

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

PRINTED: 03/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/11/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  WASHINGTON VETERAN HOME-RETSIL	STREET ADDRESS, CITY, STATE, ZIP CODE 1141 BEACH DRIVE RETSIL, WA 98378
--	---

(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)	(X6) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000

INITIAL COMMENTS

This report is the result of an unannounced Quality Indicator Survey conducted at ~~REDACTED~~ *WASHINGTON VETERANS HOME* on 3/4/14, 3/5/14, 3/6/14, 3/7/14, 3/10/14 & 3/11/14. A sample of 42 residents was selected from census of 238. The sample included 40 current residents and 2 former and/or discharged residents.

The survey was conducted by:

Karyn Rich RN, BSN, MSN  
Gilda Warden EdD, RN-BC  
Marilyn Edwards RN, MN  
Ruth Futch RN, BSN, MBA

The survey team is from:

Department of Social and Health Services  
Aging and Long-Term Support Administration  
Residential Care Services, District 3, Unit A  
P.O. Box 45819, MS: N27-24  
Olympia, WA 98504-5819

Telephone: (253) 983-3800  
Fax: (253) 589-7240

*Drongen Shinn* 3/24/14  
Signature Date

F 000

Preparation and/or execution of this plan of correction does not constitute the provider's admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

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

*[Signature]* Associate Superintendent / Administrator 3-31-14

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.

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

PRINTED: 03/25/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/11/2014
NAME OF PROVIDER OR SUPPLIER  WASHINGTON VETERAN HOME-RETSIL			STREET ADDRESS, CITY, STATE, ZIP CODE 1141 BEACH DRIVE RETSIL, WA 98378	
(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 309 SS=D	<p><b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b></p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure a resident with diabetes received consistent monitoring of a skin condition for 1 of 1 sampled residents (#132) reviewed for skin conditions in Stage 2. This failure potentially contributed to the resident having a non-pressure-related skin ulcer. Findings include: Resident #132 was admitted on [REDACTED] 13 with multiple medical diagnoses including diabetes, diabetic neuropathy, [REDACTED]. The Minimum Data Set (MDS, an assessment tool) did not indicate alteration in skin integrity on admission. According to the Washington State Department of Veterans Affairs Nursing Department Operating Procedure Skin Integrity Management Policy effective 3/30/2011, "the skin condition of all residents is observed and monitored to ensure optimal skin integrity." Record review on 3/10/14 at 9:11 a.m. revealed Resident #132 had a right big toe blister found by staff on 2/14/14 that measured 1 x 1.2 cm. Staff R ordered Skin Prep (2/14/14) to right tip of great toe blister every day until resolved.</p>	F 309	<p>F-309</p> <p>The facility does and will continue to provide the necessary care and services for each resident to attain or maintain the highest practicable physical, mental and psychosocial well-being.</p> <ol style="list-style-type: none"> <li>1) Resident #132 had his open area debrided at Puget Sound VA Hospital Wound Clinic on 3/17/14. The open area continues to be treated and monitored.</li> <li>2) Residents of WVH are assessed weekly by a licensed nurse for skin alterations. Residents with identified skin alterations have treatment plans initiated and tracking sheets implemented to document ongoing monitoring.</li> <li>3) Licensed nurses will receive education related to the procedure for conducting and documenting weekly skin assessments.</li> <li>4) Treatment sheets will be randomly audited for documentation of weekly skin checks, and skin alteration sheets will be randomly audited for documentation of ongoing monitoring. Results will be reported to nursing management team and deficiencies will be</li> </ol>	

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

PRINTED: 03/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  03/11/2014
NAME OF PROVIDER OR SUPPLIER  WASHINGTON VETERAN HOME-RETSIL		STREET ADDRESS, CITY, STATE, ZIP CODE 1141 BEACH DRIVE RETSIL, WA 98378		
(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 309	<p>Continued From page 2</p> <p>Review of multi-disciplinary progress notes indicated staff did not document assessments (blister size, color, and appearance) of right great toe: On 2/15/14, Resident #132 refused assessment; 2/16/14, Resident #132 refused Skin Prep to R great toe; 2/17/14, the resident had shower and allowed skin check yet no documentation regarding right great toe condition; 2/18/14, skin prep to right great toe applied, no condition of blister documented; no documentation from 2/19/14 through 2/28/14. Further review of records did not reveal any documentation or progress notes for 3/1/14 to 3/6/14.</p> <p>On 3/10/14 at 9:40 a.m. the Physician Progress Note dated 3/7/14 revealed that Staff R was approached by Resident #132 with concern about right great toe infection. The Clinician Progress Notes indicated Staff R found the resident's right great toe had an ulcer with dead skin and slight redness. Staff R stated it was cellulitis and started treatment with Doxycycline for 10 days.</p> <p>At 9:46 a.m. Resident #132 was sitting in wheelchair stated the ulcer to right toe had started 3 days ago. Resident #132 had a shoe to left foot and loose dressing to right foot in an open toe boot.</p> <p>At 10:33 a.m. Staff S began dressing change to Resident #132's right great toe. Staff Z was asked to assess toe. Staff Z stated the physician did not consider it an ulcer so it was unstageable. The "Ulcer Evaluation" sheet for Resident #132 dated 3/10/14 and completed by Staff V revealed a Stage II ulcer to right great toe which measured 0.8 x 0.9 cm.</p> <p>Resident #132's Nursing Care Directive reviewed on 3/10/14 at 10:42 a.m. did not include documentation of blister to right big toe.</p> <p>On 3/10/14 at 12:12 p.m. interview with Staff C</p>	F 309	<p>reported to Quality Assurance Committee for tracking.</p> <p>5) April 2, 2014</p> <p>6) Director of Nursing</p>	

