

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

PRINTED: 12/06/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/20/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CASHMERE CONVALESCENT CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>817 PIONEER AVENUE CASHMERE, WA 98815</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 Cashmere Convalescent Center on 11/13/12, 11/14/12, 11/15/12, 11/16/12, 11/19/12 and 11/20/12. A sample of 34 residents was selected from a census of 69. The sample included 33 current residents and the record of 1 discharged resident.</p> <p>The survey was conducted by:</p> <p>Liisa Johnson, RN Pam Holt, RN Patricia Larson, RN Lisa Herke, RD</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 D 3611 River Road, Suite 200 Yakima, WA 98902</p> <p>Telephone: (509) 225-2800 Fax: (509) 574-5597</p> <p><i>Patricia Larson 10/10/12</i> Residential Care Services Date</p> <p><b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>The facility must promote care for residents in a</p>	F 000	<p>Received Yakima RCS  DEC 17 2012</p>	
F 241 SS=E	<p><b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>The facility must promote care for residents in a</p>	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE  <i>[Signature]</i>	(X6) DATE  <i>12-11-12</i>
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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 241	<p>Continued From page 1</p> <p>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, interview and record review, the facility failed to promote care for residents in a manner that maintained each resident's dignity. 1) The facility failed to maintain a dignified environment for 4 of 4 residents (#s 4, 22, 51, and 35) in the sample by publicly posting confidential health care information; 2) The facility failed to maintain dignity during dining in 1 of 4 dining rooms (Main Dining Room), including lack of timely assistance and resident's sitting for a prolonged period before dinner was served; 3) The facility failed to ensure all resident's had access to public restrooms. Findings include:</p> <p><b>POSTING IN BEDROOMS</b> During the initial environment observation on 11/13/12 at approximately 2:00 p.m. and during all days of survey the following signs listing residents' personal information and nursing staff care directives were observed:</p> <p>Resident #22. Two signs that included the resident's personal information were observed posted on the wall above the head of the bed. One yellow colored sign listed swallowing precautions such as "small bites", "sips taken slowly", "1:1 supervision required" and another white colored sign dated 6/13/10 listed "No thin liquids, no water at bedside", "Eat all meals in upright position", "Remain upright for 30 minutes</p>	F 241	<p>POC FOR ANNUAL SURVEY ENDING 11/20/12</p> <p>F-241 DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>1) POSTING OF SIGNS IN THE BEDROOM AND HALLWAY</p> <p>HOW THE NURSING HOME WILL CORRECT THE DEFICIENCY AS IT RELATES TO THE RESIDENT(S):</p> <p>For residents #4, 22, 51 and 35 all signs with personal care information have been removed from their rooms.</p> <p>HOW THE NURSING HOME WILL ACT TO PROTECT RESIDENTS IN SIMILAR SITUATIONS:</p> <p>All resident rooms checked and all signs with any personal care information found have been removed.</p> <p>Nourishment and bath lists have been removed from the hallways.</p> <p>MEASURES THE NURSING HOME WILL TAKE OR THE SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR:</p> <p>A new policy stating that no signs with personal resident information are to be</p>	

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F 241	<p>Continued From page 2</p> <p>following intake of food or liquids", "small bites, sips taken slowly", "If voice becomes gurgly encourage cough", "Setup required", and "Meds (medications): crushed."</p> <p>Resident #51. Two signs that included the resident's personal information were observed posted on the wall above the head of the bed. One sign noted: "No water pitcher" and another sign for swallowing precautions listed: "10/19/11 diet: dysphagia mech (mechanical) &amp; nectar", "no thin liquids, no water at bedside", "eat all meals in upright position. Remain upright for 30 minutes, Alternate solids with liquids; Needs to be fed", "Meds (medications): crushed" and "Feed slowly Nectars by spoon please".</p> <p>Resident #35. One sign was posted on the wall above the resident's bed noting: "would you Please (the word "Please" was underlined 3 times) put my ted hose (support hose) on when you get me up. Thank you".</p> <p>Resident #4. One sign listing swallowing precautions was taped on the above bed light fixture.</p> <p>On 11/15/12 at approximately 11:30 a.m., Staff Member A stated the posted signs were for staff and could also be information to families as "reminders".</p> <p>During an interview 11/19/12 at approximately 2:00 p.m., Staff Member B stated the speech therapist must have posted the swallowing precautions signs without letting nursing know.</p> <p><b>POSTING IN HALLWAYS</b></p>	F 241	<p>posted anywhere in the facility is completed and will be reviewed at the next nursing and general staff meetings. (See attached)</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED:</p> <p>Housekeeping and maintenance will complete environmental rounds bi-monthly to include monitoring for signs posting personal resident information and all such signs will be given to the DNS or designee for follow up.</p> <p>DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED: 12/20/12</p> <p>THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION: DNS/ADMINISTRATOR/ HOUSEKEEPING/ MAINTENANCE</p> <p>2) PUBLIC RESTROOMS</p> <p>HOW THE NURSING HOME WILL CORRECT THE DEFICIENCY AS IT RELATES TO THE RESIDENT:</p> <p>No specific resident affected by this deficiency.</p>		

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F 241	<p>Continued From page 3</p> <p>During the initial tour on 11/13/12 at approximately 12:30 p.m. and during all days of survey bathing schedules were posted with residents' names and their bath days in the South wing and West wing hallways. Additionally a nourishment list with residents' names was posted on the South wing hallway wall.</p> <p><b>PUBLIC RESTROOMS</b></p> <p>During the initial facility tour on 11/13/12 at approximately 12:45 p.m. and during all days of survey the public/resident restrooms (the Men and Women restrooms were equipped with emergency call cords) were locked. The restroom's keys were hooked on the side of the restrooms door frame at shoulder level of an average height person. Residents using wheel chairs would not be able to access the keys to use the restrooms.</p> <p>During an interview 11/19/12 at approximately 2:00 p.m., Staff Member B stated the public bathrooms were for visitors and staff use and the residents had their own bathrooms in their rooms.</p> <p><b>DINING</b></p> <p>Resident #23 was sitting at the center table from 5:00 p.m. to 6:00 p.m. waiting for her meal. Between 5:45 p.m. and 6:00 p.m. she waited for meal assistance. During this time the resident disrobed without staff noticing she had exposed her breast. There were several male residents in the main dining room. Staff Member C was the only staff available at the time, and was alerted by the surveyor at approximately 6:05 p.m.</p> <p>At approximately 6:00 p.m. Staff Member C was alone in the main dining area and stated that</p>	F 241	<p>HOW THE NURSING HOME WILL ACT TO PROTECT RESIDENTS IN SIMILAR SITUATIONS:</p> <p>Public bathrooms are no longer locked.</p> <p>MEASURES THE NURSING HOME WILL TAKE OR THE SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR:</p> <p>Public bathrooms are no longer locked. All staff notified at the next nursing or general staff meetings.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE SOLUTIONS ARE SUSTAINED:</p> <p>Public bathrooms are no longer locked.</p> <p>DATES WHEN CORRECTIVE ACTION WILL BE COMPLETE: 12/20/12</p> <p>THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE THE CORRECTION: Administrator and DNS</p> <p>3) DINING</p> <p>HOW THE NURSING HOME WILL CORRECT THE DEFICIENCY AS IT RELATES TO THE RESIDENT(S):</p>	

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F 241	<p>Continued From page 4 other staff were helping other residents in their rooms.</p> <p>At 6:15 p.m. Staff Member C had begun assisting approximately 6-9 residents that had yet to eat their meals.</p> <p>Residents #23,60 and 91 were sitting at the center table from 5:00 p.m. to 6:00 p.m. Staff Member C was feeding the residents by giving one bite of food and going to the next resident without interacting with the residents. Staff member C stated this was very "frustrating."</p> <p>At 6:20 p.m. Staff Member C was feeding Resident #60 and placed a spoon across the residents mouth to stop him from leaning forward. She told him, "no" while she was doing this.</p> <p>During a second dining observation on 11/15/12 at 12:05 p.m. in the Main Dining area Resident #60 was observed seated at the center table. At 12:35 p.m., Resident #60 was observed trying to move his chair and trying to get up from his chair. No food had been distributed until 12:45 p.m. to Resident #60 and others at his table. Resident #60 continued to try and move away from the table and ate a small amount of his food. The resident stated to Staff Member D that he was tired and wanted to go to sleep.</p> <p>A review of Resident # 60's medical record revealed the following Diagnoses: [REDACTED]</p> <p>[REDACTED] The current assessment of 10/12/12 revealed significant cognitive impairment, difficulty communicating, and total dependence on others for eating.</p>	F 241	<p>Resident #23's clothing was adjusted.</p> <p>Staff member C who was assisting Residents # 23, 60 and 91 has been counseled about talking to residents while assisting them with eating and proper ways of redirecting residents.</p> <p>HOW THE NURSING HOME WILL ACT TO PROTECT RESIDENTS IN SIMILAR SITUATIONS:</p> <p>All residents have been screened for appropriate dining room assignments. Resident with special care needs will take meals in the Vista room where there are more appropriate activities at meal times.</p> <p>MEASURES THE NURSING HOME WILL TAKE OR THE SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR:</p> <p>Nursing staff in-service completed regarding dignity &amp; respect while assisting with meals and getting residents to the dining room in a timely manner.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED:</p>	

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F 241	Continued From page 5	F 241	Staff Development and Restorative RN's will perform random dining room audits to include, but not limited to food handling, hand washing, infection control and dignity and respect while working in the dining areas.		
F 279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure a plan of care was developed for 1 of 1 resident (#76) reviewed for smoking safety; and the facility failed to</p>	F 279	<p>DATES WHEN CORRECTIVE ACTION WILL BE COMPLETE: 12/20/12</p> <p>THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE THE CORRECTION: DNS/ Restorative Coordinator/Staff Development Coordinator</p> <p>F-279 DEVELOP COMPREHENSIVE CARE PLANS</p> <p>1) SAFETY</p> <p>HOW THE NURSING HOME WILL CORRECT THE DEFICIENCY AS IT RELATES TO THE RESIDENT:</p> <p>Smoking assessment completed 11/19/12 for Resident # 76</p> <p>Smoking care plan put in place for Resident #76 on 11/19/12.</p> <p>New, revised smoking policy presented to Resident #76 on 12/11/12</p>		

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F 279	<p>Continued From page 6</p> <p>ensure 3 of 6 residents (# 7,9,64) reviewed for use of antidepressant medications had plans of care that included monitoring for side effects. This failure placed the residents at risk for not receiving consistent care and services for safety and depression. Findings include:</p> <p><b>SAFETY</b> Resident #76 was admitted to the facility on [REDACTED] with diagnoses that included [REDACTED]</p> <p>The comprehensive assessment dated 5/29/12 indicated the resident used tobacco.</p> <p>Resident #76 was observed smoking outside on facility grounds on 11/13/12 through 11/19/12.</p> <p>On 11/13/12 at approximately 3:00 p.m. Resident #76 stated she had her own cigarettes and lighter that she keeps in her room.</p> <p>On 11/19/12 at 12:15 p.m. Staff Member E and Staff Member F stated that they are a non-smoking facility and had not assessed Resident #76's safety related to her smoking and keeping the paraphernalia in her room.</p> <p>Review of Resident #76's plan of care indicated that she had poor judgment and staff were to monitor her whereabouts.</p> <p>Record review revealed there was no smoking safety assessment or plan of care as of 11/19/12.</p> <p>On 11/19/12 at 1:50 p.m. the Director of Nursing stated she had not reviewed Resident #76's smoking safety.</p>	F 279	<p>HOW THE NURSING HOME WILL ACT TO PROTECT RESIDENTS IN SIMILAR SITUATIONS:</p> <p>Residents who choose to smoke unsafely on the facility grounds will face consequences as outlined in the smoking policy.</p> <p>MEASURES THE NURSING HOME WILL TAKE OR THE SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR:</p> <p>Revised smoking policy will be addressed &amp; reviewed with all potential new admissions prior to or at the time of admission. (See attached)</p> <p>DATE WHEN CORRECTIVE ACTION WILL BE COMPLETE: 12/20/12</p> <p>THE TITLE OF PERSON RESPONSIBLE TO ENSURE THE CORRECTION: DNS and Administrator</p> <p>2) SIDE EFFECTS</p> <p>HOW THE NURSING HOME WILL CORRECT THE DEFICIENCY AS IT RELATES TO THE RESIDENT:</p> <p>Flow sheet side effects monitors put in place for Resident # 7, 9 and 64 on</p>	
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F 279

Continued From page 7

**SIDE EFFECTS**  
Resident #7. Review of an assessment dated 10/1/12 noted the resident had several diagnoses that included [REDACTED]

Review of the November 2012 physician orders and medication administration record revealed the resident took [REDACTED] every morning for [REDACTED]

The resident's current care plan for [REDACTED] did not include directions to monitor for the potential side effects of the ordered antidepressant.

A psychoactive medication review report dated 8/14/12 noted the potential side effects for [REDACTED] were somnolence, dizziness, anorexia, weight gain, head ache and nervousness, however this information was not included on the plan of care to be monitored daily by nursing staff.

Resident #9. The resident had diagnoses that included a [REDACTED]

Review of November 2012 physician orders and the medication administration record revealed Resident #9 received [REDACTED] every morning for [REDACTED]

Review of the current care plan did not include the potential side effects of [REDACTED] or provide directives for nursing staff to monitor for potential medication side effects.

F 279

11/16/12 and added to the interventions on their care plans on 12/7/12.

**HOW THE NURSING HOME WILL ACT TO PROTECT RESIDENTS IN SIMILAR SITUATIONS:**

Flow sheet side effects monitors put in place for all Residents who take Antidepressants on 11/16/12 and intervention to monitor side effects added to their care plans.

**MEASURES THE NURSING HOME WILL TAKE OR THE SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR:**

Side effects per medication have been added to the care plan library interventions so can be added to individual care plans as needed.

**HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE SOLUTIONS ARE SUSTAINED:**

Quarterly reviews are done on all resident care plans and the interdisciplinary team will make sure interventions for monitoring side effects of antidepressant are in place at the interdisciplinary care plan meeting.

