

8846

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL, PAT N			STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15TH NORTHEAST SEATTLE, WA 98155	
(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 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Fircrest School Pat N on 11/04/13, 11/05/13, 11/06/13, 11/07/13, and 11/08/13. A sample of 27 residents (including three former and three supplemental resident) were selected from a census of 86 residents.</p> <p>Survey team members included:</p> <p>██████████, R.N., B.S.N. ██████████, M.S., R.D. ██████████, R.N., B.S.N. ██████████, R.N., M.N.</p> <p>The survey team is from: Department of Social and Health Services Aging and Adult Services Administration Residential Care Facilities District 2, Unit C 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388</p> <p>Telephone: (253) 234-6000 Fax: (253) 395-5070</p> <p>██████████ 11-14-2013 Residential Care Services Date</p>	F 000		

RECEIVED
DEC 02 2013
DSHS/ADSA/RCS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE ██████████	TITLE Director	(X6) DATE 11/26/13
---	-------------------	-----------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL, PAT N			STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15TH NORTHEAST SEATTLE, WA 98155		
(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 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to provide dining services in a manner that enhanced dignity for each resident. Failure to ensure staff did not use terms of endearment, residents received timely assistance with meals and ensure staff feeding residents were positioned at eye level with residents who required assistance placed four of four residents observed during dining of the 27 sampled residents (#55, 81, 83 and 6) at risk for a diminished quality of life.</p> <p>Findings include and not limited to:</p> <p>TERM OF ENDEARMENT</p> <p>Although Resident #55 was seated at the table and recieved a lunch meal at 12:01 p.m., she did not recieve assistance with the meal until 12:25 p.m. When Staff EE was available they verbally cued the resident by addressing her as "Momma Jockey."</p> <p>During a follow up interview on 11/07/13 at 11:45 a.m., the Licensed Nurse, Staff V, was asked if residents residing in the unit used any nick names. She stated no, and explained the staff might refer to a resident as a momma or grandma, but had never heard the term "Momma</p>	F 241 F 241	<p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>A) Use of nicknames B) Timely meal assistance C) Standing while feeding clients</p> <p>A)</p> <p>1. The staff that referred to client #42 using a nickname was provided training on how to properly address clients per F tag 241 by November 26, 2013.</p> <p>2. PAT N staff will be provided training on how to properly address the clients as well as other issues related to dignity and will be trained annually on the topic which will be added to the annual training check list. This will include a "Self Survey" module for F tag 241</p> <p>B)</p> <p>1) The staff that assisted clients# 55 and# 81 will be instructed to provide meals at the time the client arrives or very close to that time. Food will not be placed in front of the client until they are promptly ready to eat. These staff will receive further training. Completed by November 26, 2013.</p>		

RECEIVED
DEC 02 2013
DISHMAN

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL, PAT N			STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15TH NORTHEAST SEATTLE, WA 98155		
(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 241	<p>Continued From page 2</p> <p>Jockey" being used to address Resident #55.</p> <p>During a follow up interview on 11/13/13 at 2:00 p.m., Staff Z stated she had never heard staff address Resident #55, using the term before.</p> <p>TIMELY MEAL ASSISTANCE</p> <p>On 11/04/13 during the meal observation on Hickory, two residents were noted to be seated in the dining room around 12:00 p.m. Resident #81 and #55. Resident #81 and 55, recieved their trays shortly after noon. However Resident #81 was not assisted until 12:22 p.m. The resident was awake and noted to be observing residents and the staff interactions while waiting for assistance in the dining room. The resident's plate remained on the table covered on the table and out of reach until Staff N was available to feed the resident. Resident #55 was not provided assistance with the meal until 12:35 p.m., which was approximatly 35 minutes after the meal had been placed on the table in front of the resident.</p> <p>On 11/06/13 during observation of the breakfast meal the same residents (#55, and 81) sat for extended periods of time before receiving assistance with the meal. Upon entering the dining room at 8:10 a.m., resident #81 and #55 were observed seated in the dining room, their meals had been placed on the table before them; however there was no staff available to assist them. Resident #81 waited for until 8:30 a.m., before a staff member provided assistance. The CNA, Staff W then left the table to assist other residents, once for 5 minutes and the other time for 7 minutes. When Staff W, left the Resident #81, the resident tracked the CNA as they walked around the dining room helping others.</p>	F 241	<p>2) PAT N staff will be retrained on the requirement to serve food to the client in a timely manner , at the time of arrival or promptly thereafter. Food will not be placed in front of them until such time staff can assist them to eat. . Clients that require minimal assistance (or set up assistance) will come to the dining room first. This will be added to each units meal time instructions and Federal Regulation 241 will be added to the annual training checklist as well as be part of the meal time observation process.</p> <p>C)</p> <ol style="list-style-type: none"> The staff who were standing and feeding clients # 83 and #6 were re- trained on the need to follow meal card instructions and care plan by November 26, 2013 as well as receiving feedback as the rationale as to how they were assisting the clients was not in a dignified manner as describe in Federal Regulation 241. The OT will re assess all residents that require being fed at an increased height and appropriate chairs will be ordered. This requirement will be added to the care plan, meal card instructions and OT assessment. Staff will be trained on this information (adjustable height chair required to assist in a dignified manner). 		