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

PRINTED: 03/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  03/11/2014
NAME OF PROVIDER OR SUPPLIER  WASHINGTON VETERAN HOME-RETSIL			STREET ADDRESS, CITY, STATE, ZIP CODE 1141 BEACH DRIVE RETSIL, WA 98378		
(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 309	<p>Continued From page 3</p> <p>revealed that "with limited resources and a resident who refuses care, the question is whether nursing has done all they can. Social Work has to be creative. Staff have to go back to interdisciplinary team and find out what else to do. Are we doing full justice for residents?"</p> <p>During record review at 1:22 p.m. care plan dated 10/14/13 revealed problem of alteration in skin integrity, but there was no documented right great toe blister on the care plan.</p> <p>Care plan dated 10/14/13 under problem of diabetes included intervention of use of healing shoes and to assess feet and nails weekly.</p> <p>On 3/11/14 at 11:40 a.m. during right big toe dressing change, Staff V reported that right toe ulcer was dry and red, and right foot had 3+ pitting edema. Upon the request of the surveyor, Staff V removed the compression stocking that revealed swelling and redness to mid leg. Staff R was notified and at 11:55 a.m. determined that Resident #132's right great toe was red and warm, that the "cellulitis to right toe was worse on antibiotic Doxycycline (not effective)." Resident #132 reported his shoes had been used for 3 years (currently using left shoe).</p> <p>On 3/11/14 at 12 noon Resident #132 was interviewed. The resident stated s/he was not aware of when the right toe blister started.</p> <p>At 12:20 p.m. observation of Staff V dressing change to right toe. Staff V reported the ulcer was unstageable and that the physician stated it was a venous ulcer.</p> <p>The facility failed to consistently assess the right great toe blister from 2/14/14 until 3/7/14 which became an infected non-pressure related ulcer. This failure placed Resident #132 at risk of receiving intravenous antibiotics to treat an infection.</p>	F 309			

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

PRINTED: 03/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  03/11/2014
NAME OF PROVIDER OR SUPPLIER  WASHINGTON VETERAN HOME-RETSIL			STREET ADDRESS, CITY, STATE, ZIP CODE 1141 BEACH DRIVE RETSIL, WA 98378		
(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 322 F 322 SS=E	Continued From page 4 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS  Based on the comprehensive assessment of a resident, the facility must ensure that --  (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and  (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to provide the appropriate services and monitoring of tube feedings for 4 of 4 Sampled Residents (#s 95, 104, 166 & 213) reviewed for tube feeding of the 42 Residents who were included in the Stage 2 review. This failure had the potential to place residents at risk for malnutrition, dehydration and potential complications.  Findings Include:	F 322 F 322	F-322 The facility does and will continue to ensure residents with tube feedings receive the appropriate treatments and services.  1) Residents receiving tube feedings (#s 95, 104, 166, & 213) have been reviewed for accuracy of documentation of the amount of formula delivered. The actual amount of tube feeding administered will be recorded each shift, and the pumps will be cleared each shift.  2) Any residents who have tube feeding initiated will be included in the new procedure for documentation of amounts received.  3) a. Licensed staff will be educated to insure they are knowledgeable about how to manage the pumps b. New worksheets will be implemented to make documentation of the actual amount of formula, water, etc. administered every shift easier and more accessible. c. Signs were made and laminated explaining the expectations for documentation.		

