 6/5/14 at 9:14 a.m., during administration observation for Resident #184, Staff P placed the following crushed medications, roxicodone, norvasc and premarin into a cup and diluted with tap water. Staff P did not check placement of the nasogastric tube prior to administration of the three crushed medications. While the medications were administered, the syringe with the diluted crushed medications was infusing slowly. Staff P stated, "It is starting to move (referring to the medications in the syringe)." Once the medication was infused, Staff P flushed the nasogastric tube with water.	F 281	Resident #184 nasal gastric tube was discontinued on 6/12/14. No other resident residing in the facility has a nasal gastric tube at this time. Education has been provided by the Staff Development Coordinator/and or designee to the licensed nursing staff on ensuring that medications are administered according to standards of practice. This includes but not limited to checking proper placement of nasal gastric tube prior to administering medications. The Resident Care Manager (RCM)/and or designee will conduct random audits on residents with a nasal gastric tube to ensure licensed staff check proper placement of nasal gastric tube prior to administering medications. These findings will be given to the Director of Nursing Services (DNS). The DNS will bring findings to the QAPI Committee monthly for 3 months then as needed thereafter. The QAPI Committee will review findings and make recommendations as needed. The DNS will ensure compliance.	7/14/14	

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F 281	Continued From page 7 Physician's orders were reviewed for other facility residents with a gastric tube or nasogastric tube, and physician orders included "Placement verification via auscultation and aspiration prior to feedings/flushes/meds." Physician's orders for Resident #184 did not include the above mentioned placement verification orders for the nasogastric tube. At 9:30 a.m., when asked about the facility policy regarding giving medications per nasogastric tube, Staff P stated, "We just check residuals, this is only the second nasogastric tube resident that I have had so not sure what the procedure is." At 1:30 p.m., when asked for facility policy on medication administration via nasogastric tube, Staff B stated, "It is standard procedure, we do not have a policy for it, they need to check placement of the tube, you have to check the placement, you have to."	F 281	F 309 Provide Care/Services for Highest Well Being Resident #57 was discharged from facility on 6/9/14. Resident #81 bowel regimen has been assessed and care and services provided as necessary. Resident #158 bowel regimen has been assessed and care and services provided as necessary. Current resident's bowel regimen has been audited by the Resident Care Manager (RCM)/ and or designee to ensure that care and services provided and proper bowel management is in place. The Director of Nursing Services (DNS)/and or designee has put a bowel monitoring process into place for daily monitoring and timely interventions. Education provided to licensed nurses by the Staff Development Coordinator (SDC)/and or designee on ensuring that monitoring bowels daily and providing timely interventions occur as required.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309	The RCM/and or designee will conduct random audits to ensure bowel daily monitoring and timely interventions are occurring as required. Findings will be given to the DNS. The DNS will bring findings to the QAPI Committee monthly for 3 months and as needed thereafter.	

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F 309	<p>Continued From page 8</p> <p>by: Based on interview and record review, it was determined the facility failed to provide necessary care and services for 3 of 21 residents (#158, 81, & 57) reviewed for care. This failure placed residents at risk of experiencing pain and poor bowel management.</p> <p>Findings include:</p> <p><Pain></p> <p>1) Resident #57 was readmitted to the facility on 1/13 with diagnoses including 1/1 and a 1/1.</p> <p>The resident's Minimum Data Set (MDS), an assessment tool, dated 05/12/14 indicated the resident was cognitively intact, frequently experienced pain that made it hard to sleep at night and had a pain intensity of 8 on a scale of 1 to 10.</p> <p>The resident's care plan directed nursing staff to anticipate the resident's need for pain relief and to monitor and document the resident's pain level every shift and provide pain medications as needed.</p> <p>On 06/03/14 at 9:42 a.m., Resident #57 stated he was experiencing pain in his back, toes and mouth.</p> <p>06/05/14 at 2:30 p.m., when asked how Resident #57's pain level was monitored, Staff AA stated, "He tells us when he is in pain."</p> <p>At 2:55 p.m., Staff N stated, "Sometimes he asks for pain medication and sometimes not." Staff N stated, "We do have a pain assessment for each</p>	F 309	<p>The QAPI Committee will review findings and make recommendations as needed.</p> <p>The DNS will ensure compliance.</p>	7/14/14
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F 309	<p>Continued From page 9 resident in the MAR (medication administration record)."</p> <p>Upon review of the resident's MAR, Staff N stated, "It looks like we did miss this one. Pain monitoring is normally on the front page."</p> <p>Review of the June MAR showed Resident #57's pain level had not been monitored according to his care plan and showed the resident's "as needed" pain medication was only given three times during the first five days of June. The medication order was every six hours as needed for pain.</p> <p>On 06/05/14 at 3:18 p.m., when asked how his pain was being managed, Resident #57 stated, "Very poorly." The resident stated he did not always receive pain medication when he asked for it.</p> <p>This failure placed the resident at risk for unnecessary pain.</p> <p><Bowel Management></p> <p>2) Resident #81 was admitted to the facility on 1/13 with diagnoses including diabetes, dementia, and depression. The resident's MDS documented the resident required extensive assistance with activities of daily living (ADL) and was severely cognitively impaired.</p> <p>The facility's bowel management protocol indicated the following: give milk of magnesia if no bowel movement (BM) for three days, give a dulcolax suppository if no bm result for four days, give an enema if no bm result for five days.</p>	F 309		