RECEIVED
DEC 22 2013
DSHS/ROGAIROS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/08/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL, PAT N	STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15TH NORTHEAST SEATTLE, WA 98155
---	--

(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 241	<p>Continued From page 3</p> <p>On 11/06/13 Resident #81 was observed sleeping in a wheelchair in the dining room. The staff did not cue or assist her with the meal until 8:45 a.m. The resident had waited for 35 minutes before any staff were available to assist her with eating the meal.</p> <p>Review of the policy for meal service and preparation in the living unit (Hickory) found the following statement; "Bring in only those who can be attended to immediately. Do not have someone 'waiting in line' for more than a few minutes in the dining area." However, Resident #55 and #81 waited for more the 20 minutes for assistance with the meals.</p> <p>STANDING WHILE ASSISTING RESIDENTS</p> <p>On 11/04/13 at 11:54 a.m., Resident #83 was observed in the Aspen dining hall. Resident #83 was seated in his wheelchair while being fed by Staff M, who was stood off to the side while feeding the resident. Staff M was not at eye level with the resident.</p> <p>On 11/06/13 at 8:16 a.m., Resident #6 was observed in her wheelchair in the Aspen dining hall. Resident #6 was not pulled up to a table; she was placed in between two tables. Ample table space was available. Resident #6 was being fed by Staff O who was standing to the side of the resident.</p> <p>On 11/06/13 at 9:34 a.m., Staff O stated for "certain clients you can sit or stand." Staff O indicated this direction would be found in the resident's care plan. Staff O denied knowing the direction in the care plan for Resident #6 related to feeding assistance. Review of Resident #6's</p>	F 241	<p>4. Staff will be trained on Federal Regulation 241 related to meal time dignity annually.</p> <p>A), B), and C)</p> <p>1) Need to address clients in a dignified manner will be added to the PAT N Annual training checklist and will be reviewed for completion by the DDA 1 and/or the RN 4.</p> <p>2) The Meal Time Observation Form will include an observation of time waited before eating and specific issues related to meal time dignity, (staff not standing unless clinically indicated per OT recommendations as well as not using nick names and not waiting for meal for excessive periods and having meal served without being assisted). The observations will be done by the DDA 1 and the RN 3 each week and anything less than promptly eating will be documented and the RN 4 will be notified of any non-compliance. Supervisors will be given feedback.</p> <p>3) The meal time observation form will be reviewed at the quarterly QA meeting for compliance, outcomes and actions taken in response.</p>	
-------	---	-------	--	--

RECEIVED

DEC 02 2013

DSHS/ADSAR/PCS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL, PAT N			STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15TH NORTHEAST SEATTLE, WA 98155		
(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 241	Continued From page 4 care plan did not have any direction to staff to sit or stand while assisting residents during dining. In interview on 11/07/13, after the meal, the Staff AA (unit manager) stated the staff had to stand while assisting some residents because the wheelchairs were too high and there were no chairs that would place the staff at eye level while assisting residents to eat.	F 241			
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is	F 278	<u>F 278 The assessment must accurately reflect the residents status. A registered nurse must participation of health professionals.</u> 1. Resident #61's record was reviewed and corrected to include accurate information regarding the [REDACTED] pressure [REDACTED] that was present at admission by [REDACTED], 2013. 2. The RNs will be re-trained on the pressure [REDACTED] section of the Resident Assessment Instrument (RAI). 3. Pressure ulcer status and the MDS coding for pressure ulcers will be reviewed at the quarterly QA meeting and presented by the RN3.		

