

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

PRINTED: 10/12/2012  
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>C</b> <b>10/10/2012</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 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Cashmere Convalescent on 10/02/12 and 10/10/12. A sample of 6 residents was selected from a census of 63. The sample included 3 current residents and the records of 3 former and/or discharged residents.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#2674183 #2678694 #2678800 #2684276 #2686215 #2687251</p> <p>The survey was conducted by:</p> <p>Priscilla Becker, R.N.</p> <p>The survey team was 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>Priscilla Becker</i> Residential Care Services Date <i>10/10/12</i></p>	F 000	<p>Received Yakima RCS <b>OCT 26 2012</b></p>	
-------	--	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Priscilla Becker</i>	TITLE <i>CC</i>	(X6) DATE <i>10-25-12</i>
--	--------------------	------------------------------

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.

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>C</b> <b>10/10/2012</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 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide care in a manner that promoted and enhanced resident dignity for 1 of 3 sampled residents (#5). Resident #5, cognitively impaired and incontinent at times, was sent to the hospital without appropriate undergarments and incontinence products. He arrived at the hospital in a soiled condition. Findings include:</p> <p>Resident #5: Review of the medical record revealed the resident had multiple diagnoses including dementia with behavioral disturbances. The resident's plan of care noted he had difficulty communicating his needs, was incontinent of bowel and bladder at times, and was on a toileting program. Staff were to assist the resident by taking him to the bathroom, managing his clothing, and placing incontinent products.</p> <p>According to the facility investigative documents and nursing documentation, on 9/24/12 the resident experienced a fall with facial injuries, a skin tear to his left hand, and an abrasion to his left knee. The resident was sent to the hospital for care.</p> <p>The resident's Power of Attorney (POA) was interviewed on 10/02/12 at approximately 7:15</p>	F 241	<p>POC FOR DEFICIENCIES CITED OCTOBER 16, 2012</p> <p>F-241-DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>HOW THE NURSING HOME WILL CORRECT THE DEFICIENCY AS IT RELATES TO THE RESIDENT:</p> <p>Per skin assessments of 9/6/12 and 9/10/12 and progress note of 9/10/12 this resident was on a trial of no briefs to assist with healing excoriation to his bilateral buttocks-see attached progress notes.</p> <p>The facility will assure that the resident is completely dressed including under garments daily as his behaviors allow per his care plan.</p> <p>HOW THE NURSING HOME WILL ACT TO PROTECT RESIDENTS IN SIMILAR SITUATIONS:</p> <p>The nursing home will ensure that residents who are sent to the emergency room have on proper undergarments. Nursing staff will be in-serviced on making sure residents are properly dressed prior to being sent out the ER.</p> <p>MEASURES THE NURSING HOME WILL TAKE OR THE SYSTEMS IT WILL ALTER TO</p>	

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>C</b> <b>10/10/2012</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 241	Continued From page 2 p.m. The POA stated the resident arrived at the hospital and they placed a hospital gown on him. When his pants were lowered, there were feces "all over" (his genitals and lower body). According to the POA even his socks had urine and feces on them.  On 10/05/12 at approximately 8:56 a.m., Staff Member A, a Nursing Assistant, stated that on 9/24/12 the resident had been incontinent of stool and was cleaned prior to going to the hospital but no underwear was placed (or incontinent products). The resident was wearing pants.  Failure to place appropriate undergarments/incontinent products put the cognitively impaired resident, with incontinence issues, at potential risk for an affront to his dignity.	F 241	ENSURE THAT THE PROBLEM DOES NOT RECUR:  The discharging nurse sending a resident to the emergency room will double check with NAC staff to be sure the resident has on undergarments.  HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED:  Findings reviewed by QA committee-focused audits on dignity, respect and resident appearance in progress.  All hospital transfers will be reviewed by the DNS or designee to be sure residents were sent out in a dignified, properly dressed manner.  DATES WHEN THE CORRECTIVE ACTION WILL BE COMPLETED: October 26, 2012  THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION: DNS	
F 323 SS=D	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, record review, and interview, the facility failed to provide sufficient supervision to prevent accidents and/or ensure the residents' plans of care were appropriately implemented for 2 of 6 sampled residents (#1 &	F 323	F-323-FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  HOW THE NURSING HOME WILL CORRECT THE DEFICIENCY AS IT RELATES TO THE RESIDENT:	