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F 309	<p>Continued From page 10</p> <p>Review of the resident's bowel management record showed the resident went without a bowel movement (BM) for seven days from 02/05/14 to 02/12/14. According to the resident's MAR, no interventions were initiated. From 02/18/14 to 02/22/14, the resident went without a BM and dulcolax was not given per protocol.</p> <p>Record review documented Resident #81 went without a BM from 04/10/14 to 04/15/14. The facility's policy was not followed and no interventions were initiated.</p> <p>3) Resident #158 was admitted to the facility on 1 14 with diagnoses including diabetes and 3 The resident's MDS, dated 04/29/14, indicated the resident was moderately cognitively impaired and required extensive assistance with ADLs.</p> <p>Record review showed the resident the resident went without a BM for more than three days between 05/03/14 and 05/07/14. The resident's MAR showed the facility policy was not followed and no interventions were initiated.</p> <p>On 06/05/14 at 4:23 p.m., Staff L stated the facility has a bowel management protocol that nurses should have started for residents who went without a bowel movement for three days.</p> <p>On 06/06/14 at 9:26 a.m., Staff P stated nurses are to utilize the green sheet at the front of the MAR to track when an intervention should begin.</p>	F 309			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314			

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F 314	<p>Continued From page 11</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure necessary application of treatment, follow and implement interventions consistent with recognized standards of practice for 2 of 3 current sampled residents (#13 and 111) reviewed for pressure sores. This failure placed residents at risk for developing or worsening pressure ulcers.</p> <p>Findings include: <Resident #111></p> <p>Resident #111 admitted on 1/4 with diagnoses including bilateral knee pain non-surgical, osteoarthritis, 1 joint pain, difficulty walking and 1</p> <p>The resident's Minimum Data Set, an assessment tool, dated 4/24/14, indicated the resident is cognitively intact and required a two person physical assistance with bed mobility, transferring, dressing, bathing and toileting, along</p>	F 314	<p>F 314 Treatment/Svcs to Prevent/Heal Pressure Sores</p> <p>Resident #111 wound was assessed and proper treatment provided as required per physicians orders.</p> <p>Resident #13 wound was assessed and proper treatment provided as required per physicians orders.</p> <p>Current residents with treatment orders for Calcium Alginate dressing usage had wounds assessed and audited by Resident Care Manager (RCM)/and or designee to ensure proper placement of Calcium Alginate dressing treatment as required.</p> <p>Education provided by the Staff Development Coordinator (SDC)/and or designee to licensed nursing staff to ensure necessary application of Calcium Alginate dressing treatment, indications for use, contraindications, precautions, and proper dressing change and removal.</p> <p>Resident Care Manager (RCM)/and or designee will conduct random audits to ensure residents have proper placement of Calcium Alginate dressing as required. Findings will be given to the Director of Nursing Services (DNS) for review.</p> <p>The DNS will bring findings to the QAPI Committee monthly for 3 months and as needed thereafter.</p> <p>The QAPI Committee will review findings and make recommendations as needed.</p>		

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F 314	<p>Continued From page 12</p> <p>with one person physical assist for personal hygiene.</p> <p>The resident's care plan included encouraging frequent position change and cueing every two to three hours. Complete a pressure ulcer risk assessment weekly.</p> <p>The resident's treatment administration record included a physician order for the coccyx pressure ulcer to wash wound, pat dry, apply an alginate and a foam dressing until resolved.</p> <p>According to Calcium Alginate Dressing product information for its intended use, the dressing can be trimmed to fit. Protect the peri-wound skin as needed with a barrier ointment or liquid film. Place dressing directly on wound bed. For deeper wounds, loosely pack dressing into the wound. Make sure the dressing does not overlap the wound margins.</p> <p>On 6/4/14 at 9:51 a.m., during wound care for Resident #111's coccyx pressure ulcer, Staff F washed around the wound and then washed the center open area, instead of starting at the center of the wound and working your way outward. When drying the wound with a clean 4X4 gauze, Staff F started by drying the area around the wound and then dried the center open area then went back over the open wound area twice with the same side of the 4X4 clean gauze.</p> <p>At 9:51 a.m., after cleaning and drying the pressure ulcer on Resident #111's coccyx, Staff F applied the alginate dressing over top of the wound. The wound was 2.9cm by 1 cm oblong shape with rounded irregular edges and the piece of alginate dressing that was cut was a</p>	F 314	The DNS will ensure compliance.	7/14/14	

