

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

PRINTED: 02/12/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>50A181</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/11/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>COLUMBIA BASIN HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 NAT WASHINGTON WAY EPHRATA, WA 98823</b>		
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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 Columbia Basin Hospital on 02/09/16, 02/10/16 and 02/11/16. A sample of 12 residents was selected from a census of 12. The sample included 12 current residents.</p> <p>The survey was conducted by:  Melly Thompson, RN Lisa Herke, RD</p> <p>The survey team is from:  Department of Social &amp; Health Services Aging &amp; Long Term Support Administration Residential Care Services, Region 1, Unit D 3611 River Road, Suite 200 Yakima, Washington 98908</p> <p>Telephone: (509) 225-2800 Fax: (509) 574-5597</p> <p><i>Robert L. [Signature]</i> 2/12/16 Residential Care Services      Date</p>	F 000			

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

*Josephine Kibby*      Administrator      03/01/16

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 285 SS=D	<p>483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI &amp; MR</p> <p>A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.</p> <p>A nursing facility must not admit, on or after January 1, 1989, any new residents with:</p> <p>(i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission;</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>For purposes of this section:</p> <p>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).</p>	F 285	See attached <i>PK</i>	3/28/16	

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F 285	<p>Continued From page 2</p> <p>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to coordinate the pre-admission screening and resident review assessments to ensure specialized services were provided if needed for 3 of 6 residents (#s 3, 6 and 13) reviewed for pre-admission screening. This placed the residents at risk of not receiving needed mental health services. Findings include:</p> <p>Resident #6. Admitted on [REDACTED] 13 with diagnoses to include [REDACTED]. Her latest comprehensive assessment dated 01/25/16 revealed the resident experienced [REDACTED] and [REDACTED] and had mild cognitive impairment.</p> <p>Review of the resident's Level 1 Pre-Admission Screening and Resident Review (PASRR, revised 04/2015), revealed the resident had a diagnosis of [REDACTED] which was noted in Section I.A. In Section II.A, titled Exempted Hospital Discharge, none of the boxes were checked. In Section IV, the section for Service Needs and Assessor Data, the check box selected was "Level II evaluation required for SMI (serious mental illness)." The form was signed by Staff Member B, the Social Services Director (SSD) and dated 05/04/15.</p> <p>Review of the resident's medical record revealed no further documentation of a Level II evaluation.</p>	F 285			

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F 285	<p>Continued From page 3</p> <p>Resident #3. Admitted on [REDACTED] 14 with diagnoses including [REDACTED] and [REDACTED]. A quarterly comprehensive assessment dated 08/24/15 documented the resident with a fluctuation of psychomotor retardation during the assessment period.</p> <p>Review of the resident's Level 1 PASRR, signed and dated 05/04/15 by Staff Member B, documented the resident had a diagnosis of [REDACTED]. Section IV of the document revealed the selection of "Level II evaluation referral required for SMI." There was no further documentation that revealed completion of the Level II evaluation.</p> <p>Resident #13. Admitted [REDACTED] 14 with diagnoses to include [REDACTED]. Her latest comprehensive assessment dated 11/23/15 revealed the resident was severely cognitively impaired.</p> <p>Review of the resident's Level 1 PASRR, revised 04/2015, revealed the resident had a diagnosis of [REDACTED]. In Section IV, the section for Service Needs and Assessor Data, the check box selected was "Level II evaluation required for [REDACTED]". Also in Section IV, a second box was checked. It designated "No Level II evaluation indicated." The form was signed by Staff Member B, the SSD and dated 05/04/15.</p> <p>Review of the resident's medical record revealed no further documentation of a Level II evaluation.</p> <p>In an interview on 02/10/16 at 5:02 p.m., Staff Member B stated she filled out a new PASRR Level 1 for Resident #13 and other residents in May 2015. At that time, the Level 1 form</p>	F 285			

