

CENTERS FOR MEDICARE & MEDICAID SERVICES

461

FORM APPROVED  
OMB NO. 0938-0391

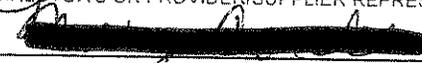
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/14/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  BAYVIEW MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 11 WEST ALOHA STREET SEATTLE, WA 98119
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Federal Quality Indicator Survey conducted at the Health Center of Bayview Manor on 02/10/14, 02/11/14, 02/12/14, 02/13/14, and 02/14/14. A sample of 24 residents was selected from a census of 35. The sample included 22 current residents and the records of 2 former and/ or discharged residents.</p> <p>The survey was conducted by:   M.N., R.N.   M.S.W.   M.S.W.   B.S.N., R.N.   B.S.N., R.N.</p> <p>The survey team is from:                  Department of Social and Health Services                  Aging and Long-Term Support Administration                  Residential Care Services, District 2, Unit D                  20425 72nd Avenue South, Suite 400                  Kent, Washington 98032-2388</p> <p>Telephone: (253) 234-6000                  Fax: (253) 395-5071</p> <p> 2-24-2014                  Residential Care Services Date</p>	F 000	<p>The statement made on this plan of of correction are not an admission to and do no constitute an agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the facility has taken the action set forth in the following plan of correction.</p>	
-------	--	-------	--	--

RECEIVED  
MAR 10 2014  
DSHS/ADSA/RCS Kent

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Adm	(X6) DATE 3/7/14
--	--------------	---------------------

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.

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

FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/14/2014
NAME OF PROVIDER OR SUPPLIER  BAYVIEW MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 11 WEST ALOHA STREET SEATTLE, WA 98119	
(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 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide timely dining assistance to Resident #38, one of three dependent residents reviewed for assistance with Activities of Daily Living (ADL's) in order to maintain good nutrition. Failure to provide this assistance created the potential for physical discomfort and further weight loss.</p> <p>Findings include: Resident #38 was admitted to the facility in 2008 with care needs related to multiple chronic conditions including [REDACTED] disease and [REDACTED]. According to her most recent Minimum Data Set (MDS) assessment, dated 11/14/13, and her care plan, dated 10/29/13, she was not interviewable and needed extensive assistance from staff with meals. Staff also assessed the resident as having no behavioral symptoms or refusal of care.</p> <p>She was identified as being at risk for weight loss. Between 1/31/14 and 2/7/14, this resident lost [REDACTED] pounds, from [REDACTED] to [REDACTED] pounds. When observed on 2/11/14 and 2/13/14, she was totally dependent on staff for meals. During observations of the noon meal on 2/13/14 from</p>	F 312	<p>Resident #38's significant weight loss was sudden and identified as of 2/7/14. Prior to this date the resident had no significant weight loss noted. Interventions included labs that were ordered on 2/10/14. In addition the resident was placed on meal monitor, receiving [REDACTED] supplement with medications, and placed on weekly weight monitoring to monitor any additional weight loss trend. Resident noted to have increased refusal to eat a full meal and has been leaving greater than or equal to 50% of food uneaten during some meals. This may be natural evolution of her disease processes which include but are not limited to: [REDACTED] with [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. It is not uncommon for failure to thrive to be a component of any of the previously mentioned diagnoses and appropriate interventions, as listed prior, were put into place when the resident's sudden weight loss was first noted.</p> <p>The Staff Development Coordinator will provide in-service training to all care staff by no later than 3/17/2014 to include the following:</p> <p>Quick tips on how to encourage resident's to eat and drink at meal time</p> <p>Food will not be served to any resident who is dependent upon staff for feeding until a caregiver is ready to provide feeding assistance</p> <p>3/7/14</p>