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F 314	<p>Continued From page 13</p> <p>rectangular shape. The corners and some of the sides of the alginate dressing did overlap the wound edges and came into contact with the intact/healed skin.</p> <p>On 6/5/14 at 2:21 p.m., Staff F stated that she was not aware that alginate should not cover intact skin.</p> <p><Resident #13></p> <p>Resident admitted on 1/13 with diagnoses including atrial flutter, urinary tract infection, 3/3 due to pneumonia.</p> <p>The resident's minimum data set, an assessment tool, dated 5/16/14, indicated the resident required a two person assist for bed mobility, dressing and toileting.</p> <p>The physician orders dated 5/30/14 included 3 would care cleanse with wound wash pat dry, apply Calcium Alginate and cover with foam dressing once a day and PRN {as needed}."</p> <p>On 6/4/14 at 10:07 a.m., during wound care for Resident #13, Staff G cleansed wound as ordered then applied the alginate dressing over top of the wound. The alginate dressing covered the wound and overlapped the wound edges. When asked about covering the wound with the alginate dressing, Staff G stated, "I would cover the wound bed and make sure the alginate is outside the wound bed." When shown the product information leaflet, Staff G stated, "I should have covered the wound bed but not the outside of the wound."</p>	F 314			

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F 314	Continued From page 14	F 314			
F 328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure care and services were provided for 4 of 8 (#2, #16, #36 and #135) current sampled residents reviewed for tracheal suctioning. This failure places residents at risk of not receiving timely tracheal suction and decreased quality of life.</p> <p>Findings include:</p> <p>The resident's Minimum Data Set, an assessment tool, dated 3/31/14 and 4/7/14 indicated the resident had no short term or long term memory problems, required a two person physical assistance for bed mobility, toileting and dressing.</p> <p>The resident's care plan indicated the resident required assistance with activities of daily living.</p>	F 328	<p>F 328 Treatment/ Care for Special Needs</p> <p>Resident #2 respiratory needs were assessed by a Respiratory Therapist and received required services necessary to meet needs.</p> <p>Resident #16 respiratory needs were assessed by a Respiratory Therapist and received required services necessary to meet needs.</p> <p>Resident #6 respiratory needs were assessed by a Respiratory Therapist and received required services necessary to meet needs.</p> <p>Resident #135 respiratory needs were assessed by a Respiratory Therapist and received required services necessary to meet needs.</p> <p>Current residents requiring suctioning were assessed by a Respiratory Therapist (RT) to ensure required services as necessary are provided to meet their needs.</p> <p>New system for communication utilizing radios and headsets was reviewed by the Executive Director/and or designee and RT's on duty provided with individual radio and headset to facilitate timely response to resident requests for tracheal suction.</p> <p>Education provided by Staff Development Coordinator (SDC)/and or designee for RT's, nursing staff, and other facility departments on effective communication to include acknowledging the request for resident assistance with timely arrival or need for transfer of request to another</p>		

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F 328	<p>Continued From page 15</p> <p>On 6/5/14 at 2:11 p.m., Staff CC {nursing staff} in room providing care, Resident #135 pressed call light for assistance and he grabbed his suction catheter. Staff CC asked the resident if he wanted to be suctioned. Resident #135 shook his head yes and Staff CC immediately called respiratory therapy informing them of the room number and the resident's need for suctioning. Staff CC called on the ear communication piece. Staff CC stated s/he also went and told the respiratory manager in person of the Resident #135's request for suctioning.</p> <p>At 2:25 p.m., Resident #135 communicated that he had to wait a long time for suctioning, normally waited 30 minutes on the average 30 percent of the time.</p> <p>At 2: 30 p.m., Staff DD, a respiratory therapist, entered Resident #135's room and proceed to greet the roommate's visitor for a short time, then placed stethoscope on Resident #135's chest to listen for breath sound, placed a pulse oximeter on the resident's finger, fix her face mask as it was caught in his/her hair and ear phone, did some charting in Resident #135's respiratory chart, and then ask Resident #135 if he wanted to be suctioned.</p> <p>At 2:38 p.m., Resident #135 was suctioned for 20 seconds, the first pass collected a moderate amount of light yellowish thick secretion and the second pass had very little light yellowish secretions.</p> <p>During the 27 minutes the resident was waiting to be suctioned, Resident #135's eyes were wide open and shoulders were held up in a tense</p>	F 328	<p>licensed staff as needed to ensure care and servicers provided to meet resident's needs for quality of life.</p> <p>Respiratory Therapy (RT) Manager/and or designee will conduct random audits to ensure residents needs/request are met timely. Findings will be given to the Executive Director.</p> <p>The Executive Director will bring findings to the QAPI Committee for 3 months and as needed thereafter.</p> <p>The QAPI Committee will review findings and make recommendations as needed.</p> <p>The Executive Director will ensure compliance.</p>	<p>7/14/14</p> 

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F 328	<p>Continued From page 16</p> <p>position. Once suctioned, Resident #135's eyes were half closed and his/her shoulders were down in a relaxed position. The resident communicated that he was much more relaxed after being suctioned.</p> <p>At 2:53 p.m., when asked about the process for communication between the nursing staff and the respiratory staff, Staff EE stated, "They {nursing staff} usually just come and get us, we just got these ear phones two days ago."</p> <p>At 2:56 p.m., when asked about the process for communication between the nursing staff and the respiratory staff, Staff DD stated, "I was on lunch break at 2:11p.m., but they {nursing staff} come get me or call on this ear phone."</p> <p>At 2:59 p.m., Staff FF stated, "I cannot remember if I got the call {for Resident #135's request to be suctioned at 2:11 p.m.} I don't remember, and yes I was here at 2:11 p.m., I must have got the call but I was busy answering other calls. I have not stopped and not even taken a break at 1400. I was here. I also have to help transfer and get residents up. I try to get there as soon as possible. If I am not available, I try to find another respiratory therapist."</p> <p>At 3:22 p.m., Staff E, the respiratory manager, stated, "I don't have an ear phone, because I thought it was more important for my staff to have them {ear phones}." At first Staff CC didn't remember the nursing staff informing him/her of Resident #135's suctioning request. Although after confirming with the nursing staff, Staff E stated, "I do remember now the CNA coming to get me, but I heard a ventilator alarm from room # {indicating the room next door to Resident</p>	F 328			

