

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

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/31/2012
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NAME OF PROVIDER OR SUPPLIER CASHMERE CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 817 PIONEER AVENUE CASHMERE, WA 98815
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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
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Cashmere Convalescent Center on 10/30/12 and 10/31/12. A sample of 8 residents was selected from a census of 62. The sample included 5 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>#2689587 #2692764 #2694458</p> <p>The survey was conducted by: Priscilla Becker, R.N.</p> <p>The survey team was from: Department of Social & Health Services Aging & 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>Robert B. [Signature]</i> 11/2/12 Residential Care Services Date</p>	F 000	<p>Received Yakima RCS NOV 19 2012</p>	
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>[Signature]</i>	(X6) DATE 11-16-12
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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 312 SS=E	<p>Continued From page 1 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, record review, and interview, the facility failed to ensure nail care and/or bathing was consistently provided in accordance with the resident's plan of care for 6 of 7 sampled residents (#1, #2, #4, #5, #7, & #8). Failure to maintain the resident's hygiene represented a potential affront to the resident's dignity and/or a potential risk for mobility, discomfort, and/or skin integrity in the case of poorly maintained fingernails or toenails. Findings include:</p> <p>Resident #8: On 10/31/12 at approximately 9:00 a.m. and 9:18 a.m. cognitively alert Resident #8 stated that over the last few months she had not consistently received her twice weekly showers. She stated she had a skin condition and when she did not receive the appropriate number of showers, her legs itched more. Resident #8 stated the facility had staff shortages at times and pulled the Bath Aide (BA) to work on the floor instead of providing showers. Observation of the resident's fingernails revealed they were long and had jagged edges.</p> <p>On 10/31/12 at approximately 11:50 a.m. the resident's toenails were observed with Staff</p>	F 312	<p>F-312 ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>HOW THE NURSING HOME WILL CORRECT THE DEFICIENCY AS IT RELATES TO THE RESIDENT(S);</p> <p>Resident #1 has an appointment with a podiatrist in November. Resident #2 is no longer in the facility. Resident #3 has expired. Resident #4 has an appointment with a podiatrist in December. Resident #5 has an appointment with a podiatrist in November. Resident #6 has expired. Resident #7 has an appointment with podiatrist November. Resident #8 has requested that NAC staff trim and file her nails. MD order rec'd to dc having licensed nurse provide nail care. Resident #8 states that she does not prefer to go to the podiatrist office and prefers to have CCC Staff trim her toenails & fingernails.</p>	

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F 312	<p>Continued From page 2</p> <p>Member A, a Licensed Nurse (LN). The resident's left great toe nail was very thick and jagged and the 3rd and 5th toenails on the left foot were also long. On the right foot the resident's 2nd and 4th toenails were long. Staff Member A stated she could do "some trimming" but other toenails need the care of a Podiatrist (a foot care physician). The resident stated in the past the Podiatrist cared for her toenails and had to "sand them" down. Additionally, the resident stated she wanted her fingernails short. Although LNs were to perform the nail care due to her diabetes, the resident stated it was typically the Nursing Assistants (LNs) who cut her fingernails.</p> <p>Review of the resident's medical record revealed she had multiple medical conditions including diabetes. The resident's plan of care documented she required total staff assistance for her twice weekly baths/showers. Bathing documentation provided by the facility revealed the resident received 5 of 8 showers during August 2012 and September 2012. A physician's order documented that LNs were to perform weekly nail care.</p> <p>Resident #7: On 10/31/12 at approximately 9:20 a.m. the cognitively alert resident stated she hadn't had her toenails cut for a while. The Podiatrist used to cut her toenails. The resident's right 5th fingernail was jagged.</p> <p>On 10/31/12 at approximately 11:45 a.m. the resident's toenails were observed with Staff Member B, a LN. The resident's right compression stocking was shredded at the toe and her toes were protruding beyond the stocking. In addition, there was a string from the</p>	F 312	<p>HOW THE NURSING HOME WILL ACT TO PROTECT RESIDENTS IN SIMILAR SITUATIONS;</p> <p>All residents will be checked weekly for long, jagged or thick toenails.</p> <p>Licensed nurse will obtain order for Podiatry referral as needed & the Activity Director will set up appointments and transportation.</p> <p>Licensed nurses will continue to trim nails for Diabetic residents twice monthly and shower aides will trim nails for all other residents during their weekly shower.</p> <p>MEASURES THE NURSING HOME WILL TAKE OR THE SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR;</p> <p>Altered weekly skin check-shower charting worksheet to include a place to add why the resident</p>	

