

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

PRINTED: 10/29/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505421</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/16/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WASHINGTON ODD FELLOWS HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>534 BOYER AVENUE WALLA WALLA, WA 99362</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Washington Odd Fellows Home on 10/08/12, 10/09/12, 10/10/12, 10/11/12, 10/12/12, 10/15/12 and 10/16/12. A sample of 55 residents was selected from a census of 96. The sample included 49 current residents and the records of 6 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>Liisa Johnson, RN Pam Holt, RN Lucy Fromherz, RN Brenda Webster, RN</p> <p>The survey team is from:</p> <p>Department of Social &amp; Health Services Aging &amp; Disability Services Administration Residential Care Services, District 1, Unit C 3611 River Road, Suite 200 Yakima, WA 98902</p> <p>Telephone: (509) 225-2800 Fax: (509) 574-5597</p> <p><i>C. Webster 10/29/12</i></p> <p>Residential Care Services Date</p>	F 000	<p><b>Received Yakima RCS NOV 8 2012</b></p>	
F 225 SS=E	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p>	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE <b>ADMINISTRATOR</b>	(X6) DATE <b>11/7/12</b>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	<p>Continued From page 1</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 225	<p><b>F225</b></p> <p>Resident #57: The surveyor failed to recognize that the resident self-reported that the injury was self-inflicted and present prior to admission. Nonetheless, facilities policies have been modified to clarify that the incident investigation must include the final conclusion and determination of cause.</p> <p>Resident #19: The surveyor failed to note the clearly established and correct assessment date of [REDACTED] the date of injury, where staff was cautioned to use extra care in transferring with the hoist lift. It is unclear how the surveyor conjured a date 18 days hence. Nonetheless, facility policy has been modified to specifically state that causal factor must be included in the conclusion of the investigation.</p> <p>Resident #104: Facility policy has been modified to specifically state that causal factor must be included in the conclusion of the investigation.</p> <p>Resident #70: Facility policy has been modified to specifically state that causal factor must be included in the conclusion of the investigation.</p>	
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F 225	<p>Continued From page 2</p> <p>by: Based on interview and record review the facility failed to ensure all allegations of potential mistreatment, neglect, or abuse, including injuries of unknown source, were thoroughly investigated and reported to the appropriate entities, including the state survey agency, in accordance with 42 CFR 483.13(c)(2-4). Deficient practice was identified for 1 of 2 sampled residents (#57) who had injuries in areas not generally vulnerable to trauma. In addition, the facility failed to thoroughly investigate and/or develop interventions for 4 of 12 sampled residents (#19,57,70,&amp;104) with incident investigations reviewed for 'injury during handling' by staff. Without thorough investigations, the facility was unable to determine whether the 'staff handling' incidents were related to abuse or neglect. Findings include but are not limited to:</p> <p>Resident #57. Admitted to the facility on [REDACTED] with multiple diagnoses and was dependent on staff for assistance with care and activities of daily living.</p> <p>Review of the facility incident log revealed on [REDACTED] at 7:00 p.m. staff noted Resident #57 had a substantial injury in an area not generally vulnerable to trauma with no definite cause identified and not reported to the state agency hotline.</p> <p>The facility occurrence report dated [REDACTED] described a 19 centimeter (cm) by 5 cm bruise to left inner thigh/knee area and the resident stated the bruise was tender. The assessment and conclusion on the report noted the "resident may have caused the bruising herself " or "(the</p>	F 225	<p>This will be monitored by the DNS and will be completed by November 30, 2012.</p>		

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F 225	<p>Continued From page 3</p> <p>bruise) may have been from (the) x-ray table prior to admit." No further investigation was provided to establish if the bruise had been present since admission 10 days prior or if it was a new injury.</p> <p>On 10/16/12 at approximately 1:00 p.m. the Director of Nursing stated their policy was to notify the hotline for allegations of abuse, neglect and substantial injuries of unknown origin. She stated she did not further investigate the cause of Resident #57's inner thigh bruise or call the hotline because she thought she had established a reasonable cause.</p> <p>Resident #19. Review of the facility incident log noted an "injury during handling" had resulted on [REDACTED]. The 'incident investigation' documented the arm of the Hoyer bar (mechanical lift for transferring) had bumped her in the forehead causing a bruise 1x1 centimeters (cm).</p> <p>The resident was admitted with diagnosis of a [REDACTED]. The current plan of care noted the staff was directed to provide extensive assistance with transfers. A [REDACTED] revision of the care plan, 18 days after the incident causing the bruising, staff was directed to provide extra care when transferring with Hoyer lift to avoid injury and updated transfer instructions were provided.</p> <p>However, the facility had not completed a thorough investigation of how the arm of the mechanical lift bar had specifically hit the resident and how/why staff was involved.</p>	F 225		

