

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

PRINTED: 10/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505421	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/04/2013
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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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INITIAL COMMENTS

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This report is the result of an unannounced Off-Hour Quality Indicator Survey conducted at Washington Odd Fellows Home on 09/30/13, 10/01/13, 10/02/13, 10/03/13 and 10/04/13. The survey included data collection on 09/30/13 from 7:00 p.m. to 9:00 p.m. A sample of 34 residents was selected from a census of 96. The sample included 30 current residents and the records of 4 former and/or discharged residents.

The survey was conducted by:

_____, RD
_____, RN
_____, RN
_____, RN

The survey team is from:

Department of Social & Health Services
Aging & Long-Term Support Administration
Residential Care Services, District 1, Unit C
3611 River Road, Suite 200
Yakima, WA 98902

Telephone: (509) 225-2800
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Residential Care Services

10/5/13
Date

Received
Yakima RCS
OCT 21 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Administrator

10/5/13

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 159 SS=E	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the</p>	F 159			

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F 159	Continued From page 2 SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to provide reasonable and ready access to resident trust funds for all residents who kept funds in the trust. Failure to provide residents with ready access to the funds potentially denied those residents the right to use their funds. Findings include: On 10/02/13 at approximately 1:15 p.m. Staff Member G, Accounting, stated the business office is open Monday through Friday from 8:00 a.m. until 5:30 p.m. and Saturday 8:00 a.m. until 4:30 p.m. She stated no money is available from the trust when the business office is closed and funds from the trust are not available to the residents on Sunday. Observation of the posted business office hours on 10/02/13 confirmed the hours of operation of the business office were as Staff Member G stated. Per record review on 10/02/13, 49 residents had funds in the trust. On 10/02/13 at 2:30 p.m. Staff Member A, Administrator stated he thought there was a slush fund at the nurse's station for after-hours trust fund access.	F 159	The facility has instituted a new policy to accommodate 24/7 access to person funds. This will be monitored by the administrator and will be corrected by November 15, 2013.	11/15/13

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F 159	Continued From page 3 On 10/02/13 at 2:40 p.m. Staff Member E, charge nurse stated she did not know how residents would get funds after the business office is closed. She further stated it was her understanding "it is like a bank" and only accessible at certain hours. She stated there is not a slush fund at the nurse's station. On 10/02/13 at 2:45 p.m. Staff Member D, Social Services stated the facility did not have a petty cash fund for after hours access to trust funds and stated there is no way for resident to get their money after hours as the fund is managed from the business office.	F 159			
F 170 SS=E	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on interviews the facility failed to promptly deliver mail to all residents who receive mail. Findings include: On 10/02/13 at 8:40 a.m. Staff Member D, Social Services, stated the West Care Center residents do not receive mail on Saturdays. On 10/02/13 at approximately 8:40 a.m. Staff Member I, Activity Aide, stated "activity staff is responsible for delivering the resident mail but there is no activity staff here on Saturdays to	F 170			
		F170	The facility has instituted a new policy to accommodate mail delivery on Saturdays. It is interesting to note that the USPS, after more than a decade of no Saturday mail delivery, has only recently started Saturday delivery. This will be monitored by the administrator and will be corrected by November 15, 2013.	11/15/13	

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F 170	Continued From page 4 deliver the mail. The West Care Center residents have not been receiving their Saturday mail for three years." On 10/02/13 at approximately 8:45 a.m. Resident #53, Resident Council representative for the West Care Center stated "we do not get mail on Saturdays." She added "I would like to get my mail on Saturdays. As it is, I do not get much mail." On 10/02/13 at approximately 9:30 a.m. Resident #12, Resident Council representative for the East Care Center stated "we do not get mail on Saturdays because the United States Postal Service has stopped delivering the mail." On 10/02/13 at 10 a.m. the local United States Postal Service office was contacted by phone. A staff person from their office confirmed that mail was delivered on Saturdays to the facility.	F 170			
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. 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;	F 272			