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F 328	Continued From page 17 #135's} and assumed it was the resident requesting to be suctioned." On 6/5/14 at 3:30 p.m., when asked about suctioning wait times, Resident #2 stated, "I wait up to an hour to be suctioned. I really don't want to get anyone in trouble, but it's true." On 6/5/14 at 4:54 p.m., when asked about suctioning wait times, Resident #6 stated, "I wait up to an hour to be suctioned." On 6/6/14 at 11:30 a.m., when asked about suctioning wait times, Resident #16 {Resident #135's roommate} stated, "We wait 20 minutes at night to be suctioned, we ring the call bell, staff come in and shut the light off and then we have to ring it again. I have seen him {pointing to Resident #135} also wait a long time for suctioning." Eight minutes elapsed from the time the respiratory therapist entered the room to the time the resident was suctioned, and 27 minutes elapsed from the time the resident pressed the call light requesting suctioning to the resident being suctioned. Waiting for suctioning needs to be met can cause undue stress for the residents and has potential to decrease their quality of life.	F 328			
F 371 SS=D	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	F 371			

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F 371	<p>Continued From page 18</p> <p>(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 food was served under sanitary conditions. This failure placed residents at risk of consuming contaminated foods and distributing food under less than sanitary conditions.</p> <p>Findings include:</p> <p>On 06/04/14 at 12:16 p.m., Staff R was observed placing butter containers directly on top of bread to be served to residents. When asked about the unsanitary butter containers on top of the bread, Staff R indicated the containers were not sanitary and should not be placed on top of the bread.</p> <p>At 12:19 p.m., Staff S was observed touching slices of bread to center them on the plate with gloved hands that had touched various unsanitary surfaces (carts, handles and railings).</p> <p>At 12:28 p.m., Staff R indicated he did not think about the butter container not being sanitary when he put it directly on the bread.</p> <p>At 12:30 p.m., Staff S indicated she had not thought about her gloved hands being dirty when she touched various surfaces and then directly touched the bread with the same gloved hands.</p>	F 371	<p>F 371 Food Procure, Store/Prepare/Serve</p> <p>Residents #111, #175, and #181 were reviewed to ensure no signs and symptoms of a food born illness/and or GI infection.</p> <p>The Infection Control nurse will continue to monitor, track and trend residents infections per policy as required.</p> <p>The dietary staff were provided education by the Registered Dietician/and or Infection Control nurse/and or designee on serving food under sanitary conditions, preventing cross-contamination on eating surface and while food is being prepared for service while on tray line, handling dishes and utensils appropriately, operating the plate warmer correctly, and proper glove changing and hand hygiene as required to ensure that food is stored, prepared, distributed and served under sanitary conditions.</p> <p>Staff assigned to assist in the dinning rooms and assist in passing of room trays to residents were educated by the director of staff development/and or designee regarding appropriate areas to handle plates, utensil, glasses, cups, bowls and the appropriate use of hand washing versus use of hand sanitizer. This education to include when hand washing is required.</p> <p>The Registered Dietician/and or the Infection Control nurse/and or designee will conduct random audits in the kitchen during meal service to ensure that food is stored, prepared, distributed and served under sanitary conditions. These findings will be</p>		

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F 371	<p>Continued From page 19</p> <p>At 12:41 p.m., Staff R was observed serving noodles into bowls and onto plates to be served to residents. Staff R touched the noodles directly with gloved hands that had touched various surfaces including a rag to clean and a plate warming cart.</p> <p>At 12:43 p.m., Staff R was observed getting plates from a warming cart by touching the eating surface of the top plate when releasing the plates.</p> <p>At 12:54 p.m., Staff T indicated Staff R and Staff S were not aware they contaminated the eating surface and food being prepared for service while on tray line. The rag used to clean during tray line should have been put into a sanitation solution bucket after being used. The staff will need to be in-serviced.</p> <p><Mount Baker Hall Trays></p> <p>Facility policy entitled "Tray line Set Up, Service and Meal Delivery" reads, "Avoid touching food contact surfaced of dishes and utensils. This includes the rim of bowls, cups, and glasses ...Hold cups by their handles. Hold glassware in the middle bottom or stem."</p> <p>On 6/2/14 at 12:06pm, Staff H picked up a plastic glass by putting his/her finger in the glass prior to refilling the glass with water for Resident #111.</p> <p>At 12:11 p.m. Staff H touched the top of the rim of a glass while serving drinks to Resident #175.</p>	F 371	<p>given to the Dietary Service Manager (DSM) to review.</p> <p>The Registered Dietician/and or the Infection Control nurse/and or designee will conduct random audits during meal service in the dining rooms and during hall tray pass to ensure appropriate sanitary measures are in place. These findings will be given to the Director of Nursing Services (DNS) to review.</p> <p>The DSM and DNS will bring findings from audits to the QAPI Committee monthly for 3 months and as needed thereafter.</p> <p>The QAPI Committee will review findings and make recommendations as needed.</p> <p>The DSM and DNS will ensure compliance.</p>	7/14/14	