RECEIVED  
MAR 10 2014  
DSHS/ADS/RCS Kent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505439	(X2) MULTIPLE CONSTRUCTION A BUILDING _____  B WING _____		(X3) DATE SURVEY COMPLETED  02/14/2014
NAME OF PROVIDER OR SUPPLIER  BAYVIEW MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 11 WEST ALOHA STREET SEATTLE, WA 98119		
(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 312	<p>Continued From page 2</p> <p>12:05 pm until 12:50 pm. Resident #38 would occasionally say she didn't want to eat more, but if offered a sip of fluids or allowed to rest for a minute, she would again accept more food and fluids.</p> <p>On 2/13/14 at 5:42 pm, Resident #38 was taken to the main dining room by staff. At 5:45 pm, a Nursing Assistant (Staff E, NAC) offered Resident #38 sips of thickened milk, which she accepted. At 5:58 pm., Resident #38's dinner was served. Staff E, started to feed Resident #38 a few bites at 5:59 pm, but at 6:00 pm he left the dining room to help another resident. Between 6:00 p.m. and 6:13 p.m., she was not assisted with eating.</p> <p>At 6:13 pm, Staff F, an NAC, approached Resident #38 and offered her a bite of potatoes. The resident accepted one bite, and refused a second one. Staff F then left the resident seated at the table, after providing one minute's assistance with the meal. Resident #38 continued to sit in the dining room until 6:38 pm, without further assistance from staff with being fed.</p> <p>Continuous observation of Resident #38 from 5:42 pm until 6:40 pm found she received approximately two minutes of assistance with this meal. She remained at the table with her plate uncovered, and did not attempt to feed herself. Between 6:10 pm and 6:40 pm, Staff D, a Registered Dietitian and Staff K, an RN, were present in the dining room, but neither staff observed or responded to the lack of dining assistance for Resident #38.</p> <p>At 6:40 pm, Staff E was asked about Resident #38 being left in the dining room without assistance. He said he had to help another</p>	F 312	<p>The assigned caregiver will stay with the resident until he or she has either eaten 100% of the meal served, or has indicated he or she has finished eating.</p> <p>In the event another resident requests to leave the dining room during a meal, one of the caregivers monitoring the hall will be radioed to come and provide this assistance.</p> <p>The licensed nurse will be responsible to monitor and enforce information provided in this training.</p>		

RECEIVED

MAR 10 2014

DSHS/ADSA/RCS Kent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/14/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  BAYVIEW MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 11 WEST ALOHA STREET SEATTLE, WA 98119
---	--

(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 312	<p>Continued From page 3 resident and had "traded" with Staff F.</p> <p>Staff F was then interviewed. She said she did help feed Resident #38 but stopped "because the resident refused". Observation of Resident #38 receiving one minute's assistance, and earlier observations of this resident continuing to eat after she was allowed to rest were reviewed with Staff F.</p> <p>After the interview at 6:40 pm, Staff E returned to Resident #38 in the dining room, and fed her for another five minutes without refusal. Staff E did provide another five to six minutes assistance for Resident #38, although he did not heat up her food, which had been served over 45 minutes previously.</p> <p>On 2/14/14 at 10:55 am, Staff L, a Resident Care Manager, was interviewed about supervision of staff during meals. She said Licensed Nurses were responsible for supervising nursing assistants (NACs) during meals.</p> <p>On 2/14/14 at 11:15 am, Staff J, a Licensed Nurse, was interviewed about supervision of NACs during meals. She acknowledged Licensed Nurses were responsible for supervision of NACs during resident meals. When asked how many residents were dependent upon staff for assistance at meals, she said there were 12 dependent residents in the Health Center, including Resident #38. There were 4 to 5 staff available at mealtime to provide assistance.</p> <p>During an interview with the DNS (Staff B) on 2/14/14 at 12:32 pm, she acknowledged Resident #38 had a recent weight loss. The observed problem with staff not providing sufficient</p>	F 312		
-------	--	-------	--	--

**RECEIVED**  
**MAR 10 2014**  
DSHS/ADSA/RCS Kent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/14/2014
NAME OF PROVIDER OR SUPPLIER  BAYVIEW MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 11 WEST ALOHA STREET SEATTLE, WA 98119	

(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 312	Continued From page 4 assistance during the evening meal on 2/13/14 was discussed. She also stated that even if a resident refused to eat during a meal, staff did need to provide assistance and offer or encourage them to eat or drink, especially if the resident had dementia.	F 312		
F 363 SS=D	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED  Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow written menus for Resident #38, one of two residents on a pureed diet who was assessed to need regular portions. Failure to follow menus during meal service created the potential for weight loss for residents who received less than the planned amount of calories during meals.  Findings include:  During observations of the noon meal on 2/12/14 from 11:53 am until 12:45 pm, the menu for that meal specified residents who were to receive regular portions of a pureed diet were to receive a half cup of potatoes with the meal. Observations of the meal service revealed that Resident #38, who was on a pureed diet and was to receive	F 363	Retraining of proper portion sizes was implemented immediately by the dietitian upon knowledge of error on 2/12/14 and again on 2/13/14. A formal retraining on proper portion sizes per production sheet instructions will be reviewed by the dietitian with Health Center dietary staff during their staff meeting on 3/11/14.  The Dietitian will be responsible for monitoring proper quantity of serving equipment called for on the production sheet during her routine kitchen audits on an ongoing basis.  Resident #38 did not appear to suffer any negative outcome as a result of the error in portion sized on 2/12/14 or 2/13/14, as she refused to consume the entire amount of food that was provided to her during those meals.	3/7/14

