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

PRINTED: 07/03/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505151		C 06/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASHMERE CONVALESCENT CENTER	817 PIONEER AVENUE CASHMERE, WA 98815

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F 000	INITIAL COMMENTS	F 000		

This report is the result of an unannounced Abbreviated Survey conducted at Cashmere Convalescent Center on 6/20/12 and 6/29/12. A sample of 9 residents were selected from a census of 62 residents. The sample included 8 current residents and the record of 1 former and/or discharged resident.

The following were complaints investigated as part of this survey:

#12-05-16795
#12-06-17903
#12-06-19010
#12-06-20401

The survey was conducted by:

Priscilla Becker, R.N.

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

Telephone: (509) 225-2800
Fax: (509) 574-5597

7/9/12
Residential Care Services Date

Received
Yakima RCS
JUL 19 2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

7-18-12

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 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, record review, and interview, the facility failed to provide sufficient supervision to prevent accidents (or unwarranted entry or contact) for 7 of 8 sampled residents (#2, #3, #4, #5, #7, #8, & #9). Cognitively impaired Resident #3 wandered throughout the facility into others' rooms, pushed residents in their wheelchairs without permission evoking protests, and was prone to react to their reactions of disapproval. Resident #2 had swallowing problems and was known to access the facility nourishment cart placing himself at risk by eating unsafe foods, constituting a safety hazard. Findings include but were not limited to: Resident #3: Review of the medical record revealed the resident had multiple medical diagnoses including dementia with behavioral manifestations. The resident's plan of care noted he was moderately to severely impaired cognitively and had difficulty communicating his needs. The resident walked independently. Staff were to monitor his whereabouts when he was off the hallway where he lived.	F 323	~~PLAN OF CORRECTION F323 SAFETY AND~~ SUPERVISION HOW THE FACILITY PLANS TO CORRECT THE DEFICIENCY AS IT RELATES TO THE RESIDENT Resident #2 is at risk for aspiration r/t dysphagia, with a mechanically altered diet with thin liquids and his behavior of wandering and seeking food in inappropriate places. The following intervention was added to his care plan: "Offer me appropriate snacks between routine meal and snack time or if you see me rummaging on food carts or entering other residents' rooms looking for food or if I am asking for something to eat. I burn a lot of energy because I have Parkinson's disease and get hungry between meals. I am on a dysphagia mechanical diet r/t swallowing disorder and there are snacks in the West utility room refrigerator for me." Plan to ask family if Don can move to new West SCU (see below) where he can be better supervised. Resident #3 is an ambulatory resident w/ dx of dementia with behaviors and vision loss r/t glaucoma and dry eyes. He has had multiple witnessed and un-witnessed resident to resident altercations. We fully investigated each of these altercations and were unable to substantiate the extent of resident to resident	

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F 323	Continued From page 2 According to a 4/08/12 nursing entry, at 7:20 a.m., a staff member heard female Resident #7 yelling and screaming for help. She stated a man was in her room trying to force himself on her. The staff member entered the room and saw Resident #3 standing there (not exposed). A corresponding 4/08/12 entry in Resident #7's chart noted she was resting in bed and was startled by Resident #3 leaning over her bed staring at her. She yelled at him to get out and then he grabbed at her shirt but did not touch her inappropriately or force himself on her. When interviewed on 6/20/12 at approximately 2:08 p.m., Resident #7 (with some mild cognitive impairment documented) recalled the 4/08/12 incident as one with inappropriate touching and that the police had been involved. Resident #7 also stated she felt safe but Resident #3 liked to push people around in their wheelchairs and enter others' rooms possibly to take their things when they were out. Staff would say, 'Oh, come on, (Resident's name) can't help it.' Resident #7 also expressed concern that "they (staff) let him do what he wants." Further review of Resident #3's plan of care noted a 4/09/12 revision to include a visual check of Resident #3's whereabouts every hour. A 4/10/12 entry documented Resident #3 was resistant to redirection at times. The 4/14/12 nursing entry documented the resident grabbed the handles of a female resident's wheelchair. A staff member attempted to intervene and Resident #3 swung at the staff member but struck the right side of the female resident's head instead. No injury was sustained. On 4/16/12	F 323	~~contact, if any, of many of the un-witnessed~~ events. He resides in the SCU but he is allowed to move about the entire facility as his home because he is a wanderer and becomes agitated when staff attempts to keep him in the [redacted] hall. His wife resides at the facility in the [redacted] Hall. The following interventions were added to his care plan: 1. Work station: Please set me up with activities/items of interest at my work station in the Sunrise room prn through-out the day. 2. Visits w/ wife-Please connect me with my wife & set us up w/ some meaningful activity either at my work station or in [redacted]'s room or in the day room prn through-out the day. 3. Offer fluids with hourly checks and toilet every 2 hours to prevent wandering into rooms looking for a bathroom. Plan to ask family if he can move to new West SCU (see below) for increased supervision and meaningful activities. Per information gathered from NAC charting in POC and progress notes of 7/2/12 @ 07:30 & 7/3/12 @ 11:11 Resident #3 is actively engaging with the work station & it has been effective in decreasing his wandering (see attachment #1).	