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F 371	<p>Continued From page 20</p> <p>Staff H then picked some dirty dishes, signed a paper and performed hand hygiene with antimicrobial gel prior to returning to the food tray distribution.</p> <p>At 12:22 p.m., Staff I touched the rim of a coffee cup when serving coffee to Resident #181.</p> <p>At 12:22 p.m., Staff H removed Resident #181's footrests from the resident's closet and applied them to the resident's wheelchair. Staff H then wheeled Resident #181 to the dining room for the Baker Unit, served the resident a plate of food without first performing hand hygiene.</p> <p>At 12:28 p.m., Staff U was observed using antimicrobial gel prior to starting the delivery of trays to resident rooms.</p> <p>At 12:40 p.m., Staff H touched the rim of a coffee cup while serving hot chocolate to Resident # 114.</p> <p>On 6/5/14 at 5:15 p.m., Staff J used antimicrobial gel prior to food service and then touched the rim of a coffee cup while serving drinks to Resident #175.</p> <p>On 6/5/14 5:25 p.m., when asked how to carry drinks to residents, Staff J indicated that cups need to be handled near the base of the coffee cup. When surveyor demonstrated how s/he was carrying the coffee cup Staff J stated, "That's too close because you can touch the drinking surface."</p> <p><Spirit Lake Dining Room></p> <p>At 12:36 p.m., Staff V was observed using</p>	F 371			

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F 371	<p>Continued From page 21</p> <p>antimicrobial gel prior to entering the dining room and proceeded to pour coffee for residents without washing her hands with soap and water.</p> <p>At 12:42 p.m., Staff N was observed putting some clothes protectors on the residents and then proceeded to deliver some lunch trays without first washing his/her hands.</p> <p>At 12: 49 p.m., Staff W was observed adjusting a resident's wheelchair, moved a stool to the table and then assisted a resident with feeding without first washing his/her hands.</p> <p>At 12:54 p.m., Staff U was observed entering the dining room, used antimicrobial gel prior to assistating in feeding a resident.</p> <p>On 6/2/14 at 1:44 p.m., when asked about the policy for hand washing in regards to food service, Staff U stated, "We don't have a sink so we gel every time we serve a tray, and after any care you have to wash your hands" Staff V stated, "If we touch the wheelchair or reposition the resident it is automatic for us, we wash our hands."</p> <p>On 6/3/14 at 3:04 p.m., when asked about the hand hygiene policy in regards to food service, Staff C stated, "I have told them time and time again, if they feed the residents, use the bathroom, they have to wash their hands after any patient care contact." When asked what staff should do if they touch the wheelchair or reposition the resident she stated "they need to wash their hands."</p>	F 371			

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F 412 F 412 SS=D	Continued From page 22 483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide routine dental services for 1 of 3 current sampled residents (#57) reviewed for dental. This failure placed the resident at risk of poor dental health, and an increase in oral pain and chewing problems. Findings include: Resident #57 was readmitted to the facility on 1/13 with diagnoses including renal disease, coronary artery disease and a 3 The resident's Minimum Data Set (MDS), an assessment tool, dated 05/12/14 indicated the resident was cognitively intact and required extensive assistance with activities of daily living. On 06/03/14 at 9:14 a.m., Resident #57 was observed with missing/broken teeth. The resident stated, "My teeth are rapidly deteriorating and I have not seen a dentist in years." The resident	F 412 F 412	F 412 Routine/Emergency Dental Services in NFS Resident #57 was discharged from facility on 1/14. Oral assessments have been conducted on current residents by the Resident Care Manager/and or designee to ensure residents with broken/missing teeth or oral dental pain have been assessed and offered services as needed. Education provided by the Staff Development Coordinator/and or designee for the Social Service staff regarding the need to ensure that dental services are set up and documented to reflect when a resident refuses. Education provided by the Staff Development Coordinator/and or designee to the licensed nursing staff to ensure that resident with broken/missing teeth or oral dental pain have been assessed and offered dental service. Also, to ensure notification to the Social Services department of residents dental service needs. The Director of Nursing Services (DNS)/and or designee will conduct random audits to ensure accuracy of dental assessment and that appropriate referrals have been initiated and documented. The DNS will bring audit findings to QAPI Committee monthly for 3 months and as needed thereafter.	