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F 285	<p>Continued From page 4</p> <p>assessed Resident #13 as needing a Level II evaluation. She explained the state updated their Level 1 form in July 2015. If Resident #13's Level 1 evaluation was done using the newer form, the resident did not need a Level II evaluation. She stated that was why the resident's form had the "No Level II evaluation indicated" box hand checked which was dated 11/25/15.</p> <p>The SSD further stated she faxed the requests for the Level II evaluations to the designated Level II evaluator on 05/05/15. She stated she never heard back from him. She noted her former assistant, Staff Member F, placed a progress note that documented the requests had been faxed in the medical record of each of the residents. She noted she thought she faxed the evaluator only once, but she called "a couple times" after she did not hear back from the Level II evaluator.</p> <p>Review of progress notes for Resident #s 3, 6 and 13 revealed Staff Member F placed notes in the residents' charts on 05/05/15. For all three, the note read, "Updated PASRR form was sent to [Level II evaluator] today, for Level 2 evaluation. Fax confirmation rec'd (received). Forms placed in charts."</p> <p>On 02/11/16 at 10:54 a.m., the SSD stated she was unable to provide documentation that would indicate some type of follow-up for the pending Level II evaluations for the three residents.</p> <p>Failure to ensure the screening for mental health services was completed when indicated placed the residents at risk of untreated mental health issues and for a decrease in the quality of their lives due to those mental health issues.</p>	F 285			

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F 371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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 under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staff working in the dining room changed gloves, washed hands and handled food in a manner to avoid cross-contamination of residents and resident foods. These unsafe practices placed all residents in the dining room at increased risk for food-borne illnesses. Findings include:</p> <p>An observation on 02/09/16 at 12:06 p.m. revealed Staff Member D, a Nursing Assistant (NA), donned a glove on her right hand and grabbed a napkin and walked over to a resident and wiped some spilled food off of his clothing protector. She then threw the napkin and glove away and turned on the water at the sink for approximately four seconds while washing her hands and turned off the water and wiped her hands on her scrub top.</p> <p>After she dried her hands, Staff Member D then assisted residents at a table in the dining room. She then scratched her cheek with her right hand, touched her nose and placed her right hand over</p>	F 371	<i>See attached</i>	3/25/16 <i>PKL</i>	

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F 371	<p>Continued From page 6</p> <p>her mouth to cover her cough. A resident requested more coffee and she walked over to his table and grabbed his cup with her contaminated hands by the rim of the cup and refilled the coffee cup. She then washed her hands for approximately five seconds after she completed the task.</p> <p>On 02/10/16 at 11:56 a.m., food arrived for the residents seated in Dining Room B. Staff Member D had a disposable glove on her left hand. Her right hand was bare. Staff Member E, a NA, was observed to wash her hands and then donned disposable gloves. Staff Members D and E, with two other NAs immediately started serving food to the residents.</p> <p>At 12:05 p.m., Staff Member E began helping Resident #2 by feeding her sips of pureed food in cups. As she assisted the resident, she touched the resident's right arm and the arm of the resident's wheelchair. After helping Resident #2 for a few minutes, she began assisting Resident #3, without a hand wash or glove change. She then returned to assisting Resident #2, again placing her hand on the resident's arm. She then moved to assist Resident #12 with her meal.</p> <p>On 02/10/16 at 12:06 p.m., Staff Member D stopped to wash her hands after assisting residents with tray set up. The water in the hand wash sink was heard to run approximately 4 seconds. She did not replace her gloves, but with bare hands, began helping Resident #4 with eating her meal.</p> <p>At 12:15 p.m., Staff Member D went around the table to assist Resident #3, who was feeding herself a peanut butter sandwich with some</p>	F 371		

