

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

PRINTED: 03/25/2013  
FORM APPROVED  
OMB NO. 0938-0391

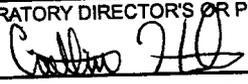
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505459	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/19/2013
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NAME OF PROVIDER OR SUPPLIER  NISQUALLY VALLEY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE P O BOX 370 MCKENNA, WA 98558
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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 Nisqually Valley Care Center on 3/15/13; 3/16/13; 3/17/13; 3/18/13 and 3/19/13. Off hours data collection started on Friday 3/15/13 at 4:30 a.m. and continued daily until completion of the survey on 3/19/13. A sample of 31 residents was selected from a census of 42. The sample included 25 current residents and the records of 6 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████ RN, BSN, MSN          ██████████ RN, BSN, MBA          ██████████ RN, BSN          ██████████ RN, BSN, MSN</p> <p>The survey team is from:</p> <p>Department of Social and Health Services          Aging and Long Term Support Administration          Residential Care Services, District 3, Unit A          1949 South State Street, MS: N27-24          Tacoma, Washington, 98405-2850</p> <p>Telephone: (253) 983-3800          Fax: (253) 589-7240</p> <p> 3/25/13          Signature Date</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  	TITLE Administrator	(X6) DATE April 5, 2013
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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 164 SS=D	<p><b>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</b></p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of the survey book it was determined the facility failed to maintain confidentiality of 4 Sampled Residents (#s 1, 18, 28 &amp; 41) reviewed during a previous complaint investigation of the 31 sampled</p>	F 164	<p>This plan of correction is being submitted in accordance with specific regulatory requirements. It shall not be construed as an admission of any deficiency cited.</p> <p>F164 Personal Privacy/Confidentiality of Records</p> <p>List of residents names were immediately removed from state survey book.</p> <p>Quarterly Audit will be completed to verify accuracy and results will be forwarded to QA.</p> <p>Administrator or designee will be responsible for completion</p> <p>Date of Completion: April 26, 2013</p>	
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**F 164** Continued From page 2  
residents who were included in the Stage 2 survey. This had the potential to result in emotional discomfort for these residents and/or their families.

Findings include:

On 3/18/13 at 10:15 a.m. a three ring binder located on a table across the corridor from the main entrance contained copies of recent facility survey results. Included in the binder were results from a complaint investigation survey dated 8/2/12.

A resident list attached with the report included the names of current residents, Resident #1, Resident #18, Resident #28 and Resident #41, and their corresponding identification numbers to identify they were reviewed during the investigation. The report included specific information related to an incident that involved Resident #1 and Resident #2.

On 3/18/13 at 10:45 a.m. Staff A and the surveyor both reviewed information contained in the survey book. Staff A observed the posted Resident Identification List attached with the survey and reported it should not be there and would immediately remove it. Staff A was aware the list should not be posted and did not know how it got there.

**F 164**

**F 272 Comprehensive Assessments**

Oral Assessment has been completed on Resident #34.

MDS Nurse will complete quarterly assessments of the oral cavity.

Has been offered further dental services.

Care plans and care directives will be updated to reflect residents preference on oral hygiene.

Audit will be completed to verify documentation of oral cavity assessment and results will be forwarded to QA.

DNS or designee will be responsible for completion.

Date of Completion: April 26, 2012

**F 272** 483.20(b)(1) COMPREHENSIVE ASSESSMENTS  
SS=D

The facility must conduct initially and periodically a comprehensive, accurate, standardized

**F 272**

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F 272	<p>Continued From page 3 reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:            Identification and demographic information;            Customary routine;            Cognitive patterns;            Communication;            Vision;            Mood and behavior patterns;            Psychosocial well-being;            Physical functioning and structural problems;            Continence;            Disease diagnosis and health conditions;            Dental and nutritional status;            Skin conditions;            Activity pursuit;            Medications;            Special treatments and procedures;            Discharge potential;            Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and            Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 272			