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F 272	Continued From page 5 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to perform a thorough comprehensive dental/oral assessment as required by 42 CFR 483.20(b)(1)(xi) for 1 of 2 residents (#65) reviewed for oral health status. Failure to accurately assess dental conditions prevented the facility from identifying potential problems that could impact the resident's health and/or nutrition status. Findings include: Resident #65 was admitted on [REDACTED] 09. On the comprehensive assessment dated 07/21/13 her oral/dental status was coded as "none of the	F 272			

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F 272	<p>Continued From page 6</p> <p>above," thereby assessing the resident as having no broken or missing teeth, no missing or broken dentures, no difficulty with chewing or other oral/dental problems.</p> <p>On 10/01/2013 at approximately 10:54 a.m. Resident #65 stated she lost her upper dentures about 3 months ago. She stated "I do sometimes have trouble chewing meat due to my missing teeth." She added that this was not the first time she had lost her dentures but she did need them and would use them if she had them.</p> <p>On 10/02/13 at approximately 11:00 a.m. Staff Member K, Registered Dietitian, stated the resident was on a regular textured diet. She was not aware of the resident having any chewing problems. She added her assistant completes the Dietary Profile assessments for this resident.</p> <p>On 10/02/13 at 12:00 p.m. Staff Member N, Rehab Nurse, stated that she had not looked at the resident's mouth (for the assessment) and she did not know the resident had missing upper dentures or chewing problems. She added she depends on input from the Nurse Aide-Certified's (NAC's) to let her know what type of care the resident needs.</p> <p>On 10/02/13 at approximately 2:15 p.m. an NAC stated she has been assisting the resident with her oral care for about a year and she has never seen the resident's upper dentures. She stated she does provide the resident with a toothbrush so she can brush her lower teeth.</p> <p>On 10/03/13 record review of Resident #65's Dietary Profile dated 07/24/13 revealed the section that documented the assessment of</p>	F 272	<p>The facility immediately assessed the mouth and dental condition of Resident #65 and updated Care Plans and other assessments as appropriate. In addition, all residents have been re-assessed for mouth, dental, or chewing problems to assure that no other residents were without a current assessment. This will be monitored by the Charge Nurse and completed by November 15,2013.</p>	11/15/13

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F 272	Continued From page 7 eating and chewing was blank. A 10/03/13 review of the Nursing Summary dated 07/25/13 did not mention the resident's oral health or identify the resident had missing upper dentures or the missing tooth on her lower right gum. The lack of a thorough comprehensive oral health assessment put this resident at a potential risk for choking and decline in nutrition status due to the unidentified missing dentures and chewing problems.	F 272	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure foods were stored, prepared and distributed under sanitary conditions. Failure to monitor refrigerator temperatures, ensure food was stored under sanitary conditions, and ensure food preparation equipment was maintained in a sanitary condition placed residents at risk for foodborne illness. Findings include:	F 371	