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F 371	<p>Continued From page 7</p> <p>difficulty. A heaping teaspoonful of dark food had fallen from her mouth and landed on her clothing protector. Staff Member D scraped the food from her clothing protector, using a spoon. She placed the food on the side of her plate, then using the same spoon, proceeded to feed the resident several more bites of food from her plate.</p> <p>Staff Member D then went to the hand wash sink, but no water was heard to run. She returned 4 to 5 seconds later with a paper towel, wiping her bare hands as she walked. She then returned to the table and began assisting Resident #4. As she was assisting the resident, she touched the arm and side of the chair.</p> <p>At 12:20 p.m., Staff Member D walked around the table to assist Resident #3. Once again, food had dropped from the resident's mouth onto the clothing protector. Staff Member D used a spoon to scrape the food off the clothing protector and placed the food to the side of the plate. She then used the same spoon to feed the resident some bites of fruit dessert.</p> <p>After feeding the resident the fruit, Staff Member D set the spoon down and picked up the peanut butter sandwich with her bare hands, and fed the resident some bites of the sandwich. She set the sandwich down, and went to talk with Resident #s 6 and 14, who were seated at another table. As she visited with the residents, she touched the sleeve of Resident #6's clothing.</p> <p>She then returned to assist to help Resident #4, and then moved around the table to assist Resident #3, all without a hand wash.</p> <p>Review of the Policy and Procedure "Hand</p>	F 371			

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F 371	<p>Continued From page 8</p> <p>Hygiene - CDC [Center for Disease Control] Guidelines," dated 10/01/14, revealed the facility policy was for staff to use the hand hygiene as set forth in the procedure before coming on duty, when hands are soiled, before each patient encounter, always after removing gloves and after blowing/wiping the nose. The policy also included "performance improvement activities shall be conducted to monitor organizational goals for compliance with hand hygiene guidelines."</p> <p>Further review of the facility policy revealed the hand washing procedure included washing hands thoroughly, "Using rigorous scrubbing action for at least 15 seconds."</p> <p>During an interview on 02/11/16 at 9:19 a.m., Staff Member C, the Infection Control Licensed Nurse (LN), the surveyor asked about training for nursing staff during dining services. The LN stated she had not recently trained the NAs about hand washing specific to dining. "That's an excellent idea to add that in to the annual review...I have to get them (LNs) on the floor to enforce it too."</p>	F 371			

DSHS Long Term Care survey conducted on February 11, 2016

**F Tag 371 Food Procure, Store/Prepare/Serve-Sanitary**

1. For all residents, including Resident #2, 3, 4, 6, 12, and 14; the facility will ensure that staff working in the dining room will follow safe practices and food handling to avoid cross-contamination of residents and resident foods.
2. Nursing staff will be re-educated on the Policy of "Hand Hygiene-CDC Guidelines" with particular focus on hand hygiene in the dining room environment. This will occur on 3/15/16. In addition, the orientation checklist for new hires; NAC's and Licensed Nurses, has been updated to include dining room hand hygiene. The policy on Hand Hygiene has also been added to the new hire packet which they receive upon orientation. The OSHA class for new hires will also review hand hygiene.
3. Random weekly audits of the dining room will be performed by the ICP or designee and be reported to the Performance Improvement Committee quarterly.
4. Date of compliance is 3/25/16.
5. Director of Nursing will be responsible to ensure correction.

**F Tag 285 PASRR Requirements for MI & MR**

- Level II PASRR Invalidation Statements were received for residents #3, 6 and 13 and filed in each medical record on 2/15/16. Documentation was placed in each resident's electronic medical record to note when received.
- SSD will review all PASRR Level I for each current resident and if Level II evaluation required, contact Level II evaluator to request copies of assessments. Documentation will be placed in each resident's chart when requested and response. Copies will be placed in each resident's record and documented when received. To be completed by 3/28/16.
- Any new admission to facility will have documentation placed in medical record if Level II is requested and response or when evaluation completed. SSD responsible to monitor.
- PASRR policy to be reviewed for accuracy and updated to include documentation of follow-up to Level II evaluator for completion. SSD responsible for completion by 3/28/16.
- ~~SSD~~ will monitor PASRR accuracy and documentation in medical record quarterly and report to PI committee.

Heidi  
(Hospital DNS)  
per Becky T's email dated 03/14/16 *[Signature]*

*[Signature]*