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F 272	<p>Continued From page 4</p> <p>Based on observation, interview and record review it was determined the facility failed to conduct a comprehensive dental assessment for 1 of 3 Sampled Resident (#34) reviewed for dental concerns. This placed the resident at risk for undetected possible cavities and associated difficulty with eating, pain and/or development of an infection.</p> <p>Findings include:</p> <p>On 3/15/2013 at 9:40 a.m. Resident #34 reported some of her/his bottom teeth and molars were missing.</p> <p>An admission re-assessment form dated 6/8/12 identified the resident had his/her own teeth. Condition of teeth were noted as "good, missing front 3 on bottom".</p> <p>A nutritional care area assessment dated 6/20/12 identified Resident #34 had partial dentures and someone needed to bring them from home. The statement included a note to "encourage family to bring in dentures."</p> <p>Dental Minimum Data Set assessments (MDS, a required assessment tool) dated 9/15/12, 11/18/12, and 2/4/13 included a place to code different types of dental concerns. The MDS did not identify the resident had any dental concerns such as ill fitting dentures or obvious or likely cavities.</p> <p>On 3/18/13 at 11:30 a.m. Staff C reported when conducting dental assessments he/she asked if residents had dentures, teeth or partial dentures. When residents did not report any dental</p>	F 272		
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F 272	<p>Continued From page 5</p> <p>concerns he/she did not always look in their mouths. Staff C reported he/she looked in mouths when residents could not answer questions regarding their teeth.</p> <p>On 3/18/13 at 11:45 a.m. Staff D talked to Resident #34 about dental concerns. The resident reported his/her dentures had not fit for more than a couple of years. Staff D and the surveyor looked inside the resident's mouth with a flashlight. The resident had three lower teeth that were blackened around the base along the gum line. At this time, the resident reported a desire to see a dentist regarding current problems "like cavities" and denied any pain or chewing problems.</p> <p>Following the observation, Staff C confirmed he/she had not looked in Resident #34's mouth and relied on verbal statements the resident made when conducting previous dental assessments. Both Staff C and Staff D did not know the resident had blackened areas surrounding the base of three lower teeth (possible cavities).</p> <p>On 3/18/13 at 12:40 p.m. Staff B reported the dietician saw Resident #34 on 1/15/13 and the resident reported dental problems at that time. Staff B also reported they notified the physician and the family and obtained a dental consult on 1/16/13.</p> <p>On 6/20/12 staff identified Resident #34 had dentures at home. The resident's record did not identify what interventions were in place to ensure dentures fit comfortably after they were brought to the facility. Staff did not look inside the resident's</p>	F 272		
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F 272 Continued From page 6  
mouth during assessments to ensure they timely identified dental concerns, timely referred and conducted ongoing monitoring.

F 272

F 309 SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  
  
Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

F 309

F309 Provide Care/Services for Highest Well Being  
Resident #56 has been discharged from the facility.

Admission procedure has been revised for DME equipment prior admission.

In-service will be completed on equipment that should be present prior to admission.

Audits will be completed of Admission procedures to maintain accuracy. Results will be forwarded to QA.

Administrator or designee will be responsible for completion.

Date of Completion: April 26, 2013

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review it was determined that the facility failed to ensure 1 of 1 Sampled Residents (#56) was admitted with the prescribed medical equipment to provide continuous passive motion out of the 31 sampled residents included in the Stage 2 review. This failure placed Resident #56 at potential risk for decline in \_\_\_\_\_

Findings include:

Record review noted Resident #56 was admitted to the facility for rehabilitation services following a surgical procedure on Thursday \_\_\_\_\_ 13 with physician orders directing staff to have the resident use a \_\_\_\_\_ machine to provide \_\_\_\_\_ to the resident's \_\_\_\_\_

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F 309	<p>Continued From page 7</p> <p>On Saturday 3/17/13 at 8:30 a.m. during an interview Resident #56 reported to the surveyor that on Friday 3/15/13 he/she received physical therapy consisting of a shower and walking with assistance. During the interview, Resident #56 demonstrated he/she could perform gentle flexing exercise to the [redacted] knee using a sling. A [redacted] was in the resident's room. The resident reported he/she was supposed to be using the machine but had not used the [redacted] since being admitted to the facility on Thursday [redacted] 13.</p> <p>Review of Resident #56's physician orders noted the facility obtained clarification telephone orders on 3/15/13 at 7:00 p.m. for the specific settings for using the [redacted].</p> <p>On 3/19/13 at 9:04 a.m. Staff J, who participated in the admission process for Resident #56, confirmed the resident was not admitted with a [redacted].</p> <p>On 3/19/13 at 10:20 a.m. Staff A confirmed Resident #56's was not admitted to the facility on Thursday [redacted] 13 with a [redacted] and a family member brought the [redacted] to the facility late on Saturday 3/16/13.</p> <p>Review of physical therapy notes noted the CPM machine was not implemented until Sunday 3/17/13.</p> <p>By failing to ensure Resident #56 was admitted on Thursday [redacted] 13 with a [redacted] as ordered by the physician and by failing to implement the [redacted] into the resident's plan of care until Sunday 3/17/13 when a physical therapist was called to the facility to set up the</p>	F 309		
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F 309	Continued From page 8 CPM machine to provide continuous passive motion to the resident's ██████████ placed the resident at potential risk for a decline in range of motion of his █████ knee.	F 309		
F 441 SS=F	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 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.  (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.	F 441	F 441 Infection Control, Prevent Spread, Linens  Test Strips have been ordered to verify accuracy of solution.  In-service will be completed on what is a pre-mixed solution, when to test and how to test concentration with use of testing strips.  Solution will be tested daily and recorded. Results will be forwarded to QA.  Housekeeping Manager or designee will be responsible for completion.  Date of Completion: April 26, 2013	