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F 225	<p>Continued From page 4</p> <p>Resident #104. Review of the facility incident log noted an "injury during handling" had resulted on [REDACTED]. The 'incident investigation' documented an aide had found a 4 cm abrasion and a 3 cm bruise/abrasion below the right knee. The resident reported it occurred when she was getting into the wheelchair in early evening; "legs weren't in position for transfer and scraped against [wheelchair]." The investigation noted sharp edges were not found on the chair. The plan was to use extra care with transfers (a standard of practice).</p> <p>She was admitted with [REDACTED]</p> <p>However, the facility had not completed a thorough investigation of how the abrasion and bruising had occurred and what responsibility the staff had who were involved.</p> <p>Resident #70. An Incident Report dated [REDACTED] documented a blood spot on his brief which was from an abrasion measuring 2 by .25 cm on the back side of the right thigh. The report stated Staff Member M had caused the scratch with his fingernail.</p> <p>On 10/16/12 at 12:23 p.m. Staff Member M stated that "we believed it was caused by a fingernail scratch and or scraping of skin while changing a brief. The abrasion could have been done during any time. It could have been mine or done before on the day shift. I was changing him and rolling him side to side and happened to notice [the scrape] and reported it. We didn't know if the</p>	F 225		

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F 225	Continued From page 5 previous shift did it or not."	F 225		
F 241 SS=E	<p>There was no evidence of an investigation of exactly when or how the incident occurred although Staff Member M had stated he reported to management that it could have been another shift causing the injury.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to promote dignity in dining for 2 of 2 dining rooms. Findings include:</p> <p>On 10/09/12 at 7:30 a.m., observations were made of the West dining area. There were three random residents observed seated at a U-shaped table at 7:30 a.m. They had their eyes closed, appeared asleep and nothing was placed on the table before them. There was no observation of staff interaction with those residents prior to the delivery of their meal at 8:15 a.m., 45 minutes after observations began. Staff was observed interacting with and delivering meals to other residents throughout the dining room during those 45 minutes. Fluids and meaningful activities were offered to other alert residents while they waited for their meal.</p> <p>On 10/09/12 between 7:35 a.m. and 8:15 a.m.,</p>	F 241	<p><b>F241</b></p> <p>Facility policies and practices have been modified to encourage meaningful activities or interaction before meals with residents who are in need of significant assistance during meals. Further, for those residents unable to actively participate in the group dining experience will not be escorted to the dining room until the meal is able to be served and assistance is able to be given.</p> <p>This will be monitored by the Charge Nurse and will be completed by November 30, 2012.</p>	

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F 241 Continued From page 6  
four residents were seated in the East dining room at each of the five U shaped tables designated for staff to assist residents with their meals. At the U shaped table close to the window, four residents were seated prior to the dining room observation which began at 7:45 a.m. Cups with coffee or water were located in front of them. During the approximately 45 minutes of waiting for their meals, the resident sat without drinking. The aides were involved with seating residents and providing meals for the residents located in the independent east dining room. Once their meals began, aides assisting residents with the meals at the U shaped tables were seated across from the residents offering utensils filled with food and/or verbally cueing residents as needed.

On 10/16/12, during the breakfast meal in the East dining room, four residents requiring staff assistance for meals were seated for 45 minutes (between 7:45 a.m. and 8:30 a.m.) prior to being served. The residents were not drinking or attempting to drink from the cups set before two of them. There were no meaningful activities taking place. Staff was escorting other residents to their tables and/or serving meals in the adjacent independent dining room. The residents were not able to be interviewed about the length of time they were seated due to their poor cognition.