RECEIVED
DEC 02 2013
DSHS/ADSA/KCS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL, PAT N			STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15TH NORTHEAST SEATTLE, WA 98155		
(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 278	Continued From page 5 subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278			
	<p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to complete an accurate assessment of the number and description of all [REDACTED] present upon admission for Resident #61, one of three sampled residents reviewed for pressure ulcers. Failure by the facility to accurately identify all of the pressure ulcers as required on MDS (Minimum Data Set, an assessment tool) assessments put this resident at risk for unmet care needs.</p> <p>Definitions: (Information obtained from the RAI (Resident Assessment Instrument) which contains the instructions for coding in the MDS)</p> <p>Stage 2 Pressure Ulcer: Partial thickness loss of dermis (the second layer of skin) presenting as a shallow open ulcer with a red-pink wound bed.</p> <p>Unstageable Pressure Ulcers can include eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like). This prevents the determination of the true depth and, therefore, the stage of the wound.</p>				

RECEIVED
DEC 02 2013
DSHS/ADS/RCS

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL, PAT N			STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15TH NORTHEAST SEATTLE, WA 98155		
(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 278	<p>Continued From page 6</p> <p>Findings include:</p> <p>Resident #61 was admitted to the facility [REDACTED]/13 with care needs related to [REDACTED], [REDACTED] and [REDACTED]. According to the [REDACTED]/13 admission MDS Resident #61 was totally dependent on staff for care needs.</p> <p>Review of a document entitled "Fircrest Wound Assessment" dated 08/14/13 identified a Stage 2 pressure ulcer to the [REDACTED] heel that was not present on the MDS. The "Nursing Assessment Form" (dated 08/14/13) also identified this pressure ulcer to the [REDACTED] heel and described it as "red with black eschar." This was also not identified on the MDS. Additionally, the "black eschar" description indicates that the pressure ulcer was unstageable, not a stage 2.</p> <p>The care plan dated 08/27/13 indicated the resident had impaired skin integrity related to "multiple decubitus ulcers." The [REDACTED] heel was listed with the pressure ulcer locations.</p> <p>On 11/07/13 at 8:53 a.m. Staff P Licensed Nurse (LN) stated Resident #61 did have a [REDACTED] [REDACTED] to the [REDACTED] heel upon admission.</p> <p>On 11/07/13 at 10:20 a.m. Staff F (LN) stated she did not code the pressure ulcer on the heel in the MDS "because it healed on the last day" (of observation in the seven day assessment window).</p> <p>Instructions for the MDS coding of a Stage 2 pressure sore read to "Enter the number of Stage [REDACTED] that were first noted at the time</p>	F 278			

RECEIVED
DEC 02 2013
DSHS/ADSA/RCS

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL, PAT N			STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15TH NORTHEAST SEATTLE, WA 98155		
(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 278	Continued From page 7 of admission..." No Stage 2 [REDACTED] were identified on Resident #61's admission MDS. Additionally, the MDS indicated that pressure ulcers covered with eschar "should be coded as unstageable." The failure of the facility to accurately identify all pressure sores and their stages on the MDS put the resident at risk for staff to be unaware of vulnerable areas to pressure and increased risk of impaired skin integrity due to a history of pressure ulcers.	F 278			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	<u>F 280 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the stated, to participate in planning care and treatment or changes in care and treatment.</u> 1. For client #13 and #64 their care plan and the Occupational Therapist annual assessment were reviewed and coordinated to reflect the accurate information by November 26, 2013.		