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F 371	<p>Continued From page 8</p> <p>On 09/30/13 between 3:10 p.m. and 3:30 p.m. during the initial review of the kitchen, the following was observed:</p> <p>The thermometer inside a roll-in refrigerator read 80 degrees F (Fahrenheit) although the interior felt cool. There were 4 trays of fruit/berry cups inside for the dinner meal.</p> <p>Review of September 2013 "storage temperature check sheet" for the refrigerators revealed no temperatures were documented on September 1, 2, 5, 12, 13, 14, 15, 20, 23, 26, 27, 28, 29 or 30 (14 out of 30 days without monitoring). Staff Member K, Registered Dietitian, stated the cooks were responsible for monitoring the refrigerator temperatures.</p> <p>Below a counter in the kitchen, there were two large rolling tubs marked flour and sugar with cracked lids. The top and rim of the lids were soiled with yellow/brown tacky substance.</p> <p>On 10/02/13 between 11:15 a.m. and 11:45 a.m. during further kitchen observations the following was observed:</p> <p>There were seven plastic crates of individual milk containers and 4 cardboard boxes containing gallon milk containers stored directly on the floor in the walk-in refrigerator. Staff Member M, Dietary Manager, stated she was aware these should be up off of the floor.</p> <p>During observation of the dish machine operation, Staff Member K stated the machine used heat sanitation and the water temperatures needed to reach at least 150 degrees F for the wash cycle</p>	F 371	<p>Staff received training and counseling regarding the appropriate monitoring of food sanitation.</p> <p>Specifically:</p> <ol style="list-style-type: none"> 1. The thermometer in the roll-in refrigerator was replaced. It is interesting to note that the built-in thermometer on the outside of the refrigerator was in working order and showed an accurate reading. 2. The "storage temperature check sheet" for the refrigerators will be completed in full. It is interesting to note that the refrigerator temperature is constantly monitored through a DDC (Direct Digital Control) system which electronically records temperature and alerts when a temperature is outside of the defined parameters. This system was in operation at the time of the survey. 3. The lids for the rolling tubs have been replaced. 		

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F 371	<p>Continued From page 9</p> <p>and 180 degrees F for the rinse cycle to sanitize effectively. She stated these temperatures were monitored by the kitchen staff three times a day.</p> <p>Review of the September 2013 "kitchen thermometer check sheet" revealed that of the 90 required temperature checks, only 26 were documented and included substandard temperatures of 120 degrees F for the wash and 170 degrees F for the rinse on 09/06/13 between 6:30 p.m. and 7:00 p.m. There was no indication on the log that anyone was notified of the substandard temperatures.</p> <p>The three compartment sink used to clean, rinse and sanitize pots and pans was observed with Staff Members K and M who stated they sanitize in the third sink with bleach water (the active ingredient in bleach is chlorine, which is a chemical compound that sanitizes). Staff Member K dipped a chlorine test strip in the sanitizing rinse in the third sink. It registered between 30 and 50 ppm (parts per million). Staff Member K stated the test strip should be between 50 and 100 ppm for proper sanitation. Staff Members K and M stated they do not test the chlorine concentration on a regular basis or document when they do check. Staff Member O, Dietary Aide, stated he used 1 cup of bleach to a full sink of water to set up the sanitizing sink; however, he did not test the concentration.</p>	F 371	<p>4. A new plastic pallet was installed in the walk-in refrigerator to keep milk off the floor.</p> <p>5. The temperature of the dish machine will be recorded on the "kitchen thermometer check sheet" on a daily basis. It is interesting to note that the dish machine water temperature is constantly monitored through a DDC (Direct Digital Control) system which electronically records temperature and alerts when a temperature is outside of the defined parameters. This system was in operation at the time of the survey.</p> <p>6. The concentration of sanitizer in the three compartment sink will be routinely tested and recorded. These items will be monitored by the Dietary Supervisor and will be corrected by November 15, 2013.</p>		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 505421	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 10/4/2013
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 167	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by: Through interviews on 10/02/13, Residents #57, 53, 35 and 12 stated they did not know where the survey results were located.</p> <p>On 10/02/13 the survey results were observed hanging on the walls about 5'5" off the floor near the nurse's stations in the West and East Care Centers.</p> <p>On 10/03/13 record review revealed 45 of 50 residents living in the East Care Center and 30 of 45 residents living in the West Care Center were wheel chair bound therefore making the survey results not visible or accessible to them.</p>		
F167	<p>The facility has relocated the binders containing copies of the annual nursing home survey to the ADA height of 48" from the finished floor. The binders have also been relabeled with 100 point font to help ensure the visibility of the report. This will be monitored by the administrator and will be corrected by November 15, 2013.</p>		

11/15/13

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

The above isolated deficiencies pose no actual harm to the residents