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>C</b> <b>10/10/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>CASHMERE CONVALESCENT CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>817 PIONEER AVENUE</b> <b>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 323	<p>Continued From page 3</p> <p>#3). Failure to follow the resident's plan of care or provide necessary staff supervision in the dining room resulted in resident falls with injuries. Findings include:</p> <p>Resident #1: Review of the medical record revealed the resident had multiple medical diagnoses including Alzheimer's disease and an anxiety state. A comprehensive assessment, dated 9/18/12, and the resident's plan of care noted the resident required two persons to transfer her and to reposition her in bed. The cognitively impaired resident's plan of care also noted she had severe language deficits and required two caregivers to perform peri-care with clothing management and peri-care after incontinent episodes.</p> <p>According to a 9/08/12 nursing entry, Staff Member B, a Nursing Assistant (NA), was putting the resident to bed. The resident was lying in bed and the NA turned to move the wheelchair out of the way and the resident fell from the bed to the floor. The resident was found to have a 2.5 centimeter (cm), about one inch, by 3 cm hematoma (a collection of blood in the tissue) on the top of the left side of her head.</p> <p>Facility investigative records for the 9/08/12 fall documented that the resident "does not move in the bed usually. Feel she may have been positioned too close to the edge of the bed."</p> <p>On 10/02/12 at approximately 1:20 p.m., Staff Members A and C transferred the resident from the wheelchair to her bed and provided peri-care. The resident was not observed moving herself in the bed at that time. Staff Member A stated the</p>	F 323	<p>Resident #1 continues to be a two person assist for transfers and repositioning and peri-care. She is recovered from her fall and has suffered no ill effects.</p> <p>Resident #3 continues to require one person extensive assist for transfers and to eat in the Annex after being assisted to a stationary chair with a tub under her feet. She has no further injury and has no change to her status as a result of this fall.</p> <p>Staff member "B", an NAC who was involved in not following the care plans or the nursing home policy on dining room service, has been disciplined and is currently on probation.</p> <p>HOW THE NURSING HOME WILL ACT TO PROTECT RESIDENTS IN SIMILAR SITUATIONS:</p> <p>Staff member "B" has been counseled and placed on a probationary period pending improved performance with understanding of possible termination of employment with any further incidents r/t to her not following care plans.</p> <p>All NAC staff has been in-serviced regarding following safety interventions, using gait belts and with reminders that a staff member is to be in the Annex, MDR</p>	

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>C</b> <b>10/10/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>CASHMERE CONVALESCENT CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>817 PIONEER AVENUE</b> <b>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 323	<p>Continued From page 4 resident did not move/reposition herself.</p> <p>An interview was conducted with Staff Member B on 10/02/12 at approximately 2:35 p.m. Staff Member B reported that she transferred Resident #1 by herself at times if other caregivers were busy assisting other residents and on 9/08/12 she had transferred the resident without assistance from another caregiver (despite the care plan directive). She placed the resident in bed on her back and provided some personal care. She further stated she had never seen the resident move herself. Staff Member B reported she was unaware of how/where the resident was placed in the bed but as Staff Member B was exiting the doorway to the resident's room the resident fell to the floor.</p> <p>Resident #3: Review of medical record revealed the resident had multiple diagnoses including dementia, anxiety state, muscle weakness, eye conditions, and a fall history. A Fall Risk Assessment on 7/19/12 identified the resident was at high risk for falls. The resident's plan of care noted the resident had a problem with communication related to her dementia, required 1-2 persons to assist with transfers, and used her wheelchair as her primary mode of transportation.</p> <p>According to a 9/15/12 nursing entry the resident had an unwitnessed fall onto her right side. The resident stated she hit her head on the floor. Although no injuries were noted at the time of the fall, the September 2012 treatment record and facility investigation documented the presence of a bruise on the top of the resident's head and a 4 cm by 4 cm bruise on the resident's right hip. There was ongoing monitoring of the areas and</p>	F 323	<p>and Vista rooms while resident have meal trays in front of them.</p> <p>MEASURES THE NURSING HOME WILL TAKE OR THE SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR:</p> <p>Findings reviewed with the QA committee. Fall statistics reviewed with continued efforts to decrease falls through activity interventions and educating all nursing staff regarding knowing and following individual safety interventions. Focused dining room audits are in progress.</p> <p>Routine Care Protocol has been amended to include -RNA in Annex at breakfast and lunch. Licensed nurse in Annex at dinner-see attached protocol.</p> <p>Ongoing reviews/evaluations with NAC's to be sure they continue to know and follow routine care protocols and provide care for residents per their Kardexes and standards of practice.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED:</p> <p>Personnel will track all NAC education, in-services and keep a log in each staff members file.</p>	

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

PRINTED: 10/12/2012  
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>C</b> <b>10/10/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>CASHMERE CONVALESCENT CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>817 PIONEER AVENUE</b> <b>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 323	<p>Continued From page 5</p> <p>no further injuries or complications were identified.</p> <p>Review of the facility investigation associated with the 9/15/12 fall revealed the fall occurred in a facility Annex dining room. The caregiver, Staff Member B, left the residents unattended in the dining room to get a tray for one of the residents. Resident #3 had bowel urgency and got up by herself and fell.</p> <p>Observations were conducted during the 10/10/12 lunch meal service in the Annex dining room where Resident #3 ate. Staff were present during the meal service. At approximately 12:25 p.m., Staff Member D, a NA, transferred the resident from her wheelchair to a stationary chair without the use of a gait belt (a belt place around the resident's waist in order to prevent pulling on the resident's body parts) despite the NA having the gait belt around her waist. The resident took a couple steps and did not appear steady with her gait. At approximately 12:55 p.m. Staff Member E, a NA, transferred the resident from the stationary chair to her wheelchair but did not use a gait belt for the transfer.</p> <p>During 10/10/12 interviews with the Director of Nursing (DNS), she was asked about the facility policy about gait belt use. The DNS stated staff were to use gait belts when they had to touch the residents (for transfers). When asked about gait belt use for Resident #3's transfers she stated, "I would say so." The DNS also stated that staff were to be present during meal service in the Annex dining room where Resident #3 ate (and in other dining rooms).</p>	F 323	<p>All incident reports will be reviewed by DNS or designee to monitor for incidents involving not following the care plan and staff members will be followed up with on an individual basis.</p> <p>DATES WHEN THE CORRECTIVE ACTION WILL BE COMPLETED: OCTOBER 26, 2012</p> <p>THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION: DNS</p>		