

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

PRINTED: 01/13/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505437	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/31/2014
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NAME OF PROVIDER OR SUPPLIER  BOOKER REST HOME ANNEX	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 SOUTH 3RD STREET DAYTON, WA 99328
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

F 000

This report is the result of an unannounced Abbreviated Survey conducted at Booker Rest Home Annex on December 31, 2014. A sample of 4 residents was selected from a census of 82 residents. The sample included 4 current residents.

The following was a complaint investigated as part of this survey:

#3062692

Patti Zimmer, R.N.

The survey team is from:  
Department of Social & Health Services  
Aging & Long Term Support Administration  
Residential Care Services, District 1, Unit C  
3611 River Road, Suite 200  
Yakima, Washington 98902

Telephone (509) 225-2800  
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**RECEIVED**  
JAN 30 2015  
DSHS ADSA RCS  
SPOKANE WA

Cindy Co. [Signature] 1/12/15  
Residential Care Services Date

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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[Signature] CEO 1/22/15

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 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure the protection of 1 of 3 female residents (#1), from an incident of inappropriate physical contact by a male resident (#2), as a result of inadequate supervision. Failure to adequately supervise the male resident placed other residents at risk. Findings include:</p> <p>Review of facility investigation reports dated 10/23/14 and 11/29/14 revealed Resident #2 was involved in two incidents related to inappropriate touching of two female residents. Following the incident on 11/29/14, the plan for prevention was for 1:1 supervision of Resident #2 by staff when he was up in his wheelchair.</p> <p>Review of a facility investigation report dated 12/15/14 revealed Resident #2 was witnessed by a dietary aide to have his right hand resting on Resident #1's left thigh, close to her perineal area, during the dinner meal. The investigation report documented Resident #1 was seated in her wheelchair at a dining room table, with Resident #2 seated next to her. Staff A (Nursing Assistant) was present at the same dining room table during the incident, and was assisting</p>	F 323	<p>On 12/15/2014 resident #2's care plan was updated to have the resident to sit in a stationary chair with a bedside table in the dining room during meal times where they could not reach out and touch female residents. Resident #2's sitting arrangement is located in the dining room where staff can provide one to one supervision at all times during meals. Resident #2's care plan was also updated on 01/09/2015 to not place resident #2 within reaching distance of female residents, and to place the resident behind nurses station with a cup of coffee, newspaper, and etc. with 1:1 supervision until meal time is ready. Resident #2's care plan continues to have the following interventions in place: Q shift behavior monitoring; If resident makes inappropriate gestures or comments ask the resident to stop and remind them it is inappropriate; report behaviors to nurse; Offer resident to sit in the foyer in recliner; Involve family if available;</p>	1/9/2015

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F 323	<p>Continued From page 2</p> <p>another resident with his meal. She did not witness the incident.</p> <p>A telephone interview on 12/31/14 at 5:47 p.m. with Staff A revealed she was at a dining room table feeding Resident #1 (seated to her left), and Resident #3 (a male resident seated on her right side). She stated Resident #2 was seated on the other side of Resident #1. She said she was unaware Resident #2 was inappropriately touching Resident #1, as she had her "head turned the other direction" to feed Resident #3. It was at that time the dietary aide witnessed the inappropriate touching and separated the two residents.</p> <p>Despite the protective intervention of 1:1 staffing for Resident #2 to prevent further incidents of inappropriate physical contact, staff failed to implement that plan to safeguard residents.</p>	F 323	<p>Bring resident to the DNS; SSD/AD; or nurses station for one to one monitoring; Transfer resident to a regular dining room chair from wheelchair during meals; involve and offer resident to attend early afternoon activities such as exercise group, reminisce, arts and crafts, and etc.; After meals ask resident if they would like to go watch television in their room, if not staff will provide 15 minute increments of 1:1 time until resident is ready to go to their room; The resident is to be a 1:1 with staff when up in wheelchair; If resident is expressing behaviors even after proper education change caregivers or get two caregivers to assist with cares. These interventions are monitored by the charge nurses and DNS.</p>		