F 252  
SS=E 483.15(h)(1)  
SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT

The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings

F 241

F252

The surveyor failed to recognize the intent of §438.15(h)(1) Guidance to Surveyors, which states:

*A "homelike environment" is one that de-emphasizes the institutional character of the setting, to the extent possible, and allows the resident to use those personal belongings that support a homelike environment. A personalized, homelike environment recognizes the individuality and autonomy of the resident, provides an opportunity for self-expression, and encourages links with that past and family members. The intent of the word "homelike" in this regulation is that the nursing home should provide an environment as close to that of the environment of a private home as possible. This concept of creating a home setting includes the elimination of institutional odors, and practices to the extent possible.*

F 252

*Many facilities cannot immediately make these types of changes, but it should be a goal for all facilities that have not yet made these types of changes to work toward them. A nursing facility is not considered non-compliant if it still has some of these institutional features, but the facility is expected to do all it can within fiscal constraints to*

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F 252	<p>Continued From page 7 to the extent possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a home-like environment for residents who ate in the East and West dining rooms. This failure placed the residents at risk for a diminished quality of life. Findings include:</p> <p>On 10/09/12 and 10/16/12 breakfast was observed in the East dining room between 7:30 a.m. and 8:30 a.m. During both observations, a medication cart was parked in the dining area and a nurse provided medications to various residents during the meal. The dining tables were bare without placemats, place settings or home like decor. Many residents ate their meals off of a plain cafeteria style tray set on the table. The U shaped tables for residents who required assistance with their meals were colored gray and had no 'home-like' appearance.</p> <p>On 10/09/12 at 7:30 a.m. dining was observed in the West dining room. A medication cart was outside the North door and the medication nurse provided medications residents during the meal.</p> <p>On 10/16/12 at 8:30 a.m. in the east dining room a random resident was noted eating her breakfast meal served on a tray. She stated it was what she did here, "so the waitress can take it back to the kitchen." She stated, "this was how I ate in the cafeteria at school."</p> <p>On 10/16/12 at approximately 8:45 a.m., Staff Member D stated many residents eat off the</p>	F 252	<p><i>provide an environment that enhances quality of life for residents, in accordance with resident preferences.</i></p> <p>The surveyor failed to recognize the following issues:</p> <ol style="list-style-type: none"> <li>1. It is absolutely homelike to take medications with a meal. Anecdotally, most Americans who take prescription medications do so during their meal.</li> <li>2. As noted above, the regulation is interpreted that the facility must make a good faith attempt to provide a homelike environment to the residents. Although the typical American home does not include a U-shaped dining room table, it also does not include scores of adults who need extensive assistance with eating. The U-shaped table is the most dignified way of providing this type of assistance to the elderly. It allows staff to interact with residents face to face rather than scooting a stool and sitting off to the side as is often done with a standard shaped table.</li> <li>3. The Odd Fellows Home extensively experimented with and rejected the idea of eliminating medication carts. The experiment concluded that without carts, resident safety was jeopardized, accuracy of medication</li> </ol>	
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F 252	Continued From page 8 cafeteria trays in this dining room, "I have been instructed to serve certain residents their meal on their tray."  On 10/16/12 at approximately 8:55 a.m., Staff Member E stated that the Director of Nursing and Food Manager were responsible for overseeing the dining experience.  On 10/16/12 at approximately 4:45 p.m. Staff Member F stated some of the residents wanted to eat off of the cafeteria trays and when asked why they wanted the trays, she stated one particular resident wanted a demarcation of space the tray provided. However, no other alternatives had been tried that were less institutional.	F 252	delivery was compromised and control of prescription medications was hindered.  4. The facility attempted to remove tray service from the dining rooms. However, that attempt was not entirely successful partially because the Resident Council objected to removing the tray service.  5. The surveyor failed to note that at any time did a resident have a concern about the "homelike" qualities of the Odd Fellows Home.		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a clean environment for residents in 2 of 2 dining rooms, the West hallways and door/entryways as evidenced by soiled base board moldings and corners of floors. Failure to address observed problems in the resident environment placed residents at risk for a diminished quality of life. Findings include:  On 10/09/12 at approximately 7:30 a.m. the floors in west dining area and hallways to include door/entry ways were noted throughout to have	F 253	6. The surveyor stated that the residents " <b>do not have the right to have a dining tray</b> " at their meal. I take exception to this statement and will always uphold the residents' right of choice when it does not adversely affect another person.  7. Further, the surveyors failed to recognize that the Odd Fellows Home cares for seniors at the least restrictive level of care practicable. The Odd Fellows Home cares for a group seniors of which 66.0% are over the age of 85. The average resident at the Odd Fellows home is 79% older (and hence more frail) than the state average of 36.9% and 70% older than the national average of 38.9%		

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F 253 Continued From page 9  
dark, tacky, gritty residue at the base of the rubber coving along the floor.