RECEIVED
DEC 02 2013
DSHS/ADSA/RCS

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL, PAT N		STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15TH NORTHEAST SEATTLE, WA 98155		
(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 280	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to revise care plans to reflect current care needs related to a hand splint and a foot strap for Resident #13 and #64, two of three sampled residents reviewed for Range Of Motion (ROM). Failure to revise and update care plans placed residents at risk for unmet needs and/or incorrect implementation of services needed.</p> <p>Findings include:</p> <p>RESIDENT #13</p> <p>Resident #13 was admitted to the facility [REDACTED]/94 with care needs related to [REDACTED] and [REDACTED] disabilities. The 10/12/13 quarterly Minimum Data Set (MDS), an assessment tool, indicated Resident #13 was totally dependent on staff for all Activities of Daily Living (ADLs) to include dressing.</p> <p>On 11/06/13 at 7:27 a.m. Resident #13 was observed sitting in his wheelchair with a splint applied to the [REDACTED] hand.</p> <p>Review of the care plan dated 10/23/13 listed the [REDACTED] hand splint under therapeutic devices. The intervention read "Client wears hand splint to maintain ROM of hand and thumb." Not present was any specific direction to staff for the splint program.</p> <p>On 11/07/13 at 1:32 p.m. Staff N, Nursing Assistant Certified (NAC), stated "PT (Physical Therapy) puts it on and we take it off when when we lay him down." Staff N stated the splint is</p>	F 280	<ol style="list-style-type: none"> Staff that work on the unit with client #13 and #64 will re-trained on the care plan and meal card instructions by November 26, 2013. PAT N clients will have their annual OT assessment, care plan and meal card instructions reviewed, and if indicated, updated to ensure accurate and coordinated information. Staff will be trained on any new updates as well as their requirement to apply and/or remove splints. A daily flow sheet will be added for staff to record application and/ or removal of devices, along with instructions if direct care staff are required to do so. The flow sheets will be reviewed quarterly by the OT and pertinent information will be added in the data section of the care plan for team review quarterly. Findings and outcomes will be reviewed by the QA group quarterly by the OT or the RN 3 as a designee. 	

RECEIVED
DEC 02 2013
DSHS/ADSA/RCS

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL, PAT N			STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15TH NORTHEAST SEATTLE, WA 98155	
(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 280	<p>Continued From page 9 usually on for "about an hour."</p> <p>On 11/07/13 at 1:55 p.m. Staff G (Licensed Nurse) stated Occupational Therapy (OT) was the service that placed the splint on Resident #13. Staff G was not able to say how long the splint should have been in place before removal by a NAC.</p> <p>On 11/07/13 at 2:12 p.m., Staff K (OT) stated she had not set an expectation on the care plan for how long the splint should remain on. Staff K indicated the splint should have been on for two hours.</p> <p>RESIDENT #64</p> <p>Resident #64 had multiple medical diagnoses. Throughout the survey, the resident was observed seated in a wheelchair with the residents' foot strapped to the foot pedal. The resident was able to self-propel the wheelchair around the living unit independently using the foot.</p> <p>Although the staff routinely provided the assistance with placing the positioning device, there was no notation in the care plan concerning the device.</p> <p>Review of the last annual occupation therapy assessment completed found no evidence the device was identified.</p> <p>The Occupational Therapist, Staff K, was interviewed about the use of the device. She reported the device had been in use for a long time and stated the resident ability to self-propel the wheelchair would be disrupted if the device</p>	F 280		

RECEIVED
DEC 02 2013
DSHS/ADSA/RCS

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/08/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL, PAT N	STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15TH NORTHEAST SEATTLE, WA 98155
---	--

(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 280	Continued From page 10 was not used. She then stated it should have been identified in the care plan and was just over looked.	F 280		
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 under sanitary conditions	F 371	<u>F 371- The facility must procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute and serve food under sanitary conditions.</u> 1) PAT staff will be retrained on the requirement to take food temperatures for the following a), food delivered in bulk, b) reheating of food and c) when food is cooked on the unit.	
	This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to ensure food temperatures were monitored when food was cooked at the living units; holding temperatures of food delivered in bulk and when re-heating of meals occurred. This failure to monitor food temperatures put residents who received meals in five of five dining halls at risk for food borne illnesses. Findings include: The Food Service Manager, Staff Q was interviewed on 11/7/13 at 2:30 p.m., stated breakfast meals were cooked on units on the weekends by the NACs (Nursing Assistant Certified) working in the units. She reported the units recieved liquid eggs and dry hot cereal from the main kittchen for the NAC staff to cook. When		2) The flow sheets will be revised and reviewed as needed and temperatures will be tracked accordingly 3) The flow sheets will be turned in monthly to the RN 3 and reviewed by the QA group at least quarterly. 4) When temperatures are not recorded, the staff(s) involved will be given written feedback and if warranted corrective action will be taken by the RN 4 or Director. 5) Staff will be trained and expected to not serve food at the improper temperature. 6) The dietary manger of designee will train staff annually on the subject and train new employees, this will be added to the annual training check list.	

DEC 02 2013
DSH/RS/RS

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL, PAT N			STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15TH NORTHEAST SEATTLE, WA 98155		
(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</p> <p>asked what kind of training they recieved. Staff Q did reported some training in food handling was provided during staff orientation.</p> <p>On 11/07/13 at 2:30 p.m., Staff Q, the Dietary Manager, stated the main kitchen staff delivered to each living unit raw food items i.e. pasteurized eggs and cereal to be cooked in the living unit kitchens on weekends and holidays. The NAC staff were expected to monitor food temperatures according to regulations and record temperatures in the log. Staff Q stated the nursing staff received some training regarding handling food during staff orientation.</p> <p>Staff Q also reported foods were provided in bulk to the units on the weekends and the NACs were responsible for assembling the resident's plates and monitoring the temperatures. Holding food temperatures were to be monitored by the nursing staff and recorded in the log. These temperatures were not monitored consistently by staff.</p> <p>Staff Q expected the staff to reheat foods and retest the temperatures to ensure the food stayed out of the danger zone of 41 to 135 degrees. She also stated she expected staff to reheat foods then retest the temperatures to ensure the food reached and maintained 165 degrees for 15 seconds.</p> <p>Review of the temperature log in the Cherry dining hall for August through November revealed temperatures were logged for one of 29 breakfasts cooked on the unit for those weekends and the Labor Day holiday.</p> <p>An interview on 11/07/13 at 11:59 a.m., Staff R,</p>	F 371			

RECEIVED
DEC 02 2013
DSHS/ADSA/RCS

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/08/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL, PAT N	STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15TH NORTHEAST SEATTLE, WA 98155
---	--

(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>AC (NAC) Manager of Cherry Hall, stated he expected the nursing assistant staff to monitor and log the food temperatures on weekends and holidays for breakfast. Dinner temperatures were to be monitored for holidays only. Staff R reviewed the food temperature logs for the month of August through November and stated the staff had not followed the policy regarding temperature documentation. Staff R stated he intended to monitor the temperature logs twice a month and acknowledged this had not been done for the past three months.</p> <p>On 11/07/13 at 11:00 a.m., record review of the temperature logs in the kitchen of Birch Hall revealed no breakfast temperatures recorded for the month of August. The food temperature log for the month of September did not include dinner temperatures for the Labor Day holiday or temperatures for breakfast eggs the entire month. The temperatures for hot cereal were logged daily with the identical temperatures recorded in the log for October and November.</p> <p>In an interview on 11/07/13 at 12:54 p.m. Staff S, the AC Manager for Birch Hall, stated the staff were not documenting the food temperature according to the policy. He reviewed the monthly temperature logs for August through November and confirmed the temperatures were identical so frequently he was not sure if the staff followed the policy of recording the actual temperature the food maintained for 15 seconds. Staff S also confirmed temperatures for dinners on the weekend and holidays should have been on the log.</p> <p>On 11/07/13, the managers on the Elm and Hickory units were asked for food temperature</p>	F 371		
-------	--	-------	--	--

RECEIVED
DEC 02 2013
DSHS/ADSARCS

RECEIVED
DEC 02 2013
DSHS/ADSARCS

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/08/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL, PAT N	STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15TH NORTHEAST SEATTLE, WA 98155
---	--

(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 logs. At 1:30 p.m., Staff AA, manager of Elm Hall, was asked about the food temperature log found in the kitchen. The November log only documented the breakfast meals. When asked about other meals, she stated all meal temperatures should be monitored and did not know why they had not been documented. Review of the previous months logs, which were provided by Staff AA also found only temperatures recorded were taken during the breakfast meal.	F 371		
	<p>On 11/7/13 at 11:55 a.m., Staff X, Attendant Counselor 2, was interviewed about the NAC's involvement in preparing foods. He stated the NACs working on the weekends were expected to prepare the breakfast meals. When asked about the low temperatures documented in the log, (i.e. the log noted lunch entrees were only 131 degrees on 11/3/13), he stated the foods should have been reheated in the microwave. When asked if they check the temperature after reheating the food items he stated he had not observed staff retesting the food items.</p> <p>On 11/06/13 at 8:59 a.m. Staff T, Nursing Assistant Certified (NAC), demonstrated the procedure of temping the food sent in a bulk unit to be served to each residents in the dining area. She found the temperature for the hot cereal was 132 degrees which is below the regulatory standard of 135 degrees. She recorded the temperature in the log and stated, "The food is hot sometimes and other times it is cold." She proceeded to serve the cereal to the residents. She made no reference to the policy printed at the top of the log sheet to re-heat food below 140 degrees.</p>			

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL, PAT N			STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15TH NORTHEAST SEATTLE, WA 98155		
(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 14 On 11/6/13 at 9:27 a.m. Staff BB indicated if food temperatures were below the specified range, the service would continue and the manager would be informed. On 11/06/13 at 3:15 p.m., Staff B, the NH Administrator, and Staff C, the Director of Nursing Services, were interviewed about the meal services provided on the units on the weekends. Both Staff B and Staff C stated they thought staff was only reheating foods on the units and were unaware the staff were cooking in the units.	F 371			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked,	F 431	F 431 Drug records, label/store drugs and biologicals. The outdated supplies were located and removed by November 26, 2013. The monthly medication room and storage area check list was reviewed and updated as needed Nurses will be trained on the revised form and the requirement to complete monthly. This will be completed by the LPN4's. The completed forms will be turned into the RN 3 at the end of the month and reviewed at least quarterly by the QA group for compliance. Instances of non-compliance will be addressed in writing and written feedback which may include corrective action by the RN 3 or the RN 4.		

RECEIVED
DEC 02 2013
DSHS/ADSA/ROS

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL, PAT N			STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15TH NORTHEAST SEATTLE, WA 98155		
(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 431	Continued From page 15 permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to monitor and remove all biologicals and medications according to manufacturer's expiration dates on three of five Living Units. This placed the residents at risk to receive ineffective medications or biological supplies with compromised integrity. Findings include: BIRCH LIVING UNIT On 11/05/13 at 9:02 a.m., an observation of the medication storage rooms in Birch Living Unit revealed five irrigation syringes with expiration dates of 02/13 and 08/13; three containers of [REDACTED] juice with expiration date of 09/13; connecting tubing with an expiration date of 06/12; eight tracheostomy care kits with expiration dates of 06/13 and 08/13; and six vacutainer kits used for emergency blood draws with an expiration date of 09/12. An observation of the medication cart on Birch Living Unit revealed a large bag of individual packets of [REDACTED] with an expiration date of 10/25/13.	F 431			

RECEIVED

DEC 02 2013

DSHS/ADSA/RCS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL, PAT N			STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15TH NORTHEAST SEATTLE, WA 98155	
(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 431	Continued From page 16 An interview with Staff U, Licensed Nurse (LN), stated expiration dates were to be checked monthly, but these items were overlooked. CHERRY LIVING UNIT On 11/05/13 at 10:00 a.m., on obervation of the medication stage rooms in Cherry Living Unit revealed three urinary catheter kits with an expiration date of 02/13 and a box of flush bags used for tube feeding with and expiration date of 02/12. In an interview with Staff H (LN) revealed the medication storage rooms are routinely checked but this was not documented. Staff H stated the flush bags found were from a tube feeding system no longer used, but she was unable to explain why they remained available in the storage room. ASPEN LIVING UNIT On 11/07/13 at 4:00 p.m., two boxes of 3 inch by 3 inch gauze were found that had expired 04/12. These were located on "Aspen Left." At 4:15 p.m. seven tracheostomy care kits were found that had expired 08/13. These were located on "Aspen Right." At 4:30 p.m. Staff L (LN) was present and confirmed the items were expired.	F 431		
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.	F 441		

RECEIVED

DEC 02 2013

DSHS/ADSA/ROB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL, PAT N			STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15TH NORTHEAST SEATTLE, WA 98155	
(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 17 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and records review the facility failed to ensure staff completed handwashing, proper gloving, and proper use of medical supplies. This failure put residents at risk for an environment that was not safe or sanitary	F 441	<u>F 441- The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help to prevent the development and transmission of disease and infection</u> A) Hand washing during dining B) B) Infection control related to resident care C) Proper gloving and hand washing during resident care A) <u>Hand washing during dining</u> 1. Staff will be trained on instructions developed for hand washing during meal time as well as hand washing in general. This will include the procedure for hand washing and the development of a hand washing checklist. This will be monitored by the RN 3 and training will be completed by the RN 2's. 2. The RN 3 and the DDA 1 will each complete 6 meal time observations each month over two shifts. The DDA 1 will receive additional training related to hand washing for observation purposes. Once completed they will be turned into the RN 4 for review and any necessary corrective action.	