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F 412	<p>Continued From page 23</p> <p>pointed to his upper and lower jaw and stated he had pain in his mouth.</p> <p>On 06/05/14 at 2:18 p.m., the resident stated he had not been asked if he wanted to see a dentist and stated he would like to.</p> <p>On 06/05/14 at 2:47 p.m., when Staff BB was asked if Resident #57 had been seen by the dentist, Staff BB looked in the resident's medical chart and stated, "There is nothing in there." Staff BB stated she would ask the resident if he wanted to be seen.</p> <p>At 3:30 p.m., Resident #57 stated Staff BB had just been in his room and offered him a dental appointment. He stated he would be seeing the dentist soon.</p> <p>At 4:55 p.m., the Administrator stated the resident had never been seen by the facility dentist and did not provide documentation that he had previously been asked.</p> <p>The facility failed to ask if a resident with dental problems was interested in seeing a dentist for routine dental care leading to mouth pain without care being offered.</p>	F 412	<p>The QAPI Committee will review findings and make recommendations as needed.</p> <p>The DNS will ensure compliance.</p>	7/14/14
F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug</p>	F 431		

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F 431	<p>Continued From page 24</p> <p>records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to dispose of expired medications, and failed to ensure medications were stored under sanitary conditions in 6 of 7 medication and treatment carts and 2 of 2 medication storage rooms reviewed for medication storage. This failure placed residents at risk of receiving expired medications and at</p>	F 431	<p>F 431 Drug Records, Label/Store Drugs & Biologicals</p> <p>Medication carts were cleaned, medications were organized and stored appropriately, and expired medications were disposed of as required. Also, Sharps containers were disposed of as needed and new sharps containers were put in place.</p> <p>Medication rooms including ice machine, sink, counter tops, cupboard doors, lighting covers, walls, ceiling, and floor tiles, were cleaned and repaired/replaced as needed. Expired medications were disposed of as required.</p> <p>Refrigerators & freezers were cleaned and temperature adjusted as required. Medications were organized and stored appropriately and expired meds were disposed of as needed.</p> <p>System set up to review current medications in medication carts and in medication rooms monthly to ensure medications stored under sanitary condition and to dispose of expired medications as required. This includes cleaning schedules for medication carts and medication rooms.</p> <p>Education provided by the Staff Development Coordinator/and or designee to the licensed nursing staff in regards to ensuring medication carts are kept clean, medications are organized and stored appropriately, and expired medications are disposed of as required. Also, Sharps containers are disposed of when 2/3rds full.</p>		

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F 431	<p>Continued From page 25</p> <p>risk for not receiving the full benefit and/or experiencing adverse effects of medications.</p> <p>Findings include:</p> <p>On 06/05/14 at 10:27 a.m., the first Mount Saint Helens Hall Medication Cart was observed to have several loose medication tablets in the bottom of the dirty top drawer. Staff K stated, "Yeah, they fall out. Maybe pharmacy will clean it out."</p> <p>A resident's Promethazine tablets were found to have expired 04/2014. Staff K stated, "Usually the RCM (Resident Care Manager) goes through the cart looking for expired meds."</p> <p>Four (4) loose Amoxicillin tablets were observed in a medication cup with a resident's name and room number. Staff K said, "They (nursing staff) probably pulled those from the e-kit last month for his dental appointment. He never went. They are probably saving them in case he goes."</p> <p>A Lidocaine patch was found out of its package with a sticker attached, dated 06/04/14. Staff K stated, "Oh, it's a patch from out of the package. They (the nursing staff) probably pulled it and planned to use it. They should throw it out."</p> <p>At 10:30 a.m., the 300 Hall Medication Room's refrigerator was observed with a temperature logs. The log noted guidelines for appropriate refrigerator temperature, 34 to 38 degrees Fahrenheit (F). The June Refrigerator Temperature Log showed the following refrigerator temperatures: On 06/01/14 - 30 degrees; on 06/02/14 - 28 degrees; and on 06/03/14 - 25 degrees. The May Refrigerator</p>	F 431	<p>Education also includes ensuring that refrigerator temperatures remain between 34-38 degrees or refrigerator temperature will be adjusted and re-checked, also to notify maintenance for follow-up as needed.</p> <p>Refrigerators, ice machines, counter tops, lighting covers and floor tiles have been added to the Preventative Maintenance Program (PMP) for routine inspections.</p> <p>The Director of Nursing Services (DNS)/and or designee will conduct random audits to ensure medications are stored under sanitary conditions and that disposal of expired medications are occurring as required. This includes sharps containers are properly maintained for safety. The DNS will report findings to the QAPI Committee for 3 months and as needed thereafter.</p> <p>The Facility Maintenance Director/and or designee will review the PMP monthly for completion and issues will be reported to the QAPI Committee for 3 months and as needed thereafter.</p> <p>The QAPI Committee will review findings and make recommendations as needed.</p> <p>The DNS and the Maintenance Director will ensure compliance.</p>	7/14/14	

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F 431	<p>Continued From page 26</p> <p>Temperature Log showed 18 days out of the temperature range of 34 to 38 degrees (F), as high as 42 degrees F and as low as 28 degrees F. Staff K stated the staff on night shift checks the refrigerator temperatures. "They should have adjusted it (the refrigerator) and rechecked it."</p> <p>The sink in the Medication Room was observed to be dirty. Staff K stated, "Housekeepers are supposed to clean. It (the sink) was worse. Not sure why the sink looks like that. It is better than it was."</p> <p>When asked about medication stored in the medication room, Staff K said the medications were waiting to go back to the pharmacy. Staff K stated, "The pharmacy is supposed to take it..." when we changed pharmacies six (6) months ago.</p> <p>At 10:40 a.m., the 300 Hall Treatment Cart was observed with two (2) tubes of Prep-H cream that had expired 03/2013. Staff K stated, "We got two bad tubes."</p> <p>At 10:45 a.m., the ice machine in the 300 Hall Storage Area was observed to be dirty, dripping of water, covered in a white scaly substance with unidentified object floating in the tray. The counter around the sink and ice machine was stained with a rusty colored residue around the ice machine. The counter under the ice machine was damaged with wood particles exposed through the Formica covering. Staff K stated, "Housekeeping is supposed to keep it clean." When asked about the floating substance in the ice machine tray, Staff K stated, "Oh, not sure what that is."</p>	F 431			