RECEIVED  
MAR 10 2014  
DSHS/ADSA/RCS Kent

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B WING _____	(X3) DATE SURVEY COMPLETED  02/14/2014
NAME OF PROVIDER OR SUPPLIER  BAYVIEW MANOR			STREET ADDRESS, CITY STATE ZIP CODE 11 WEST ALOHA STREET SEATTLE, WA 98119	
(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 363	Continued From page 5 regular portions, was served one quarter cup of potatoes, half of what was specified on the menu.  A similar observation was made during the evening meal on 2/13/14. When Resident #38's meal was served at 5:58 pm, she had received a quarter cup of potatoes with the meal, instead of half a cup, as specified by the menu.  At 6:25 pm, after the conclusion of the meal service on 2/13/14, a quarter cup (#16) scoop was in the pan of mashed potatoes. Review of the menu for Resident #38 again showed she was to receive a half cup (#8 scoop) of potatoes with her meal.  This observation, and the earlier error during the noon meal service on 2/12/14, when Resident #38 was served half of the planned portion, was discussed with the facility's Registered Dietitian (Staff D) at 6:30 pm. When Staff D asked the staff who served the meal if residents on a regular diet were served one or two scoops of potatoes, Staff M replied "One", confirming this resident had received half of what was on the planned menu. Staff D later acknowledged serving the proper portion size was something that she would "work on" with staff.	F 363		
F 371 SS=E	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	F 371	1) An In-Service training meeting was conducted on Wednesday February 19th and March 5, 2014 with all food service staff in the main kitchen and dining room. All staff were reminded and instructed to leave the door closest to the kitchen closed at all times. A sign was also posted next to the door to	3/7/14

RECEIVED

MAR 10 2014

DSHS/ADSA/RCS Kent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/14/2014	
NAME OF PROVIDER OR SUPPLIER  BAYVIEW MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 11 WEST ALOHA STREET SEATTLE, WA 98119		
(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 371	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to store and prepare resident meals under sanitary conditions, in the main kitchen and in a secondary kitchen in the Health Center. Failure to adhere to sanitary standards placed residents at risk for food-borne illness.</p> <p>Findings include:</p> <p><b>UNSANITARY FOOD STORAGE:</b> 1. Doors to outside propped open/Food on floor: On 2/10/14 at 2:15 pm, two doors leading from an outside loading area into the kitchen were found blocked open, which in a freezer located by this exit, a box containing bread was on the ground.</p> <p>At 2:22 pm on 2/10/14, Staff D and Staff G were interviewed about the open doors and food on the freezer's floor. Staff D acknowledged the doors to the outside were not to be left open since it created the potential for insects or vermin to enter the kitchen area. She also acknowledged all food was to be stored at least six inches off of the floor.</p> <p>2. Unsanitary Refrigerators/ Freezers need of cleaning: On 2/12/14 at 10:55 am in the main kitchen, observation of refrigerator #2 found rusted/corroded areas present along several seams of the ceiling, above food storage shelves.</p>	F 371	<p>remind staff to keep it closed at all times. In-service training of proper storage in all freezers and refrigerators were also reviewed. The staff was reminded and showed how items are to be at least 6 inches off the ground.</p> <p>2) All walk-in refrigerators and freezers were thoroughly cleaned and sanitized on 2/10/14. During our in-service, the dishwashers were shown how to clean the floors more thoroughly and to regularly clean them twice a day. All refrigerators and walk-in freezers are swept and mopped twice daily.</p> <p>3) A in-service training done on February 19th and March 5th, 2014. During this training, proper storage, sealing and labeling of all opened items, including dry goods, were discussed. All staff is to follow proper procedures of sealing and dating at all times.</p> <p>4) The insect adhesive coated strip was removed immediately. Kitchen staff and maintenance staff were trained and educated that this practice would not be allowed.</p> <p>5) On 2/14/14, the food processor, the sides of ovens and walls as mentioned was cleaned and sanitized. All walls, equipment and oven cleaning are part of the staff's daily cleaning duties. The cleaning procedures were part of our in-service training on 2/19/14 &amp; 3/5/14. At</p>	