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

PRINTED: 03/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  03/11/2014
NAME OF PROVIDER OR SUPPLIER  WASHINGTON VETERAN HOME-RETSIL		STREET ADDRESS, CITY, STATE, ZIP CODE 1141 BEACH DRIVE RETSIL, WA 98378		
(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)	(X6) COMPLETION DATE
F 322	<p>Continued From page 5</p> <p><b>RESIDENT #166</b> Resident #166 was admitted to the facility on [REDACTED] 14 with the diagnoses of [REDACTED] wound infection, and malnutrition.</p> <p>The Minimum Data Set (MDS, an assessment tool) dated 1/21/14 identified Resident #166 was admitted to the facility with a feeding tube. Resident #166 was not able to take food or liquid by mouth and was dependent on the tube feeding for all nutritional intake.</p> <p>"Tube Feeding Order" dated 1/10/14 revealed IsoSource 1.5 kilocalories (kcal)/ millimeter (ml) at 55ml per hour for 18 hours. The order read in bold all capital letters "Do not turn off pump until 1000 cubic centimeters (cc) is complete". "Start feedings at 4:00 p.m. and run through 10:00 a.m. for a total of 18 hours. Continue tube feeding until 1000cc is reached". A total of 1000ml in 24 hours, a total of 1500 kcal in 24 hours and a total of 778ml of water from the tube feeding formula in 24 hours. The amount of free water flush to be given was 150ml every eight hours. The tube was to be flushed with 60ml of water before and after medication pass (3 medication passes) for a total of 810ml of free water flush.</p> <p>On 3/7/14 at 10:15 a.m. during medication pass Resident #166 appeared pale in color while sitting in recliner receiving tube feeding. Tube feeding pump read 996ml of tube feeding administered and 200ml of free water administered when turned off.</p> <p>On 3/7/14 at 10:31 a.m. Staff U reported that staff documented the rate of tube feeding times the hours it was infused. Staff U confirmed that there would be variations in amounts administered</p>	F 322	<p>d. An interdisciplinary team revised the enteral feeding order form.</p> <p>e. Dietary and nursing will collaborate on an enteral feeding audit tool</p> <p>4) Nursing and Dietary staff will review the documentation monthly for three months and conduct a formal audit quarterly; any deficiencies will be reported to Quality Assurance for tracking.</p> <p>5) April 2, 2014</p> <p>6) Director of Nursing</p>	

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

PRINTED: 03/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  03/11/2014
NAME OF PROVIDER OR SUPPLIER  WASHINGTON VETERAN HOME-RETSIL		STREET ADDRESS, CITY, STATE, ZIP CODE 1141 BEACH DRIVE RETSIL, WA 98378		
(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 322	<p>Continued From page 6</p> <p>depending on the exact start and stop times of feedings and when the feedings placed on hold or if the resident received a shower or medications. Staff U confirmed that the amounts documented was not accurate to what the resident received.</p> <p>On 3/7/14 at 11:30 a.m. Staff R reported that Resident #166 looked malnourished and pale. Staff R reported that Resident #166 was admitted malnourished and that lab results confirmed that diagnosis upon admission. At 11:36 a.m. Staff R reported that the tube feeding order was written by the dietician on 1/10/14 with a 1500 kcal diet for Resident #166. Staff R reported that the resident needed to get at least 1000ml to meet his caloric needs due to malnutrition.</p> <p>During interview on 3/7/14 at 11:37 a.m. Staff U confirmed that Resident #166's feeding pump read 996ml of tube feeding administered.</p> <p>On 3/7/14 at 11:38 a.m. an order was written by Staff R for labs to be drawn for Resident #166 to compare to the previous labs upon admission to check for malnutrition.</p> <p>An observation of Resident #166's feeding pump on 3/10/14 at 9:16 a.m. read 2651ml of tube feeding administered and 601ml of free water infused.</p> <p>During interview on 3/10/14 at 9:18 a.m. Staff W reported the amount of tube feeding administered was documented based on the rate times the hours infused. Staff W reported that the pump reading 2651ml "was probably from all weekend and was not cleared".</p> <p>On 3/10/14 at 9:20 a.m. Staff H reported that if</p>	F 322		

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

PRINTED: 03/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/11/2014
NAME OF PROVIDER OR SUPPLIER  WASHINGTON VETERAN HOME-RETSIL			STREET ADDRESS, CITY, STATE, ZIP CODE 1141 BEACH DRIVE RETSIL, WA 98378	
(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 322	<p>Continued From page 7</p> <p>there is a fluctuation in weight then the amount of tube feeding administered would be reviewed and intake adjustments would be made. Staff H reported "relying on nursing staff to be accurately documenting what the resident is getting" in order to make changes as needed to the resident's intake for tube feeding.</p> <p><b>RESIDENT #95</b> Resident #95 was initially admitted to the facility on [REDACTED] 07 with the diagnosis of [REDACTED] cancer.</p> <p>During record review on 3/10/14 at 12:00 p.m. revealed that Resident #95 had a gastrostomy tube placed on 2/28/14 for supplemental feeding during the night due to diagnosis.</p> <p>"Tube Feeding Order" dated 3/4/14 revealed Osmolite 1.5 to start at 50 milliliters (ml) per hour and to be increased by 5ml every hour until goal of 62ml per hour. The feeding was to start at 9:00 p.m. and to end at 6:00 a.m. a total of nine hours. With a total of 558ml in 24 hours, a total of 837 kilocalories (kcal) in 24 hours and a total of 425ml of water from the tube feeding formula in 24 hours. The amount of free water flush to be given was 100ml every shift and at 11:00 a.m. The tube was to be flushed with 50ml of water before and after medication pass (4 medication passes) for a total of 800ml of free water flush in 24 hours.</p> <p>Review of Resident #95's record revealed that there was no documented evidence of the actual amount of ml's of tube feeding and free water every shift the resident received from 3/4/14-3/10/14.</p>	F 322		