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F 279	Continued From page 8  Resident #64. Review of a comprehensive assessment dated 10/4/12 noted the resident had diagnoses to include [REDACTED]  Review of November 2012 physician orders and medication administration record revealed Resident #64 received [REDACTED] every morning for [REDACTED]  Review of the current plan of care noted a plan for mood problems with an intervention to administer medications as ordered by physician; however the plan did not include directions for the licensed nurse to monitor for the potential side effects of the antidepressant.  On 11/20/12 at 10:00 a.m. the Director of Nursing stated that we have not monitored for the side effects for antidepressants nor have we included the potential side effects on the resident care plans.	F 279	DATES WHEN THE CORRECTIVE ACTION WILL BE COMPLETED: 12/20/12  TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION: MDS/Care plan Coordinator/SS  F 313-TREATMENT/DEVICES TO MAINTAIN HEARING/VISION  HOW THE NURSING HOME WILL CORRECT THE DEFICIENCY AS IT RELATES TO THE RESIDENT:  Resident #4 has reading glasses in her room and can read her magazine without difficulty with them on.  HOW THE NURSING HOME WILL ACT TO PROTECT RESIDENTS IN SIMILAR SITUATIONS:  The nursing home will ensure the residents visual and hearing functions are optimally maintained with appliances and/or offer of appointment or devices.  MEASURES THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR:
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION  To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.	F 313	

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(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 313	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review the facility failed to provide treatment and assistive devices for 1 of 4 residents (Resident #4) reviewed for vision. Findings include:</p> <p>Resident #4 admitted to the facility with a diagnoses that included [REDACTED]</p> <p>A review of the assessment from 10/12/10 to present indicated that the resident had moderately impaired vision (that she is unable to read headlines but can identify objects.)</p> <p>On 11/16/12 at approximately 11:30 a.m. the Activity Director, Staff Member U, stated that the resident did not like participating in group activities however, she did word games. Staff Member U also stated that resident #4 " loves getting her magazine "The Enquirer" and has gotten it for over a year. It was her favorite."</p> <p>The resident's care plan included an assessment of visual function which indicated she no longer read. She also did not wear glasses.</p> <p>On 11/19/12 at approximately 11:30 a.m. the resident stated that she needed her reading glasses to read her magazine. The resident stated she thought her reading glasses were in her drawer in a brown case and hadn't used them in a long while. The resident also stated that "her eyes were bad and had gotten worse." She said she had not had her eyes checked in years and stated that "she would be interested in an appointment to get her eyes examined."</p>	F 313	<p>The interdisciplinary team will present their information at care plan conferences; then each care plan focus will be reviewed to assure that sensory needs are being met. Any sensory need identified that requires appointments and/or devices will be reviewed by the business office for financial concerns. Financial information will be relayed to the resident or responsible party to make a decision about following up. Appointment needs will be referred to the Activity department.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE SOLUTIONS ARE SUSTAINED:</p> <p>The nursing homes interdisciplinary team will continue with quarterly care plan reviews and the Activity Director will continue to ask residents about activities that involve sensory input to make sure they are still able to participate as they wish.</p> <p>DATE WHEN THE CORRECTIVE ACTION WILL BE COMPLETED: 12/20/12</p> <p>TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION: MDS/Care plan Coordinator/Activity Director</p>		

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F 313	<p>Continued From page 10</p> <p>On 11/16/12 at 3:14 p.m., the Director of Nursing, Staff Member B, stated that "the nursing department was responsible for making referrals for visual issues."</p> <p>At approximately 1:00 p.m. on 11/16/12, Staff Member F indicated that Resident #4 had not been able to see for years and chose not to wear her reading glasses, and had not read due to her poor vision. Staff Member F stated that the resident "can only see objects. We monitor changes for complaints about vision. We did not ask residents if they would like to go to an eye doctor. The resident would have to request it. I do not think that every resident should have glasses. Some of these resident's that have dementia would just throw their glasses across the room."</p> <p>Although staff stated the resident refused to wear glasses and it was the resident's choice to refuse, the facility did not ensure that the resident had the opportunity to obtain an eye exam and possible prescription for reading glasses. Nor was the resident given an alternative device such as a magnifier to assist in reading her favorite magazine.</p>	F 313	<p>F-323-FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>HOW THE NURSING HOME WILL CORRECT THE DEFICIENCY AS IT RELATES TO THE RESIDENT:</p> <p>Resident #76 has been going next door to the Assisted Living Facility and accessing their smoking area for use of an ashtray when she wishes to smoke. She has been given a copy of the revised smoking policy. She has been told that the nursing home was cited for safety because she was smoking on the South patio where there is not an ashtray available.</p> <p>HOW THE NURSING HOME WILL ACT TO PROTECT RESIDENTS IN SIMILAR SITUATIONS:</p> <p>The smoking policy will be reviewed with all new admissions prior to or at the time of admission to prevent unsafe smoking on the facility grounds.</p>	
F 323 SS-D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p>	F 323	<p>MEASURES THE NURSING HOME WILL TAKE OR THE SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR:</p> <p>The smoking policy has been revised (See attached)</p>	