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F 441	<p>Continued From page 9</p> <p>(c) Linens 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 it was determined that the facility failed to have a system in place to ensure consistent, adequate levels of sanitizer dispensed when mixed with water to ensure concentration levels of disinfectant were used during cleaning . This had the potential to prevent adequate sanitization of infectious agents on surfaces cleaned with the solution.</p> <p>Findings include:</p> <p>During review of laundry procedures on 3/18/13 beginning at approximately 10:00 a.m. Staff E reported washing machine rims and laundry barrels in the laundry were wiped with a disinfectant solution. Staff F reported the tops of tables used to fold clean clothes were also cleaned with the same disinfectant.</p> <p>Staff E explained staff filled buckets with a disinfectant solution at the sink in the laundry sorting room. Staff E showed the surveyor a gallon of NI-712 Disinfecting Cleaning Concentrate stored next to the sink that had an amber colored hose placed inside the container. Staff E also reported the solution automatically mixed with water from the water supply at the</p>	F 441		
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F 441	<p>Continued From page 10</p> <p>sink to fill cleaning buckets. Staff E did not have or use test strips to use to check the level of concentration of disinfectant dispensed into the bucket.</p> <p>When asked how staff knew if the concentration dispensed was adequate to ensure sanitization, Staff E reported a manufacturer representative came to the facility twice a month to check it.</p> <p>Later on 3/18/13 at approximately 1:45 p.m. Staff F provided a copy of the Material Safety Data Sheet (MSDS) for the cleaning concentrate. Staff F made a note on the MSDS the concentration of cleaning solution should be two ounces mixed in one gallon of water.</p> <p>On 3/19/13 at 12:20 p.m. Staff G reported some housekeeping staff used the same premixed cleaning chemical in the laundry room for housekeeping duties that included cleaning floors and resident rooms.</p> <p>Staff G also reported some housekeeping staff used a different sink in another hall to fill cleaning buckets. The utility room Staff G showed surveyors had a pump in the same type of disinfectant concentrate. Staff G demonstrated filling a bucket of water halfway with water and adding one pump of the disinfectant solution to the water and also reported staff did not have method to test the concentration of the solution after it mixed with water.</p> <p>On 3/19/13 at 1:55 p.m. Staff F reported he/she contacted the manufacturer representative to inquire about testing solution concentration. Staff F reported the representative never provided test</p>	F 441		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505459</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/19/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>NISQUALLY VALLEY CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>P O BOX 370 MCKENNA, WA 98558</b>
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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 441** Continued From page 11 strips to check solution concentration and would send some to the facility.

Failure to have a system in place to routinely check concentration of disinfectant mixed in water had the potential for staff to clean with inadequate concentration and not adequately sanitize all surfaces cleaned with the solution.

**F 441**

**F 468**  
**SS=B** 483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS

The facility must equip corridors with firmly secured handrails on each side.

This REQUIREMENT is not met as evidenced by:  
Based on observation and interview it was determined that the facility failed to ensure all handrails were firmly affixed to corridor walls on 2 of 4 Halls (100 Hall & 200 Hall) and in the entry foyer. This had the potential to place residents at risk for injury if rails did not remain secure when used.

Findings include:

During observations throughout the survey between 3/15/13 through 3/19/13 residents held on to handrails in corridors when self-propelling in their wheelchairs.

On 3/19/13 beginning at 7:56 a.m. wooden handrails attached to both sides of corridors on the 100 Hall and 200 Hall were inspected by holding them with one hand and applying slight

**F 468**

**F 468** Corridors Have Firmly Secured Handrails

Mentioned handrails have been tightened and fixed for safety.

In-service will be provided to staff of maintenance log and appropriate handrail strength.

Weekly checks will be completed of handrails and results will be forwarded to QA.

Maintenance Director will be responsible for completion.

Completion Date: April 26, 2013

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

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F 468	<p>Continued From page 12</p> <p>downward pressure. Handrails measured approximately between two and six feet in length. When checked, the following sections of rails moved downward away from the wall approximately 1/4 of an inch and did not remain securely attached:</p> <ul style="list-style-type: none"> <li>- A handrail located on the right side of the door to room 112.</li> <li>- Handrails on the left and right side of the laundry entrance door on the 100 hall.</li> <li>- Handrails between room 202 and room 204.</li> <li>- The rail to the left side of the door to room 215.</li> <li>- The rail located on the right side of the door to room 221</li> <li>- Handrails located between room 220 and rooms 222.</li> </ul> <p>A gray resin handrail located in the main foyer entrance on the left side of the door exposed a part of a screw that held it in place. The rail moved away from the wall with slight downward pressure was applied with one hand.</p> <p>On 3/19/13 at 8:38 a.m. Staff H reported rails were routinely checked weekly and when staff reported problems with them. Staff H also reported wooden handrails were recently refinished.</p> <p>On 3/19/13 at 11:06 a.m. Staff B reported there were no reported resident injuries related to facility handrails.</p> <p>On 3/19/13 at 11:30 a.m. Staff A and the surveyor observed some of the handrails on the 200 Hall together and reported staff had not communicated any problems with them and</p>	F 468		

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F 468	Continued From page 13 would have them fixed right away.	F 468		
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