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

PRINTED: 03/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/11/2014	
NAME OF PROVIDER OR SUPPLIER  WASHINGTON VETERAN HOME-RETSIL		STREET ADDRESS, CITY, STATE, ZIP CODE 1141 BEACH DRIVE RETSIL, WA 98378		
(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 322	<p>Continued From page 8</p> <p>On 3/10/14 at 11:48 a.m. Staff G confirmed that the amount administered of tube feeding and water was not documented for 3/4/14- 3/10/14. Staff G reported that normally there would be a sheet to document the actual amount of tube feeding administered as well as free water.</p> <p>On 3/10/14 at 11:56 a.m. Staff G verified Resident #95's tube feeding pump that had not been cleared from night shift with 509ml of tube feeding administered and 225ml of free water flush administered.</p> <p>On 3/11/14 at 11:27 a.m. Staff T reported that tube feeding was the one source of intake that should be easily and accurately documented in relation to the other intake sources.</p> <p><b>RESIDENT #104</b> Resident #104 admitted to the facility on [REDACTED] 13 with the diagnoses of [REDACTED] difficulty swallowing, and malnutrition.</p> <p>Annual MDS dated 12/18/13 for Resident #104 was identified having a feeding tube that provides 25-50% of caloric intake with a total of less than 600ml per day.</p> <p>On 3/10/14 at 10:43 a.m. Staff CC reported that Resident #104 did not eat enough to keep up the caloric intake was the reason for the tube feeding at night. Staff CC reported that Resident #104's intake was to be monitored for oral and tube feeding. Staff CC confirmed that staff documented tube feeding intake based on the rate times hours instead of actual amount of feeding the resident received.</p>	F 322		

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

PRINTED: 03/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  03/11/2014
NAME OF PROVIDER OR SUPPLIER  WASHINGTON VETERAN HOME-RETSIL		STREET ADDRESS, CITY, STATE, ZIP CODE 1141 BEACH DRIVE RETSIL, WA 98378		
(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 322	<p>Continued From page 9</p> <p>Review of the Medication Administration Record (MAR) dated 7/23/13 revealed that Resident #104's tube feeding order was Osmolite 1.2 kcal/ml at a rate of 40ml per hour for 11 hours to total 440ml and 432 kcal. Tube feeding was started at 6:30 a.m. and end at 5:30 a.m. The amount of free water flush to be given was 100ml every 4 hours during the night.</p> <p>On 3/10/14 at 1:00 p.m. Staff Q reported that staff should be documenting the actual amount that the resident received for accurate documentation.</p> <p>Resident #213 Resident #213 was admitted to the facility on [REDACTED] 13 with the diagnoses of [REDACTED] and difficulty swallowing.</p> <p>Annual MDS dated 1/5/14 identified Resident #213 as having a feeding tube for primary source of nutrition.</p> <p>"Tube Feeding Order" dated 1/8/14 revealed Osmolite 1.5 kilocalories (kcal)/ millimeter (ml) at 50ml per hour for 24 hours. With a total of 1200ml in 24 hours, a total of 1800 kcal in 24 hours and a total of 914ml of water from the tube feeding formula in 24 hours. The amount of free water flush to be given was 150ml every eight hours. The tube was to be flushed with 60ml of water before and after medication pass (4 medication passes) for a total of 930ml of free water flush. The total amount of water received was to be 1844ml in 24 hours.</p> <p>On 3/10/14 at 9:12 a.m. Staff Y confirmed that documenting the rate times the hours of administration did not reflect the accurate amount</p>	F 322		