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F 431	<p>Continued From page 27</p> <p>The refrigerator in the 300 Hall Storage Area was observed with a temperature of 32 degrees F. The June Refrigerator Temperature Log had temperatures of 25 and 30 on the log, outside the documented guidelines of appropriate refrigerator temperatures of 34 to 38 degrees F. After reviewing the refrigerator temperature log, Staff K stated, "Oh...Look at that."</p> <p>The facility guidelines for the freezer documented freezer temperatures should be less than 0 degrees F. The refrigerator's freezer was observed with a temperature of 6 degrees. The freezer contained two black bananas and a frozen sandwich, dated 06/04/14. Staff L stated, "They are marking it out of range."</p> <p>At 11:00 a.m., the second Mount Rainier Hall Medication Cart was observed with several loose medication tablets in the bottom of the dirty second drawer. Staff G stated, "I need to take them out and put then in the sharps container." The bottom drawer contained a bottle of odor eliminator stored next to oral medications. Staff G stated, "That is an air freshener. We use it in the resident rooms."</p> <p>At 11:05 a.m., Staff M observed the refrigerator and ice machine in the 300 Hall Storage Area, and indicted the refrigerator temperature was 40 degrees F, outside the temperature guidelines. Staff L stated, "I just had the door open." Staff M stated, "I turned it down," and indicated it should get cleaned every week. When asked about the exposed wood particles in the counter top under the ice machine, Staff M stated, "That is swelling from water damage."</p> <p>At 11:09 a.m., the second Mount Saint Helen's</p>	F 431			

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F 431	<p>Continued From page 28</p> <p>Medication Cart was observed with an overflowing sharps container exposing razors and needles that had not fallen through to the bottom of the container. Sharps were 2 to 3 inches over the "full line" marked on the container. Staff N stated, "It has to be changed."</p> <p>A resident inhaler was found loose in the bottom of the medication cart. Staff N stated, "It should be in a bag."</p> <p>At 11:12 a.m., the medication refrigerator in the 100 Hall Medication Room had 3 to 4 inches of ice at the top of the refrigerator dripping water onto the medications and floor, when the door was open. Staff G stated she had "no idea about the defrost schedule. It seems like it needs it. It should be defrosted."</p> <p>The refrigerator contained an open glass vial of Acetylcystene without an open date. Staff G stated, "It should be dated."</p> <p>The 100 Hall Medication Room 's cupboard contained a bottle of Aspirin with an expiration of 03/2014. Staff G stated, "That needs to go."</p> <p>The Medication Room sink was observed to be dirty with a thick brown film around the sink. The wall next to the refrigerator had a large brown stain that appeared to have been splashed down the full length of the wall. The cupboard doors under the sink were soiled, the light fixture was cracked, and the vent cover and ceiling were covered with a black residue. Staff G she had "no idea what that splash is. Housekeeping should clean it. They should do it daily. They changed the bulbs in lights. Not sure how long ago. The black stuff is a maintenance issue. I need to put it</p>	F 431			

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F 431	<p>Continued From page 29 on the Maintenance Communication Log."</p> <p>The Medication Room contained five (5) boxes of expired medications dated 02/2014. Staff G stated, "Those are to go to the pharmacy. We changed pharmacies in January. Not sure what we are supposed to do with the new pharmacy."</p> <p>At 11:45 a.m., the first Mount Rainier Medication Cart was observed with a bottle of Rantidine without an expiration date. The bottle label noted "see product label." No product label was on the Rantidine bottle. A bottle of Oxycodone was observed covered with a red stain covering the expiration date. A second bottle of Oxycodone was observed with an expiration date of 12/2013.</p> <p>The following medications had expired: Warfarin expired 04/14, Clozapine expired 06/14, Risperidone expired 05/14 and Risperidone expired 04/14. Staff O stated, "It is everybody's responsibility to go through the cart. There is no reason these (expired medications) are here. They need to go back to the pharmacy, but not sure what they will look like now that we have changed companies."</p> <p>At 11:50 a.m., the Mount Backer Hall Medication Cart was observed with a Symbicort inhaler without an expiration date. The label documented "see product label." No product label was found on the inhaler. Staff P stated, "It must have rubbed off."</p> <p>The bottom of a medication canister was observed with a large amount of sticky black residue. Staff P stated, "Maybe it got wet. Not sure. We need to clean it out."</p>	F 431		