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F 323	Continued From page 11  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that the environment remained free from hazards for 1 of 1 sampled resident (#76) who smoked. The facility failed to identify smoking safety risks related to smoking on facility grounds and the storage of smoking paraphernalia. Findings include:  On 11/13/12, 11/14/12, 11/15/12, 11/16/12 and 11/19/12 resident #76 was observed smoking on facility grounds on a connecting patio with 2 tables and chairs. The door access from the 100 wing to the patio had a keypad code for access to and from the wing. The resident smoked out on the covered patio which also had cigarette ashes on the concrete floor where the resident was observed smoking. There was no ashtray. The resident appeared to smoke out on the patio in a safe manner.  On 11/19/12 at 12:15 p.m., the Social Services Director, Staff Member E, stated that they are a non-smoking facility and did not assess resident's risks for safety with going outside to smoke or where resident places smoking paraphernalia in her room. "There was no smoking safety assessment or plan of care to monitor resident's smoking. The resident was independent and walked to the store and buys her own lighter and tobacco. She can go where she wants to."  The resident assessment dated 5/29/12 indicated tobacco use of the resident.	F 323	HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED:  Any resident seen smoking on the facility grounds will be held accountable to the smoking policy (See attached)  DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED: 12/20/12  THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION: DNS/Administrator/SS		

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F 323	Continued From page 12 The current care plan indicated that resident was independent ambulating, accessing facility grounds, and community but staff are to monitor whereabouts.  The Director of Nursing, Staff member B and the Social Services Director, Staff Member E, on 11/19/12 at 1:51 p.m. stated that resident was to smoke only at the assisted living area (which is a separate facility) next door where there is a safe smoking ashtray.  On 11/19/12 at approximately 2:00 p.m. Staff Member T stated the "resident did go out the back door by the 100 hall to smoke and keeps her tobacco and lighter in her nightstand drawer."	F 323	F-371 FOOD SAFETY/DINING AREAS Kitchen Area  F 371 potential for Food Bourne Illness for all residents due to opened undated jug of vinegar, and open can of baking soda were disposed of 11/13/12. Cherry pie filling that was past use by date; cheese slices past use by date, 1 ounce cups of dressing count of 20, one gallon jug of pancake syrup, tomato juice all past use by date, were disposed of 11/19/12.		
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 and interview, the facility failed to prepare, store and distribute foods under sanitary conditions in the kitchen and dining areas. Failure to meet these requirements created the potential for food-borne illness for all residents receiving food prepared by the dietary	F 371	Improper storage of eggs on the floor, theses were immediately placed on a shelf in the walk-in under the ready to eat foods. Small rack is to be used if no shelf space available.  General cleanliness. Area including 2 draws and mixer shelf were cleaned immediately. Cleaning assignments reviewed with staff. Plan to update assignments.  Grill hood was cleaned. Will be cleaned weekly , assigned to the morning dishwasher. Vents were cleaned Food Service Supervisor will monitor.  Improper storage of cleaning cloths. Sanitation buckets are placed in cooks,		

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F 371	<p>Continued From page 13 department. Findings include:</p> <p><b>KITCHEN AREA</b></p> <p>Undated/Outdated Food: An initial tour of the kitchen was conducted on 11/13/12 at 12:30 p.m. Observations were as follows:</p> <p>In the preparation area on the shelf above the counter:</p> <ul style="list-style-type: none"> <li>- One opened and undated gallon sized jar of vinegar</li> <li>- One opened #10 can of baking soda labeled with a hand written date of 10/26/11</li> </ul> <p>A comprehensive tour of the kitchen was conducted on Monday 11/19/12 at 10:00 a.m. Observations were as follows:</p> <p>In the walk-in cooler:</p> <ul style="list-style-type: none"> <li>- Cherry pie filling, about 3 cups in a clear food storage container with a " UB " date of 11/17/12 (2 days past date).</li> <li>- American cheese slices individually packaged in plastic wrapping by staff and stored in a clear food storage container with a use by date of 11/15/12 (4 days past date).</li> <li>- Approximately 20 servings of Ranch dressing in 1 ounce portion cups with " UB " date of 11/17/12 (2 days past date).</li> <li>- One gallon jug of pancake syrup opened but not dated.</li> <li>- Tomato juice, opened and partly used, in the original 46 ounce container with a hand written date of 11/09/12 (outdated).</li> </ul> <p>On 11/19/12 at about 11:00 a.m. Staff Member M</p>	F 371	<p>prep cooks, and dietary aids areas with quat solution from a dispenser that measures solution. Cloths shall be stored in solution with fresh solution every 2 hours. Test strips had been used up and not replaced. On 11/14/12 test strips were replaced from storage in Food Service Supervisor's office. Staff were re-educated on proper use.</p> <p>The Dietary Supervisor will have an in-service to go over Policies and procedures for sanitary conditions in the Kitchen. The in-service will be held on 12-18-12 to go over proper labeling and the discard of perishable food items, as pertains to F371 code to store, prepare and serve food under sanitary conditions, to avoid the spread of food borne illness to the residents. The kitchen supervisor will monitor with daily checks and report at Quality Assurance meetings.</p> <p>The Dietary Supervisor will be having an in-service on 12-21-12 to go over the Policies and Procedures for cleaning the kitchen and use of cleaning supplies, as pertains to Code F 371 to store, prepare and serve food under sanitary conditions, and to stop the spread of food borne illness to the residents. We will go over the proper use and disposal</p>	