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F 323	Continued From page 3 Resident #3 was pushing another resident's wheelchair. The other resident was startled and yelled out. As Resident #3 walked past the yelling resident he lightly slapped the right side of her face without causing an injury. The 5/31/12 nursing entry documented another resident to resident altercation involving another male resident. Resident #3 was banging a (doll) buggy into the back of a female resident's wheelchair. The other male resident stood from his wheelchair and stuck Resident #3 in the mouth causing a small laceration to the upper left corner of his mouth. Review of a 6/18/12 nursing entry revealed a report from Resident #4 stating that Resident #3 had grabbed Resident #4 by the head and then by the shoulder from behind. Although there was no bruising or physical injury, Resident #4 reported she was frightened by the occurrence. According to the facility investigation, the incident was reported by Resident #4 on 6/18/12 but the occurrence happened on 6/16/12 in the dining room. Resident #4 had reported to the Social Service Director, "This weekend was a nightmare." Resident #4 stated that Resident #3 waited until he saw her alone in the dining room and grabbled her head and tried to push her out of her wheelchair. She was frightened and yelled out but her voice was weak. When interviewed on 6/20/12 at approximately 2:25 p.m., cognitively alert Resident #4 briefly discussed the 6/16/12 resident to resident incident in the dining room. Resident #3 reportedly grabbed her right arm when they were	F 323	Resident #4 is alert, moves about the entire facility easily in her w/c, and is forgetful and rambling in her speech. She exhibits intermittent [redacted] and anxiety per ARNP nursing home visit note of 6/12/12 (see attachment #2). She resides in the [redacted] Hall. She does not express distress or feel unsafe in the facility per progress note of 6/20/12 @ 11:22 (see attachment #3).No change to her plan of care. Resident #5 is alert, moves about the facility in her w/c with occasional cues for finding her destination. She has not made any formal complaint regarding Resident #3. No change to her plan of care. Resident #7 is alert, moves about the facility easily in her w/c. She currently resides in the [redacted] Hall. She does not express fear or feel unsafe r/t Resident #3. She has cognitive deficits and exhibits very little insight or understanding of the dementia residents and why they may behave the way they do. No change to her plan of care. Plan to ask her to consider moving to North or South hall. Resident #8 is alert, has difficulty moving about the facility and remains mostly in [redacted] Hall where she resides, going to the Pioneer Diner and the MDR for activities with assistance at times and independently much of the time. She self-propels albeit slowly. There is no documentation in the medical record regarding	

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F 323	Continued From page 4 alone in the dining room. The resident then stated, "I don't like to think about it." "They (staff) do what they can when they can." On 6/20/12 at approximately 2:20 p.m., Resident #5 stated that Resident #3 entered her room without permission at times. Observations on 6/20/12 at approximately 2:45 p.m. revealed Resident #8 had a [redacted] across the doorway to her room. Resident #8, identified by staff as interviewable, reported the barrier had been installed to protect her from two men who had wandered into her room without permission (including Resident #3). She had to yell for staff to come to assist her remove the resident (each time). Multiple observations of Resident #3 were conducted on 6/20/12 and 6/29/12 during the on-site investigation. During observations, Resident #3 was frequently observed wandering in the hallways unattended. At another time he was pushing a doll stroller in the hallway bumping into the door jamb and the medication cart. During one observation on 6/29/12 at approximately 11:55 a.m., without staff observation, Resident #3 walked up to the nourishment cart on the east wing, drank from a partially filled cup and then returned it to the cart. When Staff Member A, a licensed nurse (LN), was notified she stated, "It looks like cold cocoa." She stated she wondered "whose it was?" Further review of Resident #3's medical record revealed a 6/28/12 nursing entry reporting that Resident #9 stated Resident #3 had entered his bathroom 2-3 days earlier and struck him in the	F 323	the gate on her door and interview with M-F evening shift RN revealed a story re: a male resident from [redacted] hall who had entered her room prior to the gate being placed. This RN has no recollection of Resident #3 being in that room and states he rarely comes down the [redacted] hall, but stops at the counter of the Nurses' Station and then turns to go back to [redacted] Hall. Resident #8 has not made any formal complaint regarding Resident #3. Plan to offer her a private room on [redacted] hall. Resident #9 is alert with medical dx that include [redacted] weakness, [redacted] and major [redacted] He continues to express dislike of Resident #3 and to threaten harm if he should enter his room. He was offered a room on [redacted] Hall and has moved to room [redacted] MEASURES THE NURSING HOME WILL TAKE OR THE SYSTEMS IT WILL ALTER TO ENSURE THE PROBLEM DOES NOT RECUR: A cart cover is being purchased for the current snack cart for East hall to prevent any unwanted access. A second cart will be provided for dirty items and this cart will also be kept covered and supervised. The facility is moving ahead with a plan to move the SCU to the West hall. West hall can accommodate 30 residents. It is a long hallway and has a wonderful day room/dining room at the far end. There is another available room	