RECEIVED

MAR 10 2014

DSHS/ADSA/RCS Kent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/14/2014
NAME OF PROVIDER OR SUPPLIER  BAYVIEW MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 11 WEST ALOHA STREET SEATTLE, WA 98119	
(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)
F 371	<p>Continued From page 7</p> <p>At 10:58 am, similar findings were made in refrigerator #4. Observations of freezer #1 also revealed the floor was soiled with an accumulation of black residue.</p> <p>At 11:10 am, Staff C was interviewed about sanitation in the dietary department. He said there was a schedule for mopping and cleaning the large walk-in refrigerators and freezers, which was to occur twice each week. When asked to observe the floor in freezer #1, and to assess if had been mopped recently, he observed the soiled condition of this floor and said "they might not have mopped it out last night...". When asked to look at the corroded areas on the ceilings of refrigerators #2 and #4, Staff C observed both units and said they were usually "deep-cleaned" quarterly. He also acknowledged the areas of corrosion needed to be removed.</p> <p>3. Improper storage of dry goods: On 2/10/14 at 1:56 pm, a box of crackers was found open and not resealed in the dry storage pantry in the main kitchen. On 2/12/14 at 11:00 am, an unsealed box of wonton noodles and another unsealed box of flaked coconut were observed in the dry goods pantry. This observation was reviewed with Staff C, the Food Service Manager at 11:10 am; he acknowledged the need for dry goods to be re-sealed after use. On 2/14/14 at 7:08 am, a box of wonton noodles was again found unsealed on a shelf in the dry storage area.</p> <p>UNSANITARY FOOD PREP AREAS: 4. Potential for contamination of food: On 2/10/14 at 2:20 pm, an adhesive-coated strip used for attracting insects was observed hanging from the ceiling in the kitchen, above a counter</p>	F 371	<p>our in-service meeting on February 19th &amp; March 5th, all staff were re-trained on specific daily cleaning duties which included cleaning and sanitizing all equipment after use. Re-Training and signing off instructions on the cleaning check list daily was conducted. The Dietary Supervisor now checks each station before employee punches out at the end of a shift.</p> <p>6) A in-service training was conducted on February 19th &amp; March 5th. At this training, staff were again educated on the difference between hand washing sinks and prep sinks. All staff agreed they are aware of this. Signs have been posted to indicate which sink is for hand washing and which sinks are for food prep only. Proper hand washing, glove changing and good sanitation practices were part of our in-service training as well. All food service staff have been re-trained on all proper food handling and proper sanitation procedures as of February 19th &amp; March 5th.</p> <p>The Executive Chef and Food Services Director are responsible for daily oversight of all corrections made.</p>

RECEIVED

MAR 10 2014

DSHS/ADSA/RCS Kent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/14/2014
NAME OF PROVIDER OR SUPPLIER  BAYVIEW MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 11 WEST ALOHA STREET SEATTLE, WA 98119	
(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 371	Continued From page 8 designated for food preparation, which held a large food processor. Dead insects were visible on the strip. At 2:22 pm, Staff D and Staff G were asked about the use of the strip above the food prep area. They acknowledged the area below was used for food preparation, and said the strip had been placed there in the past by maintenance, but did not say how long it had been used. When the concern of having it above a food prep area was discussed, they stated it needed to be removed. On 2/12/14 at 10:35 am, this observation was discussed with Staff C, the Food Service Manager, who stated the strip had been used due to past problems with fruit flies.  5. Soiled surfaces and equipment: On 2/10/14 at 2:18 pm, an area used for food prep was observed to have a food processor on a metal stand in a corner by an oven. Numerous areas of dried splatters were present on the sides of an oven, a food processor, a table and the wall in this area. On 2/12/14 at 10:38 am and again on 2/14/14 at 7:10 am, this equipment and adjacent walls/ surfaces remained soiled with dried food splatters.  6. Failure to differentiate between hand washing and food preparation sinks: On 2/12/14 at 10:10 am, observation of the Health Center serving kitchen revealed a bucket containing an ammonia-based sanitizer present on a counter. At 10:23 am, during an interview with Staff D, the Registered Dietitian, she said the sink was to be used for hand washing, not food preparation. At 10:25 am, she said the sink and counter were "sometimes" used for food preparation and meal service. At 11:58 am on 2/12/14, a dietary aide, Staff I, was observed to use this sink to wash her hands.	F 371		