On 10/10/12 at approximately 2:00 p.m. Staff Member I stated about the cleaning of the West Care Center dining area and West Care Center hallway that with the current waxed floor, there was debris that was cast off towards the walls every time the floor was buffed.

On 10/11/12 at 8:30 a.m. the door/entry ways and baseboards in the West Care Center dining room and hallways remained in the same condition with dark, greasy, gritty, tacky residue.

On 10/15/12 at 12:00 p.m. the East and West Care Center dining areas and hallways were observed to have dark, gritty, tacky residue on the floor baseboards and door/entry ways.

An interview on 10/16/12 at 11:00 a.m. with Staff Member J, Director of Environmental Services, stated that they were working on it and "would try to clean it."

F 253  
8 This standard of "homelike environment" has in this instance been applied capriciously and without objectivity.

Nonetheless, the Odd Fellows Home does embrace the concept of providing a homelike environment and has changed its practices to make the medication cart less intrusive in the dining room, to eliminate tray service for those residents who prefer not to have a tray with their meal, to improve the homelike décor of the dining rooms, and to provide table décor to the U-shaped tables to mitigate their appearance.

This will be monitored by the Administrator and Dietitian and will be completed by November 30, 2012.

F 314  
SS=G 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.

F 314

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F 314	<p>Continued From page 10</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to complete assessments for potential skin breakdown and/or ensure appropriate interventions were in place for 1 of 1 resident (#50) in the sample who a developed pressure ulcer. Findings include:</p> <p>Resident #50. Admitted directly from a hospitalization due to "not thriving" in his own home. The [REDACTED] comprehensive assessment identified intermittent confusion, poor judgment and some self-directing behavior. The assessment also documented he was admitted without pressure ulcers, but was at risk as he required a one-person extensive assist with bed mobility.</p> <p>Review of the 'quarterly care conference' notes revealed on 04/01/12 and 07/01/12, the resident's skin was intact with preventative measures in place. No further evaluations of skin were completed, including the resident's preference for wearing shoes in bed (which caused pressure on the heel).</p> <p>An 08/18/12 skin assessment documented an onset of a right heel ulcer that was unstageable due to black eschar (a scab-like covering hiding the actual wound bed). There was no further assessment as to the cause of the ulcer.</p> <p>On 08/24/12, a wound consultant evaluated the right heel wound and documented a 3 centimeter (cm) circular, open decubitus (pressure ulcer) wound with black wound bed and fixed edges. The consultant documented her 09/21/12 that the</p>	F 314	<p><b>F253</b></p> <p>Equipment and procedures for cleaning floor edging has been modified. This will be monitored by the Custodial Supervisor and will be completed by November 30, 2012.</p>		

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NAME OF PROVIDER OR SUPPLIER  WASHINGTON ODD FELLOWS HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 534 BOYER AVENUE WALLA WALLA, WA 99362
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F 314	<p>Continued From page 11</p> <p>wound had changed to 2x2 cm with black adhered tissue (eschar) over the open wound. The wound consultant debrided (cut away) part of the 100% coverage of the wound with black eschar leaving 50% of eschar covering the ulcer. She noted the heel ulcer was "responding slowly to wound care."</p> <p>On 10/16/12 at 8:50 a.m., the charge nurse, Staff Licensed Nurse A, was asked about the cause of the pressure ulcer. She stated the resident had refused to take his shoes off in bed and he had spent "a good deal of day" in bed with his shoes on. The back of the shoe where the seam lies was directly over where the ulceration occurred. As far as she knew, this was how it had been since he was admitted. She had viewed the heel when it was debrided and it was a large ulcer that once debrided was not very deep.</p> <p>On 10/16/12 at 11:00 a.m., Staff Member B stated she usually cared for the resident during the day and he would go back to bed after breakfast and again after lunch. She stated she tried to remove his shoes, but he would refuse, especially in the morning. In the afternoon, she would tell him he needed to rest his feet and was successful in taking them off at times. She said, after he had the pressure ulcer, he no longer wears shoes, but soft boots. She also stated at times the resident had kicked at her when she attempted to remove his shoe and he did not like to lie on his side, preferring to lie on his back.</p> <p>The current plan of care identified a potential loss of his skin integrity due to his age and poor vision. The plan directed staff to reposition the resident every two hours during the day and evening and</p>	F 314	<p><b>F314</b></p> <p>Resident #50: Facility staff has been successful in negotiating with the resident to remove his shoes and wear a heel protector while in bed. The Care Plan has been modified to reflect this change.</p> <p>The facility has reviewed and revised its policies and practices regarding skin assessments. A significant part of these changes includes a section on informing the resident on the risk and benefits of behaviors and interventions, and if an intervention is declined by the resident that the risk is mitigated to the extent possible.</p> <p>This will be monitored by the Charge Nurse and will be completed by November 30, 2012.</p>	
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F 314	Continued From page 12 every three hours at night, apply lotion to dry skin, and place a pressure reduction mattress (which the shoes would interfere with reducing the pressure on the feet).  Although the resident frequently left his shoes on while in bed during the day, there was no assessment regarding that specific area for skin possible breakdown.  There was no development of a care plan to address this specific issue that could and did cause a heal ulcer. The plan of care was not revised until 08/18/12, when staff was to place heel protectors on the resident when in bed and discourage the resident from wearing a shoe on the right foot.	F 314					
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 observation, interview and record review the facility failed to ensure nutritional assessments were completed for 3 of 3 residents	F 325					

