

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

PRINTED: 11/25/2014  
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>11/21/2014</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>		
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F 000	<p>INITIAL COMMENTS</p> <p>This report is a result of an unannounced Quality Indicator Survey conducted at Cashmere Convalescent Center on 11/17/14, 11/18/14, 11/19/14, 11/20/14 and 11/21/14. A sample of 25 residents was selected from a census of 64. The sample included 20 current residents and the records of 5 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>Pam Holt, RN Liisa Johnson, RN Brenda Webster, RN Refugia Botello, RN</p> <p>The survey team is from:</p> <p>Department of Social &amp; Health Services Aging and Long-Term Support 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>	F 000			

Received  
Yakima RCS  
DEC 12 2014

*[Handwritten Signature]* 11/24/14  
Residential Care Services Date

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Handwritten Signature]* TITLE *[Handwritten Signature]* (X6) DATE *12-12-14*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 253 SS=E	<p><b>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</b></p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain a safe and sanitary environment in good repair for one of one shower rooms observed. This failure left surfaces in the tub room that were not cleanable and safe. Findings include:</p> <p>On 11/20/2014 9:20 a.m. during observation of the west shower/tub room the following was observed: 1) one large 8 inch x 8 inch tile missing near the floor next to the bath tub with the insulation exposed, 2) a sharp metal trim corner guard edge was noted to protrude out approximately 1/2 inch near floor on the wall between shower stalls (above the sharp edge was a measure tape), and 3) the shower stall across from the bath tub had a coving surface that was not intact and had a rust colored coating of debris on it.</p> <p>At 9:30 a.m. Staff Member B, the Maintenance Director, stated he was not aware of the missing wall tile or the sharp metal edge on the wall. He stated that he cleans and repaints the shower stalls in here about once a year and it seemed to be due now, he was not aware it had become this bad.</p> <p>On 11/20/2014 at 10:39 a.m. Staff Member A, the Administrator, was informed of the environment</p>	F 253	<p><b>POC for 2014 QIS Survey</b></p> <p><b>F-253 Housekeeping &amp; Maintenance Services</b></p> <ul style="list-style-type: none"> <li>➤ 8 x 8 Tile missing in shower/tub room <ul style="list-style-type: none"> <li>○ The missing tile has been replaced by the Maintenance Department and the facility has been inspected for other missing tile problems.</li> </ul> </li> <li>➤ Sharp metal trim corner guard edge in the shower/tub room <ul style="list-style-type: none"> <li>○ The sharp metal edge was replaced during survey. Corrected on 11/21/14</li> </ul> </li> <li>➤ Shower/tub area had a coving surface that was not intact <ul style="list-style-type: none"> <li>○ The shower coving surface has been treated with a bacterial resistant coating resurfaced.</li> </ul> </li> <li>➤ The Bathing personnel have been reminded to monitored</li> </ul>		

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F 253	Continued From page 2 observations in the east tub room. He stated these concerns should have been reported by staff using that room and he was not aware of these issues prior to today.	F 253	daily and report maintenance concerns to the Maintenance Department. The Maintenance Department will make regular follow up inspections with regard to the shower/tub area. The Maintenance Department will monitor the continued compliance of the survey finding. Corrected 12/18/214		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  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.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to 1) provide an environment that was free from hazards which the facility had control over when portable electric space heaters were used for 2 of 35 sampled residents rooms (#s 69, 73) and one supplemental resident room (#67); 2) the facility failed to secure a portable oxygen tank to avoid a potential accident from occurring for 1 of 3 residents (#20) receiving oxygen treatments. These failures put residents at risk for potential harm. Findings include:  1) Space Heaters  On 11/17/2014 at 4:00 p.m. a portable electric heater was observed operating in Resident #73's room. The resident stated his room was real cold before the facility maintenance man put it in his room a few days ago.	F 323			