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

PRINTED: 03/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/11/2014
NAME OF PROVIDER OR SUPPLIER  WASHINGTON VETERAN HOME-RETSIL			STREET ADDRESS, CITY, STATE, ZIP CODE 1141 BEACH DRIVE RETSIL, WA 98378	
(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 322	Continued From page 10 of tube feeding that the resident received.  Review of the facility "Enteral Care Manual" on 3/10/14 revealed that documentation for enteral feeding with a pump included recording the amount of formula administered.  On 3/11/14 at 12:51 p.m. Staff S reported that staff cannot hang the tube feeding or take it down at the exact times ordered. Staff S verified that if a resident has to be repositioned, clothing changed, or take a shower then the amount of intake would vary. Staff S reported that a resident should not have tube feeding turned off for intermittent feedings unless the ordered amount of feeding has been met. Staff S confirmed that the amount of feeding documented should reflect the accurate amount of feeding a resident received.  The facility failed to monitor and document appropriately for residents who received tube feedings. The documentation was not accurate to reflect the intake of tube feeding the resident received, as well as the free water. Inaccurate documentation or no documentation of intake did not provide physicians and dieticians with correct information that would be needed to make changes if needed to prevent dehydration, weight loss or weight gain.	F 322		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371	F 371 The facility does and will continue to store, prepare, distribute and serve food under sanitary conditions.  1) Staff J, L, and M in-serviced immediately on washing of hands and changing of gloves	

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

PRINTED: 03/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  03/11/2014
NAME OF PROVIDER OR SUPPLIER  WASHINGTON VETERAN HOME-RETSIL		STREET ADDRESS, CITY, STATE, ZIP CODE 1141 BEACH DRIVE RETSIL, WA 98378		
(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 371	<p>Continued From page 11 under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to serve food under sanitary conditions in 3 of 4 Serveries (ABCD, EFGH &amp; AC Serveries). This had the potential to spread food borne or other illnesses to residents.</p> <p>Findings include:</p> <p>Refer to F 441 for information related to recent outbreak of viral illness in the facility.</p> <p><b>EFGH FOOD SERVICE</b> On 3/6/14 during observations of food service beginning at 11:46 a.m., Staff K reported staff always washed hands with soap and water and wore gloves when touching or serving food. Staff K also reported staff should re-wash hands and put on a new pair of gloves "as needed."</p> <p>At 12:10 p.m. Staff J wore a pair of gloves and picked up multiple tortillas, separated and placed individual tortillas onto plates to serve to residents. Staff J turned around and used the same gloved hand to open the food warmer and picked up a stack of tortillas and placed them in the steam table.</p> <p>Without washing hands and putting on a new pair of gloves, Staff J continued to wear the same pair of gloves and placed a tortilla onto a plate. After</p>	F 371	<p>when touching foods and equipment in the resident serveries.</p> <p>2) Residents receiving meals in all serveries have the potential to be affected by poor sanitary work practices by staff working in the serveries.</p> <p>3) Dietary and nursing staff working in resident serveries in-serviced on food handling precautions (i.e.) washing of hands and changing of gloves when touching foods and equipment in all resident servery areas. Dietary staff in-serviced on proper techniques of "when and how" hands should be washed and when to re-glove during handling of foods and equipment.</p> <p>4) Random observation of meal services in the various serveries will be conducted by the Dietary Manager/designee. Deficiencies will be corrected at the time of observation. Any ongoing deficiencies will be addressed as a performance issue with the employee's supervisor. Any identified trends will be reported to QA for trending.</p>	

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

PRINTED: 03/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  03/11/2014
NAME OF PROVIDER OR SUPPLIER  WASHINGTON VETERAN HOME-RETSIL		STREET ADDRESS, CITY, STATE, ZIP CODE 1141 BEACH DRIVE RETSIL, WA 98378		
(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 371	<p>Continued From page 12</p> <p>placing a scoop of meat mixture onto the tortilla, Staff J used the gloved hand to spread the meat mixture on the tortilla.</p> <p>While continuing to wear the same pair of gloves, Staff J opened an upper cabinet door and obtained additional dishware and returned to the steam table. Staff J continued serving food and handling tortillas without washing hands and putting on a clean pair of gloves.</p> <p>On 3/11/14 at 12:56 p.m. Staff N reported staff should know to re-wash their hands and re-glove after touching items in the serveries.</p> <p><b>ABCD FOOD SERVICE</b> During the noon meal on 3/6/14 beginning at 12:42 p.m., unidentified Dietary Staff L wore a pair of gloves and served food at the steam table. Staff L turned around and opened a drawer with gloves on and returned to the steam table with additional dishware. While wearing the same pair of gloves, Staff L handled bread on a plate to cut it up for a resident.</p> <p>Staff L then turned around from the steam table and opened the food warmer in the food service area and removed a package of tortillas. Staff L opened the package, placed a tortilla on a plate and folded it to serve to a resident while wearing the same pair of gloves that touched the drawer handle, food warmer handle and tortilla packaging.</p> <p><b>AC FOOD SERVICE</b> During food service on 3/11/14 at 12:00 p.m. Staff M wore gloves and opened the food warmer behind the steam table and placed a burgundy covered plate inside. Staff M did not wash hands</p>	F 371	<p>5) April 2, 2014</p> <p>6) Dietary Manager and Director of Nursing</p>	

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

PRINTED: 03/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  03/11/2014
NAME OF PROVIDER OR SUPPLIER  WASHINGTON VETERAN HOME-RETSIL			STREET ADDRESS, CITY, STATE, ZIP CODE 1141 BEACH DRIVE RETSIL, WA 98378		
(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 371	Continued From page 13 and re-glove and continued to wear the same pair of gloves to pick up fish nuggets and place them on a plate to serve to a resident.  On 3/11/14 at 12:20 p.m. Staff O reported if dietary staff opened the food warmer during service they should re-wash hands and re-glove since they did not know if handles were contaminated.  On 3/11/14 at approximately 4:00 p.m. following a meeting with staff, Staff P provided copies of Dietary Services Policies and Procedures. A policy titled "Dietary Services" stated "Remember gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed and hands washed."  Dietary staff contaminated gloves by touching inanimate surfaces during the process of serving food and continued to handle and serve food to residents without re-washing hands and changing gloves. This failure had the potential for staff to spread microorganisms from contaminated gloves to food that residents ate.	F 371			
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	F 441	F441 The facility does and will continue to 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.  1) a. No residents currently have signs or symptoms of gastrointestinal illness.		

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

PRINTED: 03/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/11/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  WASHINGTON VETERAN HOME-RETSIL	STREET ADDRESS, CITY, STATE, ZIP CODE 1141 BEACH DRIVE RETSIL, WA 98378
--	---

(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 441	<p>Continued From page 14 in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(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> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain an infection control program to help prevent the development and transmission of infectious disease. This failure placed vulnerable adults at risk for unsafe and unsanitary environmental conditions. The findings include:  Dining observation on 3/4/16 at 11:45 a.m. in AC1</p>	F 441	<p>Laboratory findings were negative for norovirus on all specimens sent.</p> <p>b. The Infection Control Manual is currently under review for revising policies/procedures as necessary. The contracted Laboratory will provide updated information regarding proper collection and handling of specimens.</p> <p>c. The laundry developed a routine cleaning schedule (daily, weekly, quarterly).</p> <p>d. Staff will minimize contact with clean linen.</p> <p>2) Residents of WVH are affected by the implementation of proper infection control practices.</p> <p>3) a. Education will be provided to all staff regarding:</p> <ul style="list-style-type: none"> <li>i. Need to maintain personal health and the procedure to be followed if they experience illness</li> <li>ii. Proper hand hygiene</li> </ul> <p>b. A committee of nurse managers is working on revising policies and procedures for the Infection Control Program.</p> <p>c. Laundry cleaning schedule will be incorporated into the facility Infection Control Program.</p>	

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

PRINTED: 03/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  03/11/2014
NAME OF PROVIDER OR SUPPLIER  WASHINGTON VETERAN HOME-RETSIL			STREET ADDRESS, CITY, STATE, ZIP CODE 1141 BEACH DRIVE RETSIL, WA 98378		
(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 441	<p>Continued From page 15</p> <p>dining area revealed Staff U was wearing a yellow mask while speaking with other staff. Staff U reported there was "flu and diarrhea on A wing mostly and I don't want to spread it or get it. C wing may have it, too. They are testing for norovirus."</p> <p>At 11:50 p.m. interview with staff EE revealed the diarrhea and vomiting symptoms began in the EFGH wing "about 2 weeks ago." Staff EE stated, "Some residents were being tested for Norovirus and that those residents who are sick are in their rooms. The staff that are affected with diarrhea and vomiting are encouraged to stay at home, or if they come we send them home. Nausea, vomiting and diarrhea have affected 9 to 10 residents on A wing and 2 to 3 residents on C wing."</p> <p>On 3/4/14 at 12:44 p.m. an interview with Staff D revealed that there were 16 residents that were sick with diarrhea and vomiting in the last 24 hours. Staff D notified Staff F before 8:30 a.m. and told the staff meeting attendees about the illness. Staff D had called Kitsap Health Department before 8:30 a.m. regarding the signs and symptoms of residents that were ill. Staff D stated that "as of this a.m. we are doing viral stool samples with directions to staff to do the forms to go with the samples to the lab. So far we have only one stool sample. The vomiting and diarrhea are on AC1 and sporadically through facility. Large amount of folks called in over the weekend." Staff D further reported, "I told staff that the residents should stay in their rooms." Staff D reported that the same symptoms started a couple weeks ago. The same symptoms then started downstairs sometime over the weekend. Staff D reported, "I haven't done an isolation</p>	F 441	<p>d. Laundry staff will be educated related to need for routine cleaning and safe handling of clean linen.</p> <p>4) a. Ongoing monitoring for facility acquired infections will continue and will be reported to the Quality Assurance Committee monthly. Trends will be tracked. Suspected outbreaks will be managed following current infection control guidelines and in cooperation with the county health department.</p> <p>b. Infection Control policies and procedures will be reviewed and revised according to a schedule to be developed by the reviewing committee.</p> <p>c. Random observational rounds will be made by management staff of the laundry to determine effectiveness of cleaning schedule and work practices for handling clean linen. Deficiencies will be corrected at the time and reported to QA committee.</p> <p>5) April 2, 2014</p> <p>6) Director of Nursing</p>		

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

PRINTED: 03/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  03/11/2014
NAME OF PROVIDER OR SUPPLIER  WASHINGTON VETERAN HOME-RETSIL		STREET ADDRESS CITY, STATE, ZIP CODE 1141 BEACH DRIVE RETSIL, WA 98378		
(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 441	<p>Continued From page 16 precaution in-service in a while."</p> <p>On 3/4/14 at 3:09 p.m. Staff D brought the infection control policy and procedure book that was dated 2007. During interview with Staff D the Infection Control Book was reviewed and no isolation policy was found and the Norovirus information was from 2005.</p> <p>Review of Resident Illness Record dated 3/5/14 and 3/7/14 showed that residents were ill from 2/17/14 through 3/7/14. The Staff Illness Records from the same dates revealed staff illness onsets were from 1/23/14 through 3/7/14.</p> <p>According to the CDC Norovirus Guidelines Recommendations, 1.C.1., " Consider the development and adoption of facility policies to enable rapid clinical virological confirmation of suspected cases of symptomatic Norovirus infection while implementing prompt control measures to reduce the magnitude of a potential Norovirus outbreak. "1. C.3.b personnel should not return to activities until a minimum of 48 hours after the resolution of symptoms."</p> <p>On 3/4/14 at 4:20 p.m. Staff D stated, the nausea and vomiting started on EF and GH two weeks ago then went downstairs. Staff have had symptoms of vomiting, diarrhea, or both. Staff D reported having a list of everyone on AC1 that was sick. Staff D stated that "the gastrointestinal virus is hand to mouth. Keep sick people away from rooms and the general population." Staff D reported that housekeeping had been notified by e-mail and Staff P had not been notified. Staff D stated, "I have not addressed how to handle non-disposable medical shared items or addressed the issue. The rooms downstairs have</p>	F 441		

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

PRINTED: 03/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  03/11/2014
NAME OF PROVIDER OR SUPPLIER  WASHINGTON VETERAN HOME-RETSIL		STREET ADDRESS, CITY, STATE, ZIP CODE 1141 BEACH DRIVE RETSIL, WA 98378		
(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 441	<p>Continued From page 17</p> <p>a common sink-to the left or right are common bathrooms. Each side of sink there are wall to separate the two rooms. Residents share the bathrooms." Staff D reported there was no plan in place to clean bathrooms after each resident use. "I would like to think staff are smart enough to know to have them cleaned. Probably there is a situation if one resident does have diarrhea and one doesn't. In that case we would put in a commode. I have not been able to look at that."</p> <p>On 3/5/14 at 2:36 p.m. a safety plan for possible viral outbreak was received from Staff D. A telephone interview with Staff B was done. At 4:51 p.m. an updated, "Summary Plan for Possible Viral Outbreak" was received from Staff B.</p> <p>Upon entrance into the facility on 3/6/14 at 9:15 a.m. the survey team saw a new sign on an easel directly inside the first front door in the vestibule between the two front doors into the building. The sign read, "We are experiencing increased gastrointestinal illness at this time. Please use hand sanitizer when entering or leaving the building." The sign was not at entrance upon survey team initial entrance on 3/4/14.</p> <p>At 10:20 a.m. Staff R revealed, "People's INRs are being messed up from this illness of diarrhea and vomiting. It should not be like this. People were sick in the dining room on Monday on A. There were 12 people sick on Monday. I went home sick because of this. They should have taken the most stringent infection control measures. There was no containment."</p> <p>On 3/6/14 at 11:13 a.m. during an interview, Staff GG acknowledged floating between A and C units</p>	F 441		

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

PRINTED: 03/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  03/11/2014
NAME OF PROVIDER OR SUPPLIER  WASHINGTON VETERAN HOME-RETSIL		STREET ADDRESS, CITY, STATE, ZIP CODE 1141 BEACH DRIVE RETSIL, WA 98378		
(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 441	<p>Continued From page 18</p> <p>were done by Staff GG over the last 3 weeks. Staff GG stated she was informed how to collect stool samples in jars. Staff GG reported residents were allowed back in the dining room when "there's no sign of nausea, vomiting, diarrhea or fever and the nurse makes that decision." Staff GG stated, "we are responsible to wipe up if there are feces, then custodian comes to disinfect." Staff GG reported she had a temperature on 3/4/14 and went home. Staff GG stated, "We're supposed to stay home when we're sick, but that's not what happens all the time. We feel compelled to come to work. Even if I'm really run down, I come to work. There were no specific instructions on when to return to work."</p> <p>3/6/14 at 12:42 p.m. an interview revealed Staff HH had gone home on 3/4/14 with vomiting, diarrhea, upset stomach. Staff HH came to work and saw that others had it too. Staff HH stated she was unable to "come in yesterday. Nursing told me not to get back until I felt better but they didn't really give me instructions."</p> <p>Staff II was interviewed at 1:11 p.m. and revealed "AC1 and EG1 was where I worked. Staff have been ill and we are short staffed."</p> <p>Interview at 1:26 p.m. with Staff JJ revealed, "We are not instructed on what to do regarding stool specimen". Staff JJ stated residents started eating again in dining room when they're not sick again within 24 hours."</p> <p>3/6/14 at 2:23 p.m. Interview with Staff D, "One person had a relapse. Hardly anyone is sick. If they feel up to it, they can leave their rooms." Regarding staff being ill, "if just a little cough, they can come in. Stay home with fever and should be</p>	F 441		

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

PRINTED: 03/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  03/11/2014
NAME OF PROVIDER OR SUPPLIER  WASHINGTON VETERAN HOME-RETSIL			STREET ADDRESS, CITY, STATE, ZIP CODE 1141 BEACH DRIVE RETSIL, WA 98378		
(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 441	<p>Continued From page 19</p> <p>fever free for 24 hours before coming in. It should be clear with diarrhea and vomiting that they don't have it anymore. I would like to see them free for a day before coming back to work. It's subjective. We've kept the hand sanitizer up."</p> <p>3/6/14 at 3:30 p.m. when interviewed Staff R stated, there was a resident that went everywhere, or an aide that was pulled or a float that was ill. Staff is intimidated to call in sick. They could have come with active symptoms. There are conflicting interests. Possible vectors we found with flu-one aide sick that had the flu passed it around. There are a lot of messages to not call in sick. Another staff in facilities went home last week with a temperature of 103 degrees. He said he would go home, but he was here because he had to.</p> <p>On 3/10/14 at 11:42 a.m. a preliminary report on the first sample sent for Norovirus was read by surveyor, "Usual Flora Present." At 1:10 p.m. the lab result was discussed with Staff D since it didn't indicate what the viral test revealed. Staff D reported, "The lab is giving a lot of different stories so I need to call and speak with a supervisor. They told us Norovirus stool samples were run on Tuesdays and Fridays and I called on Friday and they said the samples need to be recollected but no documentation by lab about which nurse they talked to. The latest we've been told is to keep the stool frozen."</p> <p>Staff D showed the surveyor a sheet from under the lab book cover which reads, "Any stool collected for Norovirus must be frozen or called to PacLab for STAT pickup." On 3/10/14 at 1:15 p.m. on review of the form it did not indicate what authority required it. It was dated March 2014.</p>	F 441			

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

PRINTED: 03/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  03/11/2014
NAME OF PROVIDER OR SUPPLIER  WASHINGTON VETERAN HOME-RETSIL			STREET ADDRESS, CITY, STATE, ZIP CODE 1141 BEACH DRIVE RETSIL, WA 98378		
(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 441	<p>Continued From page 20</p> <p>Staff D stated, " I just learned about this today. I don't know where it came from. It was right on front of the lab book."</p> <p>At 1:20 p.m. Staff D made a telephone call to PacLab. to clarify how to collect a sample for Norovirus. 3/10/14 at 1:24 p.m. PacLab Client Service Representative reported, " stool sample doesn't need to be frozen and container for stool needs to be leak proof. What the facility sent was in an incorrect vial. Friday we called the facility and stated the samples needed to be recollected. " - Staff D stated, they wouldn't be able to recollect from residents since they were not having anymore symptoms. PacLab Representative stated, "I will report to my supervisor that there are quite a few errors on our end. The first sample was run just as a stool culture, not as Norovirus. The other two samples weren't run for Norovirus due to improper containers for the stool samples."</p> <p>Laundry Service 3/11/14 8:40 a.m. Tour of laundry service revealed washers and dryers had film, dust, lint, oil and debris. The facility did not have cleaning schedule although deep cleaning gets done quarterly. Laundry workers were observed removing clean towels from dryer with no barrier to prevent laundry from brushing up against street clothing as laundry placed in bin.</p>	F 441			