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F 371	<p>Continued From page 14</p> <p>stated "UB " beside a hand written date on a food product means that the date is a " use by " date. On 11/19/12 at about 11:15 a.m. Staff Member R, the Food Service Supervisor, stated that it is their practice to use perishable food within 3 days or discard it.</p> <p>General Cleanliness:</p> <p>An initial tour of the kitchen was conducted on 11/13/12 at 12:30 p.m. Observations were as follows:</p> <ul style="list-style-type: none"> <li>-In the preparation area: Two drawers that contained serving utensils had a dark grimy build up on the interior of the drawers. The counter surface underneath and around the mixer had dark sticky build up.</li> <li>- The hood over the grill had a dark, slightly shiny build up grease like substance.</li> <li>- A ventilation cover located in the ceiling near the entrance of the dish room had a buildup of pale brown material between the slots of the vents.</li> <li>- In the dish cleaning area, an electric fan mounted on the wall had a pale brown fuzzy material between the spokes of the fan guard and on the fan blades.</li> </ul> <p>Storage</p> <p>A comprehensive tour of the kitchen was conducted on Monday 11/19/12 at 10:00 a.m. Observations were as follows:</p> <p>In the walk-in cooler, two cases of liquid egg product and two cases of grape juice base were in SYSCO shipping boxes stored on the floor.</p> <p>On 11/19/12 at about 11:00 a.m. Staff Member M,</p>	F 371	<p>of cleaning rags and sanitary buckets, and checking of sanitary solution for proper ppm. An updated sanitary bucket check form will be made. Cleaning schedules and positions to do the cleaning will be assigned at this time. The kitchen supervisor will monitor with daily checks and report at Quality Assurance meetings.</p> <p>Prevention shall include Quality Assurance by Food Service Supervisor including weekly sanitation inspections, supervision of logs, including quat solutions; walk-in and freezer temperatures dish room water temperatures. Reports shall be given to Quality Assurance meetings. The Dietary Supervisor will monitor this finding for continued compliance. Corrected 12-28-12</p> <p>Dining Area</p> <p>HOW THE NURSING HOME WILL CORRECT THE DEFICIENCY AS IT RELATES TO THE RESIDENT(S):</p> <p>All staff members reminded to clean hands after handling the dry erase board for Resident # 84 and after removing residents from the dining room.</p>		

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F 371 Continued From page 15  
the cook, stated that SYSCO delivers groceries to their facility each Thursday (4 days prior).

Cloth Towels in Sanitary Storage

An initial tour of the kitchen was conducted on 11/13/12 at 12:30 p.m. Observations were as follows:

Three cloth towels that appeared to have been used to wipe surfaces were observed not currently in use and not held in a sanitizing solution. One towel was on the counter near the juice dispenser, one was on the food preparation counter near the convection oven and one was on a shelf in the dish cleaning area. All were crumpled; two were dry to the touch and appeared soiled, with brown stains on them.

A follow-up visit to the kitchen was conducted on 11/19/12 at 3:25 p.m. Staff Member N stated they change the sanitizing solution that stored the cloth towels every two hours. Staff Member N tested the solution in the bucket located in the dish cleaning area with a test strip that did not work (the strip she used was to test chlorine level, not the quaternary sanitizer that was in the bucket.) Staff Member N could not find a test strip that measured the strength of quaternary sanitizer.

A follow up visit to the kitchen was conducted on 11/20/12 at 10:00 a.m. Staff Member N produced the test strip that tests for quaternary sanitizer. She stated that today was the first day that the test strips were available to her. Staff Member N demonstrated the test strips on the solution in the bucket that was located in the hot food

F 371 HOW THE NURSING HOME WILL ACT TO PROTECT RESIDENTS IN SIMILAR SITUATIONS:

Nursing staff in-service on food handling and hand washing in the Dining areas scheduled for 12/20/12.

MEASURES THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR:

Hand sanitizer devices in the MDR and Annex will be monitored by housekeeping to make sure they are filled.

HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED:

Staff Development and Restorative RN's will perform random dining room audits to include, but not limited to food handling, hand washing, infection control and dignity and respect while working in the dining areas.

DATES WHEN THE CORRECTIVE ACTION WILL BE COMPLETE: 12/20/13

THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE THE CORRECTION:

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/20/2012</b>	
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F 371	<p>Continued From page 16</p> <p>preparation area. The test strip did not show any measurable sanitizing agent present. Staff Member N discarded that solution and replaced it with fresh solution. When tested, the fresh solution contained approximately 200 ppm as required by the product label.</p> <p>Staff Member N said she was not aware of a log to document solution strength for the buckets that store the cloth towels between uses.</p> <p>The perishable items that were undated, the food that was held past their " use-by" date, unclean conditions in the preparation areas and on fixtures, and the cloth towels that were not sanitized between uses all increase the risk that high levels of harmful microorganisms could develop. Harmful microorganisms could potentially cause food borne illness to any resident who consumed food prepared in this kitchen.</p> <p><b>DINING AREA</b></p> <p>During dinner observation in the Pioneer dining room on 11/13/12 at 5:50 p.m. Staff Member O did not use a barrier to turn off the faucet after she washed her hands; potentially contaminating her hands prior to delivering the resident's their meals.</p> <p>On 11/13/12 between 6:00 p.m. and 6:50 p.m. observations in the Main Dining Room and in the Annex were as follows:</p> <p>Staff was observed using hand sanitizer intermittently during the meal period. The staff told the surveyors that the hand washing sinks</p>	F 371	<p>DNS/Administrator/Staff Development</p> <p>Coordinator/Restorative</p> <p>Coordinator/Housekeeping</p>	

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

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F 371	<p>Continued From page 17</p> <p>were across the hall, either in the staff break room or in the restroom. No hand washing sink was observed in the dining area.</p> <p>A follow up dining observation was completed on 11/15/12 from 12:00 p.m. to 1:00 p.m. in the Main Dining Room and in the Annex of the Main Dining Room. No hand washing or hand sanitizer use was observed through the entire time period, nor were staff observed walking across the hall to the staff break room or the restroom. About 12:45 p.m. it appeared that the two wall mounted hand sanitizer dispensers were not working. One was located in the Main Dining area and one was located in the Annex of the Main Dining area. Neither dispenser dispensed any hand sanitizer when tested.</p> <p>A follow up observation was conducted on 11/16/12 from 12:05 p.m. to 1:10 p.m. in the Main Dining Room and in the Annex of the Main Dining area. No hand washing or hand sanitizer use was observed through the entire time period, nor were staff observed walking across the hall to the staff break room or the restroom. It appeared that the two wall mounted hand sanitizer dispensers were not working. One was located in the Main Dining area and one was located in the Annex of the Main Dining area. Neither dispenser dispensed any hand sanitizer when tested.</p> <p>Also observed:</p> <p>At 12:12 p.m. in the Annex Staff Member H, a NAC, opened a milk carton for a resident by pulling open the carton with his thumb and forefinger resting on the area of the carton that</p>	F 371		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	<p>Continued From page 18</p> <p>the milk travels across as it is poured. About 2 minutes after opening the carton, he touched the non-handled end of the fork for another resident. Hands were not cleaned before or after these actions.</p> <p>At 12:18 p.m. in the Annex Staff Member I, a NAC, picked up a white board to help Resident #84 communicate. She handled the white board then returned to serving other residents at 12:21 p.m. She shortly thereafter handled the drinking end of a straw when assisting Resident #84. There was no hand cleaning in between any of these actions. The white board had been brought from the resident's room and the back side of the white board was made of cork like material. The cork like material was darker around the edges, appearing to be soiled where hands had held the board.</p> <p>At 12:28 p.m. Staff Member J, a RN, picked up and used the white board to communicate with Resident #84 and then returned to serving other residents without cleaning her hands.</p> <p>At 12:35 p.m. Staff Member K, a NAC, lifted glass by rim with bare fingers.</p> <p>At 12:36 p.m. Staff Member H, a NAC, picked up and wrote on the white board to communicate with Resident #84 and then immediately returned to serving and assisting residents with their food. No hand cleaning between tasks was observed. Staff Member H and Staff Member I handled warm wet clothes, assisting a resident with cleaning hands and face and then immediately returned to assisting other residents with eating. No hand cleaning occurred between these</p>	F 371		

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505151</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/20/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>CASHMERE CONVALESCENT CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>817 PIONEER AVENUE CASHMERE, WA 98815</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 371	Continued From page 19 actions.  At 12:43 p.m. Staff Member I gathered several clothing protectors and dishes from residents who were finished eating, then immediately began assisting Resident #29 with eating her meal. No hand cleaning occurred between these tasks.  At 12:51 p.m. Staff Member S, a NAC, helped Resident #7 out of dining room and into the hallway, pushing his wheelchair. He then returned to assist with feeding at the center table. No hand cleaning was observed after pushing the wheelchair.  On 11/19/12 at 3:00 p.m. Staff Member B, the Director of Nursing, stated that it was her expectation that staff would wash hands before assisting with dining and when returning to the dining room after leaving to provide care and also stated that staff should have cleaned their hands after handling the white board that came from a resident room.  The lack of hand washing after contact with potentially contaminated objects can lead to cross contamination of harmful microorganisms, potentially causing illness to residents.	F 371	F-441 INFECTION CONTROL  HOW THE NURSING HOME WILL CORRECT THE DEFICIENCY AS IT RELATES TO THE RESIDENT:  A 1:1 in-service on dressing change technique was done with Staff Member P on 11/21/12.  HOW THE NURSING HOME WILL ACT TO PROTECT RESIDENTS IN SIMILAR SITUATIONS:  Licensed staff in-service to include review of dressing change techniques will be held 12/20/12.  MEASURES THE NURSING HOME WILL TAKE OR THE SYSTEMS IT WILL ALTER TO ENSURE THE PROBLEM DOES NOT RECUR:  Staff Development Nurse will complete a dressing change evaluation along with the medication pass audit for annual reviews for all licensed staff.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program	F 441	HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED:	

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F 441	<p>Continued From page 20</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure hand hygiene practices consistent with accepted standards of practice to reduce the spread of infections were consistently implemented by one of one licensed nurse during a dressing change (Staff Member P) and by two</p>	F 441	<p>Random dressing change technique audits will be done by Staff Development Nurse Quarterly.</p> <p>DATES WHEN CORRECTIVE ACTION WILL BE COMPLETED: 12/20/12</p> <p>THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION: DNS/Staff Development Coordinator</p>	

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F 441	<p>Continued From page 21 of two Nursing Assistants (Staff Members H and Q). Findings include:</p> <p>On 11/19/12 at approximately 1:40 p.m. Staff Member P was observed during resident #69's sacrum dressing change. Staff Member P placed the clean dressing change items on a white towel that was on the resident's night stand. The resident was in bed on his left side. After explaining to the resident what she was doing, she removed the soiled sacrum dressing wearing disposable gloves and deposited the soiled dressing on another white cotton towel that was placed on the resident's night stand. Without hand washing and wearing the same potentially soiled disposable gloves she proceeded with cleaning the open sacrum wound with gauze soaked with Normal Saline. The wound was opened approximately 2 inches in diameter with yellowish colored wound bed. The soiled cleaning gauze was placed on the white towel with the soiled dressing. Staff Member P then proceeded with applying the tegaderm film dressing over the wound still wearing the same potentially contaminated disposable gloves. She assisted the resident to pull his sweat pants up still wearing the same potentially contaminated gloves. She then collected the soiled dressing and gauze that were on the white towel and removed her disposable gloves over the soiled items that she discarded in the trash can. She folded the two white towels and placed them on the resident's chair. She washed her hands, turned off the water faucet without using a barrier (potentially contaminating her hands) and then dried her hands with paper towels. Additionally she wiped the water spilled on the counter around the sink (also potentially contaminating her</p>	F 441		

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F 441	Continued From page 22 . hands.)  On 11/15/12 at approximately 2:00 p.m. Staff Member H was observed assisting Resident #44 with toileting. The resident stood up holding onto a transfer pole by the toilet and Staff Member H proceeded to wipe the resident's perineal area with toilet paper wearing disposable gloves. He then pulled the resident's pants up and assisted her to sit in her wheel chair still wearing the potentially contaminated gloves. He grabbed the round door knob still wearing the potentially contaminated disposable gloves and opened the door to let the resident out of the bathroom. He exited the bathroom wearing the gloves, then removed his gloves in the hallway and entered the resident's (door was left opened) where he washed his hands. On 11/16/12 at approximately 2:45 p.m. Staff Member Q entered Resident #69's room and washed his hands at the sink; after washing his hands he turned the water faucet off without using a barrier. Thus he potentially re-contaminated his hands.	F 441			

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # <b>505151</b>	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: <b>11/20/2012</b>
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
<b>F 356</b>	<p><b>483.30(e) POSTED NURSE STAFFING INFORMATION</b></p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> <li>o Facility name.</li> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: The facility posted the number of licensed and unlicensed nursing staff but did not post the total number and the actual hours worked by the nursing staff. Additionally the facility did not post the nurse staffing data in a prominent place readily accessible to residents and visitors. The staffing was posted on the wall above the nursing station counter and a flower vase was blocking the view of the folder where the staffing was located.</p>

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