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F 323	<p>Continued From page 3</p> <p>Portable space heaters were also observed in Resident #67 and #69's rooms at 4:15 p.m.</p> <p>The facility Administrator was informed there were portable electric space heaters in three resident's rooms at 4:35 p.m. The Administrator stated he was not aware space heaters were being used to heat resident rooms and acknowledged their use was prohibited in nursing homes.</p> <p>On 11/17/14 at 5:00 p.m. Staff Member B, the Maintenance Director, was interviewed over the phone. He stated the heat stopped working in Resident #73's room the previous Thursday night (11/13/14) and replaced the thermostat the next day (11/14/14). On Sunday (11/16/14) the heater stopped working again so he put an electric space heater in the resident's room to provide heat and comfort. Staff Member B stated that two other resident's room heaters stopped working on Sunday (Residents #67 and 69) and electric space heaters were also provided for the residents comfort. Staff Member B stated he was aware portable electric space heaters were prohibited in nursing homes.</p> <p>Review of the facility disaster manual for loss of facility heat did not prohibit portable electric space heaters or plan for loss of heat in an individual resident room.</p> <p>On 11/17/14 at 5:30 p.m. the Facility Administrator stated he was not aware the emergency manual did not include a plan for loss of heat in resident rooms.</p>	F 323	<p>zone. A new heater was installed in room #213. Room 215 did not have a heater failure. All heating issues have been resolved and the maintenance department will inventory back up units to prevent future short or long term disruption of service.</p> <ul style="list-style-type: none"> <li>○ The Maintenance Department will be responsible for continued compliance of this survey finding. Corrected 12/12/2014</li> <li>➤ The unsecured portable oxygen tank was removed from the resident's room and placed in a holder in the designated oxygen storage room immediately upon discovery.</li> <li>➤ Oxygen Use Policy and Procedure reviewed with all licensed nurses.</li> <li>➤ Oxygen Use Policy and Procedure was written to</li> </ul>		

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F 323	<p>Continued From page 4</p> <p>2) Unsecured Portable Oxygen Tank</p> <p>Resident #20. Admitted to the facility with diagnoses included [REDACTED]</p> <p>The comprehensive assessment dated [REDACTED] documented she is total dependence of bed mobility, transfers, eating, dressing.</p> <p>On 11/17/14 at approximately 4:10 p.m., a large oxygen refill station was in the resident's room and on the floor was a unsecured small portable unsecured oxygen tank. The oxygen refill station and portable tank was across the room from the resident's bed and bathroom area.</p> <p>On 11/17/14 at approximately 4:20 p.m., Staff Member A, the Administrator, stated the oxygen tank should not be on the floor and then used a oxygen tank carrier and removed the portable oxygen tank.</p> <p>On 11/19/2014 8:09 a.m., Staff Member D, the Director of Nursing (DNS), stated she was not aware the staff had left a portable oxygen tank on the floor of a resident's room. She learned about the portable tank and instructed nursing staff to store it in the designated oxygen storage room. The DNS added that oxygen tanks should be in a carrier and not left unsecured on the floor. The DNS stated the resident was cognitively and physically impaired and unable to communicate or wheel self without staff assistance.</p> <p>Review of the facility Oxygen Use Policy and Procedure dated read, "E-tanks must be stored on the refill station on top of the concentrator, in a designated oxygen storage bag on a wheelchair or in a storage rack."</p>	F 323	<p>include proper storage of portable tanks.</p> <ul style="list-style-type: none"> <li>➤ Nurses are to be aware of which residents in their care are using oxygen tanks and check during daily care to be sure portable tanks are stored properly per policy.</li> <li>➤ Correction date -December 5, 2014</li> <li>➤ The DNS will monitor continued compliance</li> </ul>		

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F 441 SS=D	<p><b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b></p> <p>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.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p><b>F-441-Infection Control-Eye drops/hand-washing</b></p> <ul style="list-style-type: none"> <li>➤ The LN who gave eye drops without using gloves stated understanding of his error and did not (per the SOD) touch resident #43 with his dirty hand while dispensing eye drops to her.</li> <li>➤ An in-service and quiz covering hand-washing technique and timing was administered to all licensed nurses on December 5<sup>th</sup>. Those not in attendance were also required to take successfully pass a quiz on this topic.</li> <li>➤ Ongoing medication pass audits with all licensed nurses completed 90 days after hire, annually and as indicated to include review of infection control and hand-washing.</li> <li>➤ Review of medication pass audits will be completed by the</li> </ul>		

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F 441	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure 1) one of two licensed nurses (Staff Member C) completed handwashing during medication observation; 2) the facility failed to ensure staff practices for catheter bag care for 1 of 4 residents reviewed for catheters (#5) prevented cross contamination. This failure put residents at risk for an environment that was not safe or sanitary and increased the chance of the spread of infection. Findings include:</p> <p>On 11/19/14 between 3:00 p.m. and 3:30 p.m. the following was observed during medication observation:</p> <p>Staff Member C, a Licensed Nurse (LN), prepared medication for Resident #43 and obtained a bottle of eye drops from the top of the medication cart. The LN then carried the medication cup and liquid tears eye drops into the residents room, setting the bottle of eye drops directly on the bedside table without a barrier. The LN went to the foot of the bed and moved a floor fall mat away from the left side of the bed with his bare right hand. The LN without first washing his hands, then picked up the bottle of eye drops with the same hand that handled the floor mat. Administered the eye drops followed by a spoon full of crushed medications. Before leaving the room, Staff Member C then returned the floor mat to the left side of the resident's bed using his bare right hand and did not wash his hands at the sink in the resident's room before leaving.</p> <p>Next, Staff Member C returned the eye drops to</p>	F 441	<p>DNS and any nurse with infection control errors will be counseled accordingly.</p> <ul style="list-style-type: none"> <li>➤ Corrected December 5, 2014</li> <li>➤ The DNS/Staff Development will monitor this finding for continued compliance.</li> </ul> <p>F-441-Infection Control-Catheter bag care</p> <ul style="list-style-type: none"> <li>➤ A dignity catheter bag was provided for resident #5 to keep his collection bag off the floor and covered.</li> <li>➤ The Urinary Catheter Care Policy and Procedure and the Bowel and Bladder Routine Resident Care Protocol were reviewed with all licensed nurses.</li> <li>➤ Nurses are to be aware of which residents in their care have catheters and check daily during care to be sure the collection</li> </ul>		

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F 441	<p>Continued From page 7</p> <p>the medication cart, prepared and administered medications to Residents #27 without washing his hands.</p> <p>At 3:34 p.m. Staff Member C was asked what the facility policy was for handwashing during medication administration. The LN stated that they are to wash their hands if they have become soiled and/or after removing gloves. He also added that he should perform hand hygiene with hand sanitizer between residents during medication administration. When asked what the facility policy was for administering eye drops, Staff Member C stated that the LN should wear gloves to administer eye drops, but only if they were going to touch the resident. (He was not observed to touch Resident #43 when administering the liquid tears.) Staff Member C stated that he should have washed his hands after moving the mat on the floor with his bare hand, but he did not.</p> <p>Review of an undated Handwashing/Hand Hygiene policy/procedure provided by the Director of Nursing, revealed hand washing or hand hygiene with an alcohol-based hand rub should be done "before preparing or handling medications and after handling contaminated equipment".</p> <p>On 11/20/2014 at 8:25 a.m. the Director of Nurses stated she expected the licensed nurses to use a barrier between eye drop bottles and resident surfaces (like a cup or paper towel); the LN should wash their hands with soap and water and wear gloves when administering eye drops. The Director of Nurses was informed of the observation during medication administration and stated Staff Member C should washed his hands</p>	F 441	<p>bags are secured in a dignity bag that covers and protects them.</p> <ul style="list-style-type: none"> <li>➤ DNS or designee will continue to monitor residents who have urinary catheters for appropriate medical diagnosis and proper use of catheter equipment.</li> <li>➤ Corrected December 5, 2014</li> <li>➤ DNS/ Staff Development</li> </ul>		

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F 441	<p>Continued From page 8</p> <p>after touching the soiled mat on floor. An observation of Resident #5 occurred on 11/17/14 at approximately 12:30 p.m. His catheter bag was uncovered and laying on the floor at his bedside on a fall mat. On 11/18/14, Resident #5's catheter bag was again observed at 12:30 p.m. to be uncovered, lying on a stained, dirty fall mat at his bedside.</p> <p>In an interview with Staff Member D, the Director of Nursing (DNS), stated it was determined that catheter bag placement did not include placement on the floor at any time.</p> <p>Review of the catheter care policy was completed on 11/20/14 at 1:30 p.m. Directives included that at no time would catheter bags be on the floor.</p> <p>The placement of the catheter bag on the fall mat, uncovered, placed the resident at risk for urinary tract infection reoccurrence.</p>	F 441			