| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505389 | A. BUILDING _____ B. WING _____ | 03/09/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| AVAMERE REHABILITATION OF CASCADE PARK | 801 SOUTHEAST PARK CREST AVENUE VANCOUVER, WA 98683 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
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| F 0550<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>. Based on observation and interview, the facility failed to ensure residents were treated with dignity when entering resident rooms in one of three resident halls (300 hallway) reviewed for dignity and resident rights. This failure placed residents at risk for diminished feelings of self-worth and a decreased quality of life. Findings included . On 03/02/2020 at 11:58 AM, Resident #47 said since her admission to the facility, there had been several incidents of staff not knocking or announcing themselves prior to entering the resident's room. On 03/05/2020 at 8:21 AM, during the breakfast meal hall tray pass, Staff P, Certified Nursing Assistant, was observed entering room [ROOM NUMBER]. Staff P did not knock or announce herself prior to entering the resident's room. At 8:22 AM, Staff P was observed entering room [ROOM NUMBER]. Staff P did not knock or announce herself prior to entering the resident's room. At 8:33 AM, Staff P was observed entering room [ROOM NUMBER]. Staff P did not knock or announce herself prior to entering the resident's room. At 10:04 AM, Staff P was observed entering room [ROOM NUMBER]. Staff P did not knock or announce herself prior to entering the resident's room. At 1:22 PM, Staff P said staff were expected to knock on residents' doors or announce themselves prior to entering residents' rooms. Staff P said knocking or announcing oneself was to ensure staff were observing residents' privacy and respecting their space. At 2:55 PM, Staff B, Registered Nurse and Director of Nursing Services, said staff were expected to announce themselves prior to entering residents' rooms. Staff B said this was done as a courtesy to residents and all staff received training in dignity during new staff orientation. Reference WAC 388-97-0180(1-4) . |
| F 0578<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>. Based on interview and record review, the facility failed to ensure the Power of Attorney (POA) or primary health care decision maker for cognitively impaired residents was identified and failed to have follow up procedures to ensure Advance Directives (AD) were obtained for two of seven sampled residents (#75 & 85) reviewed for AD. This failure placed residents and legal representatives at risk for not having the opportunity to make decisions about end of life care. Findings included . 1) Resident #75 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Comprehensive Plan of Care, dated 02/21/2020, showed the resident was unable to understand advance directives information due to advanced dementia. A Surrogate Decision Making Hierarchy form, undated, documented (daughter) may be POA, (resident) wasn't sure. On 03/04/2020 at 2:31 PM, Staff E, Social Services, was unable to locate documentation of the resident's POA. Staff E stated, This is a good lesson to me to always double check and to have a better process in place going forward. 2) Resident #85 was admitted to the facility on [DATE]. The MDS, dated [DATE], showed the resident was cognitively intact and required extensive assistance with ADLs. A progress note, dated 0[DATE], showed, (Resident #85) has an Advance Directive and a copy is to be obtained for medical records. A copy was not located in the resident's health record. On 03/04/2020 at 10:38 AM, Staff E said social services were responsible for obtaining ADs during the intake process. At 10:45 AM, Staff F, Social Services, stated We just don't follow up because most people are short stay. At 11:03 AM, Staff A, Administrator, said he was not aware social services did not have a process in place to follow up on AD. Staff A said it was his expectation social services would continue to follow up until the AD was provided to the facility. Reference WAC 388-97-0280 (3)(c)(i-ii), -0300 (1)(b), (3)(a-c) . |
| F 0623<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>. Based on interview and record review, the facility failed to ensure residents and representatives were provide a written notice of transfers for three of three sampled residents (#8, 59 & 48) reviewed for hospitalization . This failure placed residents and resident representatives at risk of not being fully informed to make decisions about transfers and not having access to an advocate who could inform about options and rights. Findings included . 1) Resident #8 was admitted to the facility on [DATE]. The Minimum Data Set (MDS), an assessment tool, dated 12/01/2019, documented the resident was cognitively intact. Progress notes, dated 12/10/2019, showed the resident had an unplanned transfer to the hospital on [DATE]. The resident's health record showed the resident and/or representative was not provided a written transfer notice information including the reason for the transfer. 2) Resident #59 was admitted to the facility on [DATE]. The MDS, dated [DATE], documented the resident was severely cognitively impaired. Progress notes, dated 10/22/2019, showed the resident had an unplanned transfer to the hospital on [DATE]. The resident's health record showed the resident and/or representative was not provided a written transfer notice including the reason for transfer.<br><br>3) Resident #48 was admitted to the facility on [DATE]. The MDS, dated [DATE], documented the resident was cognitively intact. A nursing progress note documented Resident #48 had an unplanned transfer to the hospital on [DATE]. Resident #48's health record showed the resident and/or representative was not provided a written transfer notice including the reason for transfer. On 03/05/2020 at 3:48 PM, Staff R, Licensed Practical Nurse, said the transfer packet was provided to the ambulance personnel. Staff R said there was no formal transfer form for residents. Staff R said she was unsure if residents received any information from the packet. At 4:14 PM, Staff A, Administrator, said the facility had not been giving residents and/or their representatives a written notice of transfer which identified the reason for transfer. Reference WAC 388-97-0120 (2)(a-d) and -0140 (1)(a)(b)(c)(i-iii) . |
| F 0625<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>. Based on interview and record review, the facility failed to provide written bed hold notices at the time of transfer to |

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

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| F 0625<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 1)<br>the hospital for two of three sampled residents (#8 & 59) reviewed for hospitalization . This failure placed the residents at risk for lack of knowledge regarding their right to hold their bed while in the hospital. Findings included . 1) Resident #8 was admitted to the facility on [DATE]. The Minimum Data Set (MDS), an assessment tool, dated 12/01/2019, documented the resident was cognitively intact. Progress notes, dated 12/10/2019, showed the resident had an unplanned transfer to the hospital on [DATE]. The resident's Bed Hold Notice, dated 12/11/2019, showed the amount of the daily bed hold rate was left blank. Resident #8's medical record showed no documentation the resident and/or the resident's representative received a written copy of the bed hold form. 2) Resident #59 was admitted to the facility on [DATE]. The MDS, dated [DATE], documented the resident was severely cognitively impaired. Progress notes, dated 10/22/2019, showed the resident had an unplanned transfer to the hospital on [DATE]. The resident's Bed Hold Notice, dated 10/23/2019, showed the amount of the daily bed hold rate was left blank. Resident #59's medical record showed no documentation the resident and/or the resident's representative received a written copy of the bed hold form. On 03/05/2020 at 3:05 PM, Staff Y, Admissions Coordinator, said admissions staff called the resident's family members to ask if they wanted the resident's bed held. Admissions staff then completed the Bed Hold Form and sent a copy to medical records. Staff Y said admissions staff did not send the written notice of the bed hold to residents and/or their representatives. At 4:14 PM, Staff A, Administrator, said the facility had not offered residents and/or their representatives a written notice of the bed hold explaining the cost. Reference WAC 388-97-0120 (4) . |
| F 0656<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>. Based on observation, interview and record review, the facility failed to develop and implement a comprehensive care plan for one of four sampled residents (#342) reviewed for pressure ulcers. This failure placed residents at risk for unmet care needs and a diminished quality of life. Findings included . Resident #342 was admitted to the facility on [DATE]. The Minimum Data Set (MDS), an assessment tool, dated 02/19/2020, showed the resident had a foot ulcer present on admission. The Care Area Assessment, of the MDS, showed the pressure ulcer/injury should be care planned. Resident #342's comprehensive care plans, initiated 02/15/2020, showed the resident's left heel wound was not care planned. On 03/03/2020 at 8:06 AM, Resident #342 said she had a scab on her left heel. On 03/05/2020 at 9:10 AM, the resident's left heel was observed with a dry scab, the size of a nickel. At 10:11 AM, Staff FF, Registered Nurse and Case Manager, said care planning started with the admission nurse and then was updated as needed by the Resident Care Manager (RCM). After reviewing Resident #342's care plan, Staff FF said she did not see a care plan for the left heel wound. At 10:24 AM, Staff H, RN and RCM, said there was not a care plan in place specific to the left heel wound for Resident #342. Staff H said the left heel wound should have been care planned. Reference WAC 388-97-1020(1), (2)(a)(b) . |
| F 0677<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide care and assistance to perform activities of daily living for any resident who is unable.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>. Based on observation, interview and record review, the facility failed to provide dependent residents assistance with activities of daily living (ADLs) including shaving for one of two sampled residents (#59) reviewed for ADLs. This failure placed residents at risk for poor hygiene, loss of dignity and a diminished quality of life. Findings included . