

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505516</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/04/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>WASHINGTON SOLDIERS HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1305 ORTING - KAPOWSIN HIGHWAY ORTING, WA 98360</b>	
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Quality Indicator Standard Survey conducted at Washington Soldiers' Home 11/27/12, 11/28/12, 11/29/12, 12/3/12 and 12/4/12. A sample of 32 residents was selected from a census of 91. The sample included 30 current residents and the record of 2 former residents.</p> <p>AMENDED PER IDR 1/28/2013 BY Linda Ronco for IDR Program Manager</p> <p>The survey was conducted by:</p> <p>Tara Hawks, RN, BSN Jane Adams, RN, MSN Sonya Conway, MSW</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Disability Services Administration Residential Care Services, District 3, Unit B 1949 South State Street, MS: N27-24 Tacoma, Washington 98405-2850</p> <p><i>Linda Ronco</i> 1-28-13</p>	F 000		

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

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 154 SS=D	<p>483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, &amp; TREATMENTS</p> <p>The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.</p> <p>The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to obtain an informed consent for the use of a specialized wheelchair that had the capacity to tilt into a reclined position for 1 of 3 Residents (#86) reviewed for potential restraints. This failure placed Resident #86 and his responsible party at potential risk for not understanding the risks and benefits involved with using an assistive device.</p> <p>Findings include:</p> <p>Observations on 11/28/12 at 9:18 a.m. revealed Resident #86 was sitting in his room, in a wheelchair that was reclined back approximately 40 degrees.</p> <p>During an interview on 2/3/12 at 11:26 a.m. Staff M reported Resident #86 had been hospitalized and returned to the facility on [REDACTED]. Staff M reported when Resident #86 returned the facility staff determined he was no longer safe to use his motorized wheelchair and should use the tilt</p>	F 154			

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F 154	<p>Continued From page 2</p> <p>wheelchair exclusively. Staff M further reported the facility staff used the chair to recline Resident #86 as a way of changing his position.</p> <p>Review of Resident #86's medical record revealed no documentation the facility staff had received a consent form for the use of the tilt wheel chair as an assistive device.</p> <p>During an interview on 2/3/12 at 11:30 a.m. Staff M confirmed the facility did not obtain a consent for the use of a tilt wheelchair.</p>	F 154		
F 242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure resident choices regarding frequency of bathing was honored for 1 of 3 current sampled residents (#20) reviewed for preferences. This failure placed residents at risk for diminished quality of life.</p> <p>Findings include:</p>	F 242		

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F 242	<p>Continued From page 3</p> <p>Resident #20 was admitted to the facility on [REDACTED] with diagnoses including [REDACTED]</p> <p>The resident's Minimum Data Set (MDS), an assessment tool, dated 10/20/12, indicated the resident was able to make needs known, was cognitively intact, required extensive assistance with bathing, and participated in the MDS assessment process.</p> <p>On 11/29/12 at 10:00 a.m., Staff B stated showers are only done by designated shower aids. Nursing Assistants do not provide showers. It is not in their job description. Showers and baths are only available on day shift.</p> <p>On 11/29/12 at 10:19 a.m., the resident stated he would like to have one bath a day. "This is what I am accustomed to." The resident also stated he "would rather have a shower."</p> <p>On 11/30/12 at 8:00 a.m., Staff N stated if a resident wants a shower in the evening and the shower aid is not scheduled, is sick or pulled to cover another sick call, there is not an option for the resident to get a shower. If the resident misses their shower day, the staff try to work it in or the shower may not occur until the next scheduled day (the following week).</p> <p>On 12/03/12 at 12:29 p.m., Staff C stated the resident gets baths on a "one weekly basis." This was clarified to mean one shower per week.</p> <p>At 1:11 p.m., Staff L said it is the policy of the facility for residents to have a shower once a</p>	F 242			

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F 242	<p>Continued From page 4.</p> <p>week. If the resident is wanting more than one shower a week, they would assess him to see if he can shower independently. The facility does have limitations about providing showers due to there being only one bath aid for the 200 wing.</p> <p>On 12/04/12 at 8:45 a.m., Resident #20 stated he does like the bath and wishes he could have more than one a week.</p> <p>At 8:49 a.m., Staff D stated we give only one bath a week. If the resident gets proper peri-care, they will do fine with one bath a week.</p> <p>At 10:00 a.m., Staff B said the topic of choices regarding baths has come up in Quality Assurance and she has asked what are we going to do as a facility to make this happen for residents. Staff B stated the facility did not have a current plan to ensure bathing was done due to certain labor issues.</p> <p>At 9:15 a.m., Staff E stated shower aids only schedule showers/baths on day shift, and bath aids are scheduled separately from the nursing assistants. Staff E further confirmed the shower aids are not scheduled every day, and sometimes call in sick or are pulled to floor work to cover another sick call, which leaves no shower aid for that day. Staff E reported the facility had recently decided if a shower aid was sick or pulled to the floor they were going to try to pull staff from the restorative program. Staff E confirmed that even if they pulled staff from restorative there would not be a shower aid available daily.</p> <p>Failure to have staff available to shower residents on a daily basis placed Resident #20 at potential</p>	F 242		
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F 242	Continued From page 5 risk for not having his choices honored by the facility.	F 242		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  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.	F 272		

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F 272

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This REQUIREMENT is not met as evidenced by:  
Based on observation, interview and record review it was determined that the facility failed to conduct a comprehensive assessment for 2 of 3 sample residents (#'s 65 & 86) reviewed for the use of potential restraints. This failure had potential to place residents at risk for potential accidents related to misuse of an assistive device.

Findings include:

Resident #65  
Observations on 11/27/12 at 2:07 p.m. revealed Resident #65 was in his room manually operating a motorized wheelchair.

Resident #65's medical record indicated he was

During an interview on 11/29/12 at 8:44 a.m. Resident #65's family member reported he had gotten a new motorized wheelchair and used it independently around the facility.

During an interview on 12/3/12 at 11:50 a.m. Staff K reported the therapy staff completed a Power Operated Vehicle Assessment form for all residents who use a motorized wheelchair to

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F 272	<p>Continued From page 7</p> <p>determine if the resident is safe to use the device.</p> <p>Review of Resident #65's medical record revealed no documentation to evidence Resident #65 had been assessed for the use of an electric wheelchair.</p> <p>During an interview on 12/3/12 at 12:00 p.m. Staff M reviewed Resident #65's medical record and confirmed there was not a Power Operated Vehicle Assessment in the record. Staff M confirmed Resident #65 received the chair approximately 3 months ago.</p> <p>During the above interview Staff M reported when Resident #65 applied to receive the new chair an occupational therapist from Veteran's Affairs had visited the facility to assess the resident for the chair. Staff M confirmed the therapist did not use Resident #65's chair for the assessment, but used one similar to his chair. Staff M further confirmed the facility should have completed the Power operated Vehicle Assessment when Resident #65 received the new motorized chair.</p> <p>During an interview on 12/4/12 at 9:49 a.m. Staff M confirmed she had reviewed all of the thinned records for Resident #65 and was not able to find an assessment for the use of a power chair.</p> <p>Resident #86: Observations on 11/28/12 at 9:18 a.m. revealed Resident #86 was sitting in a wheelchair that was reclined back approximately 40 degrees.</p> <p>During an interview on 2/3/12 at 11:26 a.m. Staff M reported Resident #86 had been hospitalized and returned to the facility on [REDACTED] Staff M</p>	F 272			

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F 272	<p>Continued From page 8</p> <p>reported when Resident #86 returned the facility staff determined he was no longer safe to use his motorized wheelchair and should use the tilt wheelchair exclusively. Staff M further reported the facility staff used the chair to recline Resident #86 as a way of changing his position.</p> <p>Record review revealed Resident #86's care directive was updated with a note dated on [REDACTED] that indicated the chair should be tilted to no more than 30 degrees, tilt for comfort and position change. Further record review revealed no documentation of an assessment related to the use of a tilt chair.</p> <p>During an interview on 12/3/12 at 11:20 a.m. Staff K reported the facility does not do assessments for the use of tilt wheelchairs.</p> <p>During an interview on 12/3/12 at 11:30 a.m. Staff M confirmed the therapy department does not do assessments for the use of a tilt wheelchair. When questioned about the specific directives for staff to tilt the chair up to 30 degrees, Staff M reported they did not use an assessment to determine what degree the chair should be tilted to, instead staff determined they should have a specific number on the care plan so they just added 30 to the directive.</p> <p>Without an assessment of the chair to determine what the correct degree of tilt was appropriate, Resident #86 was placed at potential risk for accidents related to inappropriate positioning in a wheelchair and at potential risk for the chair to be used as a restraint.</p>	F 272			

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F 282 SS=D	<p><b>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b></p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</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 consider a behavioral health professional's recommendation to add an anti-depressant medication to the plan of care for 1 of 10 sampled resident (#28) reviewed for unnecessary medications of the 32 sampled residents included in the Stage 2 review. This failure placed the resident at potential risk for not having his/her individual mental health needs met.</p> <p>Findings include:</p> <p>On 11/30/12 at 8:48 a.m. Resident #28 reported having no problems with his care or his medications. The resident was observed earlier in the morning interacting with staff and other residents and independently moving through the hallway of the facility.</p> <p>Resident #28 diagnoses included [REDACTED] the resident was being seen routinely by a mental health agency from the community. The resident's current medication regime included anti depressant medication(s).</p> <p>On 8/21/12 a mental health professional visited</p>	F 282		
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F 282	<p>Continued From page 10</p> <p>Resident #28 and recommend an additional anti depressant [REDACTED] medication be added to the resident's plan of care.</p> <p>Review of resident's record noted there was no evidence the facility had considered the mental health professional's recommendation made on 8/21/12 to add [REDACTED] to the resident's plan of care.</p> <p>On 11/30/12 at 7:25 a.m. Staff H, who was in charge of Resident #28's care, was asked to review the resident's record to find evidence the mental health professional's recommendation of 8/21/12 was reviewed for inclusion into the resident' plan of care. Staff H was unable to do so.</p> <p>On 11/30/12 at 8:27 a.m. Staff B was informed the mental health professional's recommendation of 8/21/12 was not reviewed for inclusion into Resident #28's plan of care.</p> <p>On 11/30/12 at 10:21 a.m. Staff H reported the mental health's recommendation to add [REDACTED] was not brought forward for review.</p> <p>On 12/4/12 at 9:15 a.m. Staff B reported when community mental health professionals visit the facility, they interface with the facility's social service department. Staff B reported the facility's social service department was responsible for following up on the mental health professional's recommendation(s).</p> <p>On 12/4/12 at 9:30 a.m. Staff J could not find evidence the facility had followed up on the mental health professional's recommendation</p>	F 282		
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F 282	Continued From page 11 made on 8/21/12 to add [REDACTED] to Resident #28's plan of care. Failure to follow up on a mental health professional's recommendation placed Resident #28 at potential risk for not having his mental health needs met.	F 282		
F 441 SS=D	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	F 441		

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F 441	<p>Continued From page 12</p> <p>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 disinfect a glucometer, a meter for testing blood sugar, during one of two medication pass observations. This failure placed residents at potential risk for exposure to a blood borne pathogen.</p> <p>Findings include:</p> <p>On 12/3/12 during the morning medication pass at approximately 7:00 a.m. on Wing 2 Staff L took a glucometer into Resident #112's room and obtained a blood sample for glucose testing. After obtaining the blood sample, Staff L returned to the medication cart and cleaned the glucometer with an alcohol wipe. Staff L reported the facility practice is to clean the glucometer with an alcohol wipe between residents. Staff L reports having one glucometer on his/her medication cart which is used between residents. In addition to Sampled Resident #112, Staff L reported having seven other residents who required blood glucose testing on his/her medication run.</p>	F 441			

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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
F 441	Continued From page 13 On 12/3/12 at 9:30 a.m. Staff N, with Staff B present, reported when a glucometer is visually soiled with blood, staff are to clean it with an alcohol pad, clean it with bleach wipe and let it air dry. Staff N reported on a routine basis the facility policy is to clean the glucometer with an alcohol pad in between each resident use. Staff N reported at the end of a medication pass where the glucometer is used multiple times between residents the glucometer is to be cleaned using a bleach wipe. Staff N confirmed there is one glucometer per medication cart. With both Staff B and Staff N present the the bleach wipe container was reviewed and the label indicated the wipes killed HIV, and Hepatitis A, B & C.  Review of the facility's policy titled: "Blood Glucose Monitoring Via-Glucometer", dated 2012, item #15, directs staff to "clean the meter with an alcohol wipe after each resident". Item #16 "Clean with bleach disinfectant wipe when all tests are done for the pass".  Review of the Owners Booklet for the facility's glucometers, page 32, directs staff to clean (the manual did not use the term disinfect) the outside of the meter using a damp cloth and: (1) mild detergent/soap and water, or (2) 70% isopropyl alcohol, or (3) a mixture of 1 part household bleach, 9 parts of water after resident use.	F 441		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION  The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	F 456		

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F 456	<p>Continued From page 14</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to have an operational suction machine in 1 of 2 dining rooms (The Crows Nest). This failure placed resident who ate meals in the Crows Nest at potential risk for not having suction immediately available should an emergency requiring suction occur.</p> <p>Findings include:</p> <p>On 11/27/12 during the lunch meal in the Crows Nest Dining Room residents were observed to require staff assistance and/or to have altered diets related to swallowing difficulties.</p> <p>On 11/27/12 at 1:45 p.m. the suction machine in the Cows Nest Dining Room had no suction connecting tubing making the machine inoperable.</p> <p>On 11/27/12 at 1:45 p.m. the suction machine was shown to Staff K. Staff K reported she/he would immediately obtain connecting tubing and put it on the suction machine.</p> <p>On 11/27/12 at 2:00 p.m. Staff B was informed there was no connecting tubing on the suction machine in the Crows Nest Dining Room Staff B reported the facility does have a system to check the machine. Staff B reports she/he would get the correct tubing and put it on the suction machine immediately.</p> <p>On 12/4/12 at 9:18 a.m. Staff B confirmed</p>	F 456		
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F 456	Continued From page 15 residents who eat in the Crows Nest Dining Room require varying degrees of assistance with eating and/or have swallowing difficulties.  Not having an suction tubing on the suction machine in the Crow Nest Dining room, would cause a delay in staff response to residents(s) who may have a choking episode.	F 456		