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F 323	Continued From page 5 face. No injuries were identified at that time for Resident #9. The facility investigation documented that on 6/26/12 staff had witnessed Resident #9 chasing Resident #3 out and away from his room. Review of Resident #9's medical record revealed the resident had dementia with [redacted] and an [redacted] disorder. When interviewed on 6/29/12 at approximately 3:50 p.m., Resident #9 reported about the entry of Resident #3 into his bathroom. He was reportedly uninjured but stated he planned to "kick" Resident #3 if he re-entered his room in the future. Despite the repeated resident to resident incidents, the facility failed to revise Resident #3's plan of care to enhance the supervision plan to prevent unwanted entry and contact with residents and their equipment.. Although Resident #3's room was on the dementia wing, he wandered throughout the facility as he wished. Resident #3 placed others at risk for injury and fear. Additionally, he was at risk of injury from others who were intolerant of his intrusive behaviors. Resident #2: Review of the medical record revealed the resident had multiple diagnoses including dementia with [redacted] and dysphagia (difficulty swallowing). The resident received speech therapy to identify the appropriate diet and eating strategies. The resident required a dysphagia mechanically altered diet with size of	F 323	that can be used for activities next to the nurses' station. All of the alert residents currently residing on West hall will be ask to consider moving to available rooms on North and South. This will consolidate residents to a smaller portion of the building and will provide enough space for residents with psycho-motor agitation to move about while making staff more efficiently placed to provide better supervision. We will be able to have more staff available for the dementia residents and enhance their activity programs to provide more meaningful activities to their day which should cut down on all accidents and promote safety and wellness. The MDR will still be accessible to all residents and be used for meals and supervised activities. The door through the Annex which leads into the MDR, the door into the Pioneer Diner and the new Activity room door will all be closed after dinner to assist with monitoring SCU residents in the evening. The plan further involves placing a wander-guard alarm in the hallway that leads to the North, South and East halls just west of the MDR entrance to alert staff of wandering dementia residents who have left the SCU. A new protocol will be added to the Routine Resident Care Protocol stating that when residents cross the wander-guard they are to be stayed with as a 1:1 by the staff member who responds to the alarm until they are ready	

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F 323	Continued From page 6 bite modification and throat clearing techniques to enhance eating safety. The resident's plan of care noted he typically used a wheelchair for mobility within the facility and had a tendency to wander within the facility and exit seek. Staff were to monitor the resident's whereabouts frequently and gently intervene for his safety. A 6/20/12 nursing entry documented the resident was at risk for aspiration (food/fluids entering the respiratory tract versus the stomach). The resident had been taking food off other residents' trays and food off the snack cart on the east wing. The cognitively impaired resident was counseled about the risk associated with eating foods not approved and he stated he understood. The plan was to continue to educate the resident. Another nursing entry later that morning documented a contact with the resident's power of attorney (POA) and a discussion about the risk associated with the resident taking foods from others and off the east wing food cart that were not approved related to his dysphagia. The POA also reported the resident entered another named resident's room looking for food. "(POA) understood that it is hard to consistently monitor (the resident) and also understands the risk if (the resident) eats something other than his current approved diet". When interviewed on 6/29/12 at approximately 1:10 p.m., Staff Member B, a LN, stated she was aware the resident went down to the east hall to the nourishment cart. There was a special tray on the cart with items such as chocolate pudding. "Have to watch him." Staff Member C, a LN, was interviewed on 6/29/12 at approximately 3:40 p.m. and stated	F 323	~~to come back to the unit and be engaged in~~ some meaningful activity. Having the remainder of the residents residing in North and South halls will also increase our ability to supervise in these areas as well as we will be able to have more staff in smaller area with a better line of sight. When the moves are complete the snacks for the new West SCU will be kept in the Utility room refrigerator. HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED: DNS or designee will monitor resident to resident altercation incidents quarterly for all residents. Benchmark for percentage of resident to resident altercations will be set at below 5% per month. DNS or designee will monitor for effectiveness of recent care plan interventions for residents #2 and #3 and f/u as needed. DNS and SS will monitor incoming residents for dementia with behaviors and assist with proper room assignments to maintain the integrity of the SCU plan. If current residents develop potentially unsafe behaviors they will be assessed for the need to reside in the SCU.	

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F 323	Continued From page 7 that staff were to supervise the nourishment cart at all times. Per 6/29/12 interviews with Staff Members A, C, and D the nourishment carts arrived at 10:00 a.m. and 3:00 p.m. and contained various items such as sandwiches, fruit, cookies, ice cream, health shakes, and beverages. Some items were permissible for Resident #2 and others were not. Although Resident #2 was not observed accessing the nourishment cart during 6/29/12 observations, Resident #3 was observed accessing the cart without staff knowledge. See above. Enhanced staff supervision was required to protect cognitively impaired Resident #2 from accessing unsafe foods. His patterns and preferences were known to staff. Counseling the resident and random observations of the resident had proved insufficient in protecting the resident. Strategic supervision was required.	F 323	COMPLETED: Care plan changes for Resident's #2 and #3 already completed. New cart covers-July 20, 2012 Resident room changes with new West SCU with wander-guard system in place-August ~~30~~ 24, 2012	PB