RECEIVED

MAR 10 2014

DSHS/ADSA/RCS Kent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/14/2014
NAME OF PROVIDER OR SUPPLIER  BAYVIEW MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 11 WEST ALOHA STREET SEATTLE, WA 98119		
(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 371	Continued From page 9  On 2/12/14 at 10:40 am in the main kitchen, a cook (Staff M) was observed to touch the lid of a trash receptacle as he disposed of trash. He did not remove the gloves he was wearing or wash his hands but continued to use a mixer, then poured the contents of the bowl into a metal pan. He handled a cloth containing bleach to wipe off the counter, then removed the gloves and disposed of them in the trash, handling the lid of this container again. He then briefly rinsed off his hands at a sink located in the food prep counter. No soap or towels were present for hand washing at this sink.  At 10:55 am, Staff C was asked to clarify if this sink was designated for hand washing or food preparation. He stated that sink was for food preparation. When the observation of Staff M was reviewed with him, he again confirmed there was a different sink designated for staff to wash their hands in the kitchen, and food preparation sinks were not to be used for hand washing.	F 371			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  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 records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431	1. Medications noted to be expired during the survey process, were appropriately disposed of the same day these issues were noted.  2. A pharmacist consultant will conduct an audit of the medication carts and medication room on a monthly basis for the next two months and then quarterly thereafter to ensure all expired medications are appropriately disposed of and that all medications are appropriately stored per manufacturer recommendations. A report will be	3/1/14	

RECEIVED

MAR 10 2014

DSHS/ADSA/RCS Kent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/14/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  BAYVIEW MANOR	STREET ADDRESS, CITY, STATE ZIP CODE 11 WEST ALOHA STREET SEATTLE, WA 98119
---	---

(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 431	Continued From page 10 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  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.  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.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure adequate medication storage according to facility policy and pharmacy standards. Failure to ensure medications were removed from medication storage when expired and that medications were stored in an appropriate location, placed residents at risk for receiving medications at less than full potency and efficacy.  Findings include:  MEDICATION ROOM: EXPIRED MEDICATIONS Observation of the storage room during initial	F 431	provided to the DNS after these visits, for appropriate follow up as needed with nursing staff. 3. The Staff Development Coordinator will conduct training with all nursing staff about how/when to dispose of medications no longer in use and how to read and follow medication labels regarding storage of medication. DNS responsible.	
-------	---	-------	---	--

RECEIVED  
MAR 10 2014  
DSHS/ADSA/RCS Kent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/14/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  BAYVIEW MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 11 WEST ALOHA STREET SEATTLE, WA 98119
---	--

(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 431	<p>Continued From page 11</p> <p>rounds on 02/10/14 at 1:55 p.m., revealed the following:</p> <p>██████████ 100 mcg/0.5 ml syringe expired on 10/13 for Resident #51.</p> <p>1 liter bag of ██████████ (██████████) expired 05/01/13</p> <p>1 liter bag 5% ██████████ and ██████████ expired 02/01/13</p> <p>1 liter bag ½ (45%) ██████████ expired 10/01/12</p> <p>1 ██████████ flush 100 units/ml (5 ml total) expired 04/06/13</p> <p>1 ██████████ flush 100 units/ml (5 ml total) expired 11/07/13</p> <p>Staff J, a licensed, nurse said the above medications had expired and should be discarded.</p> <p><b>MEDICATION ROOM: IMPROPER STORAGE OF MEDICATIONS</b></p> <p>The following were stored in the medication refrigerator at 40 degrees Fahrenheit.</p> <p>One box of ██████████ suppositories 25 mg with manufacturer's directions printed on the box to "keep at room temperature ... 59-86 degrees".</p> <p>Three boxes of ██████████ (██████████) suppositories with manufacturer's directions printed on the box to "keep at room temperature ... 68-77 degrees".</p> <p>Staff J confirmed the above should not be refrigerated.</p> <p><b>EAST WING MEDICATION CART</b></p> <p>During initial rounds on 02/10/14 at 2:18 p.m., revealed the following:</p> <p>██████████ solution with no open date .</p> <p>One bottle of ██████████, expired 10/13.</p> <p>Staff K, a licensed nurse, confirmed the above medications were expired and should not be in the medication cart.</p>	F 431		
-------	--	-------	--	--

RECEIVED  
MAR 10 2014  
DSHS/ADSA/RCS Kent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505439	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/14/2014
NAME OF PROVIDER OR SUPPLIER  BAYVIEW MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 11 WEST ALOHA STREET SEATTLE, WA 98119		
(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

RECEIVED

MAR 10 2014

DSHS/ADSA/RCS Kent