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F 312	<p>Continued From page 3</p> <p>stocking between her toes. The resident stated the string was causing discomfort. Toenails on the right 3rd and 4th toes were long and jagged. The resident's left 3rd and 4th toenails were longer and jagged as well. Staff Member B looked at the resident's toenails and stated, "Those could use a little work."</p> <p>Review of the medical record revealed the resident had diabetes. She was to receive nail care by a LN.</p> <p>Resident #2: Review of the medical record revealed the resident had dementia. Her plan of care noted she required total staff assistance for bathing but no bathing frequency was noted. Her plan also documented, "Check nail length and trim and clean on bath day and as necessary." Bathing documentation received from the facility identified the resident had a shower on 9/11/12. A nursing entry on 9/12/12 noted the resident had a scratch on her right upper lip. "Resident's fingernails have sharp and jagged corners." The fingernails were subsequently trimmed and filed. The facility investigation noted the resident's fingernails were long and a self-inflicted scratch was a possible cause of the scratch on the resident's face.</p> <p>When interviewed on 10/31/12 at approximately 9:35 a.m., Staff Member C, the Shower/Bath Aide, recalled Resident #2 was on a weekly bath schedule. Staff Member C stated she was pulled to floor duty "once in a while." During the months of July 2012 and August 2012 she recalled they were short staffed and were not always current with their showers.</p>	F 312	<p>refused shower, shaving or nail care if there are refusals.</p> <p>Altered Point of Care electronic charting "tasks" to separate nail care from the bath aid charting so that whichever staff member provides nail care can chart that they have done so.</p> <p>Charge nurses will check weekly to see if any residents have podiatry needs.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THE SOLUTIONS ARE SUSTAINED;</p> <p>DNS or designee will follow up with charge nurses monthly for podiatry referrals and list of appointments arranged.</p> <p>DATES WHEN THE CORRECTIVE ACTION WILL BE COMPLETED; November 9, 2012</p>	

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F 312	<p>Continued From page 4</p> <p>Resident #4: The resident's feet were observed on 10/31/12 at approximately 1:30 p.m. His right great toenail and 2nd and 3rd toenails were long. On his left foot the 2nd and 3rd toenails were long. The resident's fingernails showed brownish soiling under three fingernails and they were somewhat long. Staff Member D stated the resident in the past had seen a Podiatrist.</p> <p>According to the resident's medical record Resident #4 had dementia with behavioral issues. His plan of care directed that he receive weekly baths/showers and his nail length was to be checked. His nails were to be checked, trimmed, and cleaned on bath day. The facility provided a document noting the resident was last bathed on 10/30/12.</p> <p>Resident #5: Review of the medical record revealed the resident had dementia. Her plan of care documented she was to be bathed weekly and and staff were to check her nail length and trim and clean her nails on bath day.</p> <p>Observations on 10/31/12 at approximately 1:45 p.m. with Staff Member D revealed that Resident #5's left great toenail was extending over her toe and appeared thick and sharp. There were also sharp edges on the 2nd and 3rd toes on the left foot. On the right foot the 2nd toenail was thick, long, and migrated outward. The 3rd and 4th toenails were long and jagged and the 5th had a sharp edge present.</p> <p>Resident #1: Review of the medical record revealed the resident had Alzheimer's disease. Her plan of care noted she was to have twice weekly showers and weekly nail care. "Family</p>	F 312	THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION; DNS	

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F 312	<p>Continued From page 5</p> <p>prefers nails to be kept short." Bathing data noted that during September 2012 the resident received 5 of 8 showers.</p> <p>Observations on 10/31/12 at approximately 1:40 p.m. with Staff Member D, a LN, revealed the resident's fingernails were long. The resident's left 3rd-5th toenails were long, thick and deviating to the side. There were similar findings with the right 3rd and 4th toenails. Staff Member D stated, "I don't think we could trim those nails."</p> <p>On 10/31/12 at approximately 2:05 p.m. Staff Member E provided a list of residents who had seen the Podiatrist on 6/14/12, during his last visit to the facility (#1, #7, & #8). The Podiatrist was no longer visiting at the facility and toenail care was to be provided by facility staff. Residents who needed specialized care by a Podiatrist were to be sent out for an appointment.</p> <p>According to the Director of Nursing on 10/31/12 at approximately 3:12 p.m., "There is a breakdown" in their system (pertaining to providing toenail care or obtaining Podiatry services when appropriate).</p>	F 312			