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F 325	<p>Continued From page 13</p> <p>(#50,61,125) in the sample who developed significant weight loss, due for a quarterly nutritional review and/or developed a pressure ulcer. This placed residents at risk of not maintaining acceptable parameters of nutritional status. Findings include but are not limited to:</p> <p>Resident #50. Admitted directly after a hospitalization due to not "thriving" in his own home. The [REDACTED] comprehensive assessment identified intermittent confusion and poor judgment, and he was independent after tray set up. Weights were to be monitored by dietary and nursing for weight loss.</p> <p>On 10/09/12 at 9:00 a.m., an interview was attempted with the resident who was seated in his room, coughing and with congested breathing. The aide stated he had eaten breakfast in his room as he was ill and more confused than usual.</p> <p>An 08/18/12 skin assessment documented an onset of a right heel ulcer. (On 10/16/12 at 11:45 am, Staff Licensed Nurse A, stated she directly told the Registered Dietitian about the resident's pressure ulcer on 08/18/12. She stated a nutritional assessment should then be completed.)</p> <p>Review of his weights noted he had lost 14.2% in 6 months (a significant weight loss) as weights were recorded on 04/08/12 at 193 pounds (lbs.) and on 10/07/12 at 169 lbs.(a total loss of 24 lbs.). However, the weight loss from 07/08/12 to 09/09/12 was a total of 14 lbs; a 7.5% rapid weight loss in 2 months.</p> <p>On 10/15/12 at 1:50 p.m., Staff Member F, the</p>	F 325	<p><b>F325</b></p> <p>Resident #50, #61, #125: Nutritional assessments have been completed for these residents, and appropriate interventions have been implemented.</p> <p>Facility policies and practices have been modified to ensure the timely assessment of nutritional problems, especially with respect to weight loss and skin conditions.</p> <p>This will be monitored by the Dietitian and will be completed by November 30, 2012</p>		

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F 325	<p>Continued From page 14</p> <p>Registered Dietitian, stated she did not want him to gain weight as he was 95% of his ideal body weight. She stated his dementia "is becoming significant." She said "this July", his weight started down a little with a few pounds per week, and had been continuing with a steady decline. Due to weight loss, he triggered for a quarterly nutritional review.</p> <p>The 10/03/12 quarterly nutritional assessment, completed over a month after the 8/18/12 development of a pressure ulcer, identified significant weight loss in 6 months as the only real change in the last quarter. The Registered Dietitian, Staff Member F, summarized the resident ate very well and although the weight loss was within 3 months and was rapid, his weight remained within normal limits.</p> <p>However, the dietary assessment did not take into account dietary requirements related to the pressure ulcer, how the rapid weight loss of 14 pounds in approximately two months and 24 lbs. in six months, and/or how his declining cognition had impacted his nutritional status/needs.</p> <p>Resident #61. Initially with admitted with diagnoses of [REDACTED]</p> <p>[REDACTED] His weight sheet documented his weight at 188lbs. prior to a [REDACTED] hospitalization. Re-admitted on [REDACTED] his weight had decreased to 162.8 lbs., and to 158.6 lbs. by [REDACTED] (a rapid weight loss of 29 lbs.)</p> <p>On 10/09/12 at 7:45 a.m. to 8:15 a.m., he sat in a high backed wheel chair, leaning slightly to the</p>	F 325		