RECEIVED

DEC 02 2013

DSHS/ADSA/RCS

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

PRINTED: 11/14/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/08/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL, PAT N	STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15TH NORTHEAST SEATTLE, WA 98155
---	--

(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 and increased the chance of the spread of infection.</p> <p>Findings include:</p> <p>HANDWASHING DURING DINING</p> <p>On 11/06/13 at 8:16 a.m., Resident #6 was being fed by Staff O in the Aspen dining hall. At 8:17 a.m. Staff O stopped feeding the resident to answer a ringing telephone. Staff O took the container of food with her. When done with the telephone, the staff went back to continue feeding the resident, without any handwashing. At 8:28 a.m., Staff O scratched her face and went to answer the telephone again. Feeding then resumed again without any handwashing.</p> <p>On 11/06/13 at 9:34 a.m., Staff O indicated handwashing was necessary in between residents, but stated in these cases handwashing was not needed.</p> <p>INFECTION CONTROL RELATED TO RESIDENT CARE</p> <p>On 11/05/13 at 10:45 a.m. Staff CC dropped a plastic medication cup on the floor and when picked up placed it back on the bottle of medication in the medication cart. His response was, "I caught it on the bounce."</p> <p>PROPER GLOVING AND HANDWASHING DURING RESIDENT CARE</p> <p>On 11/05/13 between 3:13 p.m. and 3:30 p.m., Staff Y, an LN was observed to enter a resident's room space to administer a medication and</p>	F 441	<p>3. The observation forms will be reviewed at the QA meetings and data will be collected to include action taken, number of staff observed and need to decide if additional observations should be made.</p> <p>B) <u>Infection Control Related to Resident Care</u></p> <p>The staff that dropped the medication cup on the floor will be trained on proper infection control practices to include: a) Hand washing, b) Use of Disposable Gloves, and c) Use of Sanitizing Gels and Foams. during medication administration by November 26, 2013.</p> <p>The "Quarterly Medication Administration Observation" form will be updated to include proper infection control practices and staff will be expected to demonstrate such practices during "med pass" observation periods.</p> <p>The LPN 4's will observe nurses' administering medication a minimum of one time each quarter.</p> <p>The "Quarterly Medication Administration Observation" form will be reviewed and the QA meeting at least quarterly and the group will discuss findings and any necessary further actions.</p>	
-------	--	-------	--	--

RECEIVED
DEC 02 2013
DSHS/ADSARCS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER FIRCREST SCHOOL, PAT N		STREET ADDRESS, CITY, STATE, ZIP CODE 15230-15TH NORTHEAST SEATTLE, WA 98155		
(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 exited the area wearing the same gloves.</p> <p>Although a hand washing sink was just outside the cubical curtain the staff exited the cubical wearing the gloves. Staff Y, then opened the door handle and exited the room. She then crossed the room and sat at a table outside the nursing station. The gloves were not removed until she was seated at the desk. Staff Y then flipped through pages in the log on the counter, used the phone on the desk and ran her hand across the table top surface. When asked how she sanitized her hands, the staff pointed to a dispenser containing sanitizer mounted on the wall.</p> <p>Staff Y touched the cubical curtain, the room door handle with the soiled gloves. Even though the gloves were removed while Staff Y was seated at the desk, not completing hand hygiene after removing the gloves increased the risk that contaminants could be transferred to the surfaces she touched (i.e. the phone, the log and the surface of the desk top.) Although Staff Y, stated hand sanitizer was used after the medication was administered, she did not approach the dispenser device until asked how hand hygiene was completed after administering a suppository.</p>	F 441	<p>C) Proper Gloving and Hand washing during resident care.</p> <p>A. Gloving observation form will be developed.</p> <p>2. The licensed nurse that demonstrated improper gloving and hand washing during client care will be trained by November 26, 2013 by the LPN 4.</p> <p>3. The RN 3 and/or designee will provide the re-training for nurses and direct care staff.</p> <p>4. The findings for the staff training on hand washing and gloving will be presented to the QA group for review and any necessary action.</p> <p>A,B,and C:</p> <p>5. Facility staff will be trained on procedures: a) Hand washing, b) Use of Disposable Gloves, and c) Use of Sanitizing Gels and Foams. This will also be done annually and added to the annual training check list.</p> <p>Person Responsible: Director Completion Date: December 18, 2013</p>	

RECEIVED

DEC 02 2013

DSHS/ADSA/RCS