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F 431	Continued From page 30 At 11:55 a.m., Staff Q observed the Medication and Storage Rooms. When asked about the stain on the wall and the dirty sink in the 100 Hall Medication Room, Staff Q stated, "That's a pretty recent stain. Usually evening shift cleans in here. We definitely need to take care of it." When asked about the ice machine on the 300 Hall, Staff Q said, "Those look like hard water stains. It should be checked daily." At 11:58 a.m., broken floor tiles were observed in the 300 Hall Storage Room. The Staff M stated, "They need to be fixed." At 1:30 p.m., when asked about the expired medications and the condition of the medication and storage rooms, Staff B stated, "Yes...I can't believe it." Staff B indicated it was her goal to improve the conditions of the building. Staff B stated, "They (the prior pharmacy company) were to remove all the medications...Staff are down there (medication room) now destroying all the medications."	F 431	F 441 Infection Control, Prevent Spread, Linens The Infection Control nurse will continue to monitor, track and trend residents infections per policy as required and provide education/training as needed to prevent infections. Education will be provided by the Staff Development Coordinator (SDC)/and or designee for Staff to ensure that staff use appropriate infection control practices designed to prevent cross contamination with hand hygiene, laundry services and medication administration to decrease exposure of infectious organisms. This training will include but not limited to infection control procedures, linen handling, personal protective equipment, and transmission precautions. SDC will conduct random audits regarding hand washing, appropriate linen handling, personal protective equipment usage, and transmission based precautions. Findings will be given to the Director of Nursing Services (DSN) for review.		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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;	F 441	The DNS will bring findings to the QAPI Committee monthly for 3 months and as needed thereafter. The QAPI Committee will review findings and make recommendations as needed. The DNS will ensure compliance.	7/14/14	

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/06/2014
NAME OF PROVIDER OR SUPPLIER RAINIER REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 920 12TH AVENUE SOUTHEAST PUYALLUP, WA 98372		
(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 441	<p>Continued From page 31</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that staff used appropriate infection control practices designed to prevent cross contamination with hand hygiene, laundry services and medication administration. This failure placed residents at risk for exposure of infectious organisms.</p> <p>Findings include: <Hand Hygiene></p>	F 441			

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F 441	Continued From page 32 Facility policy entitled "Hand Hygiene/Handwashing" reads, "Hand hygiene is to be performed: After removal of medical/surgical or utility gloves." Facility policy entitled "Hand Hygiene/Handwashing" reads, "Rub hand together with a vigorous friction for 20 seconds (The amount of time it takes to sing "Happy Birthday" through twice) or as designated by state regulations, covering all surfaces of the hands, exposed arms, fingertips and between the fingers." On 6/4/14 at 9:51 a.m., during wound care for Resident #111, Staff I washed hands for 2 to 4 seconds after removing old dressing and gloves prior to commencing the cleaning of the wound. On 6/4/14 at 10:07 a.m., during wound care for Resident #13, Staff G did not perform hand hygiene after removing gloves twice during the wound care procedure. Staff G stated, "I do not wash my hands when I take off my gloves, I only wash my hands after the dirty dressing is removed. When going from dirty to clean." On 6/4/14 at 2:57 p.m., Staff C stated, "Staff is taught to wash their hands for as long as it takes to sing the happy birthday song, sing it twice or to wash your hands for 20 seconds ensuring to wash the entire surface of the hands, the wrists and under the fingernails. Get a clean paper towel to dry the hands and another paper towel to turn the faucet off. They {the staff} know better. I do spot checks and sometimes I don't tell them {the staff}, and some do rush through it {performing hand hygiene}."	F 441			

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F 441	<p>Continued From page 33</p> <p>On 6/4/14 at 2:57 p.m., Staff C stated, "They {staff} are supposed to wash their hands when they take their gloves off every time. I tell them and in-services include every time you remove gloves and I go over proper times like when soiled, entering a room things like that. It {not performing hand hygiene after removing gloves} is wrong."</p> <p>On 6/5/14 at 9:14 a.m., during medications preparation, Staff P was observed picking up a newspaper off the floor, and then took some medications to Resident #158 without washing his/her hands. Staff P proceeded to crush some medications, entered Resident #184's room, put on some gloves and gave the resident the medications without washing his/her hands.</p> <p>At 9:35 a.m., when informed of not performing hand hygiene prior to putting on gloves and giving some medications at 9:14 a.m., Staff P stated, "I should have sanitized."</p> <p>< Laundry & Housekeeping Services ></p> <p>On 6/3/14 at 10:10 a.m., Staff was observed carrying linens against her body as she walked down the hall and into a resident's room.</p> <p>On 6/3/14 at 3:04 p.m., when asked how staff should transport linens, Staff C stated, "Clean linens don't touch the body."</p> <p>On 6/4/14 at 10:53 a.m., Staff Z was observed shaking a clean sheet and in the process, it touched the floor. Staff Z proceeded to place the sheet under her chin, folded the sheet in half against her body, and laid the sheet on the table</p>	F 441			

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F 441	Continued From page 34 over other clean linens to finish folding the sheet. Staff Z then placed the folded sheet on the shelf with the other clean folded linens. On 6/4/14 at 10:37 a.m., when asked about the transport of linens, Staff I stated, "Linens must be bagged." Staff X interjected, "...or away from the body." On 6/4/15 at 11:45 a.m., when informed of the observations with folding and caring of the linens, Staff Q stated, "If it {linens} touches their body, they must rewash it {linens}. Clean linens don't touch the body. I will retrain her {Staff Z} she should have folded the sheet on the table, that's what the table is for."	F 441			