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F 325	<p>Continued From page 15</p> <p>right with his head tilted to the right. There was no use of his right arm or hand situated on the wheelchair arm. He had toast with jelly and scrambled eggs on a regular dinner plate. When cutting his toast with left hand, he held a regular fork in stiff manner, and, as he raised it to his mouth, his shoulder and elbow raised stiffly upwards. His scrambled eggs slid off of his fork and onto the tray or floor at times when he attempted bites.</p> <p>The [redacted] re-admit assessment revealed he had been found unresponsive on [redacted] and sent to the hospital. He was admitted due to acute respiratory failure and probable aspiration pneumonia. On 10/5/2012, the speech therapist documented that he had mild-moderate swallowing impairment, was at risk for aspiration of liquids and solids into his lungs.</p> <p>When interviewed on 10/16/12 at 11:30 a.m., Staff Licensed Nurse A stated there was some fluid retention that possibly was a causative factor in his weight loss.</p> <p>On 10/15/12 at 2:00 p.m., the Registered Dietician, Staff Member F, stated that he had struggled to eat, but was very independent and wanted to feed himself. She stated that he had lost about 20lbs. since his hospital admit (on [redacted]). She said she had not observed him eat since his return from the hospital.</p> <p>The [redacted] re-admit nutritional assessment noted his intake was 65-75% of his meals and he had a current weight of 160 lbs. The quarterly weight was down 18 lbs. or 10% of his former body weight. The assessment documented he</p>	F 325		

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F 325	Continued From page 16 had returned from hospital with "few changes" but has had significant weight loss over the past month and quarter. The conclusion was for monitoring of intake and weight regularly to make sure loss did not continue, but without expectations of how much loss and/or how rapid of a loss would be considered appropriate. However, there was no analysis of the pattern of weight loss and how that affected his nutritional and health status and/or contributing factors to his weight loss in the assessment.  Resident #125. Admitted [REDACTED] she weighed 95 lbs., had advancing dementia, her medications included a diuretic (water pill).  On 10/10/12, the resident was not able to be interviewed due to her inability to answer questions when asked.  When interviewed on 10/15/12 at 1:30 p.m., the RD stated she would look at re-evaluation of the resident if there was significant weight loss. She computed the resident's weights, and said the loss was over 5% but not quite 10% in 30 days; 8.9% loss one month. She stated the nutritional assessment for the significant weight loss was missed and it should not have been.	F 325			
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364			

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F 364	<p>Continued From page 17</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 residents received food that was served at appropriate temperatures to maintain food quality and palatability. This failure placed all residents at risk for decreased quality of life and potential for compromised nutritional status. Findings include:</p> <p>During the Resident Interviews, conducted 10/09-11/12, 8 of 19 interviewed residents complained that the food served was cold.</p> <p>During an observation of the breakfast meal on 10/09/12 at 8:25 a.m., Resident #35 was interviewed regarding her meal. She stated her breakfast was cool when it got to her, and her poached egg was hard that morning.</p> <p>On 10/09/12 during an east dining room breakfast observation, Resident #97 stated her hard poached egg was served cold.</p> <p>Per observation on 10/16/12, in the East dining room at 8:00 a.m., the meal was served from a steam table placed in the corner of the dining room. Staff Member G served individual plates from the steam table containers to all residents in the dining service, which included hall trays. Staff Member G stated the temperature of the foods served in the steam table was obtained when the food was initially placed into the steam table and again half-way through the meal service. Staff Member G conducted temperature measurements at 8:00 a.m. Temperatures were reviewed and were within an acceptable temperature range.</p>	F 364	<p><b>F364</b></p> <p>Procedures and equipment have been changed to ensure the palatability of meals, especially for those residents who choose to have their meals delivered to their rooms.</p> <p>This will be monitored by the Dietitian and will be completed by November 30, 2012</p>	
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F 364	<p>Continued From page 18</p> <p>At 8:15 a.m., a "test tray" was requested by the survey team. Food temperatures of the test tray were as follows: Scrambled Eggs--101.7 degrees; Pancake--94.3 degrees; Bacon--90 degrees; Oatmeal--109.2 degrees; and Milk--41.5 degrees. The scrambled eggs were cold and not palatable to taste. The oatmeal was lukewarm and only palatable if eaten rapidly.</p> <p>On 10/16/12 at 8:30 a.m. in the East dining room a random resident was interviewed about the breakfast she received. She stated her scrambled eggs were cool this morning.</p> <p>On 10/16/12 at 9:30 a.m. during the full kitchen inspection, the temperature and palatability of food was discussed with Staff Member F. She stated there were concerns with maintaining the temperatures of the foods served at the breakfast meal in all of the dining areas related to the manner in which the meals were served up. She stated plate warmers were to be used at breakfast. Per observation on 10/16/12, at 8:00 a.m., during the breakfast serve-out in the East dining room, a plate warmer was not in use.</p> <p>On 10/09/12 at 8:25 a.m., the residents eating breakfast in their rooms were served hard poached eggs. When interviewed, Resident # 35 stated her eggs were cool when they were served, "not the best when eggs are cold, not too appetizing."</p> <p>On 10/10/12 at 11:00 a.m., Resident #103 stated her food was "not always hot when it gets to her." (The resident was noted to eat in the east dining room for all meals.)</p>	F 364		



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F 371	Continued From page 20 marshmallows were on the floor; a dried brown-colored substance was on the wall below a lower shelf, about a foot off the floor.  -Freezer: one opened box of frozen uncooked cookies and a box of frozen vegetables were on the floor of the freezer.  A full kitchen inspection was conducted on 10/16/12 at 8:45 a.m. with Staff Member F. Observations were as follows:  -General kitchen area had grimy build-up noted on walls, especially around electrical socket face plates. There was black color build-up noted on the flooring, primarily in corners and edges of the walls and entrance to the walk-in freezer.  -Walk-in refrigerator: debris/grime build-up around the metal face plate on the exhaust fans within the walk-in; layered food residue on the metal shelving; areas of the metal shelving appeared to be rusty; a mold-like substance was noted on the sides of the shelving at the back of the walk-in near the stored eggs.  -Walk-in freezer: there was debris noted on the floor of the freezer on both the initial and full kitchen inspections.  -Food Preparation Equipment: there was a grimy build-up noted on the underneath side of the Kitchen-aid mixer on the counter in the food prep area.	F 371	<b>F371</b>  1. Dry storage area: The items listed have been corrected. 2. Freezer: The items listed have been corrected. 3. Kitchen area: The kitchen has been cleaned, 4. Refrigerator: The refrigerator has been cleaned and new shelving has been ordered. 5. Freezer: The freezer has been cleaned. 6. Prep equipment: The mixer has been cleaned.  Facility policies and practices have been modified to clarify to delineate the interdepartmental responsibilities for the cleaning the kitchen.  This will be monitored by the Dietary Manager and the Custodial Supervisor and will be completed by November 30, 2012		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	F 520			

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F 520	<p>Continued From page 21</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility quality assurance committee failed to analyze incident reports and the facility injury log to identify trends of resident injuries related to staff handling. This placed the residents at risk for ongoing injuries. Findings include:</p> <p>During Stage 1 of the survey, 3 of 19 residents interviewed complained of possible rough handling from staff.</p>	F 520	<p><b>F520</b></p> <p>Facility practices have been modified to include a trend analysis of incidents to the responsibilities of the Quality Assurance Committee.</p> <p>This will be monitored by the Administrator and DNS and will be completed by November 30, 2012</p>	
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NAME OF PROVIDER OR SUPPLIER  <b>WASHINGTON ODD FELLOWS HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>534 BOYER AVENUE WALLA WALLA, WA 99362</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	<p>Continued From page 22</p> <p>Review of the facility Occurrence Log between the dates 03/27/12 and 10/5/12 noted 25 resident "injury during handling" reports.</p> <p>Review of the reports noted skin tears, abrasions, bruises and a rib fracture caused by staff during resident cares and/or mechanical lift transfers.</p> <p>On 10/16/12 at approximately 1:30 p.m. the Director of Nurses stated the quality assurance committee meets quarterly and was attended by herself, the administrator, the medical director, the pharmacist and other department heads. The committee had not analyzed occurrence reports for trends and she was not aware there were so many resident "injury during handling" reports.</p> <p>By completing a trend analysis of the injury log, the administration would have a better understanding of the cause of the handling injuries in order to develop prevention strategies.</p>	F 520		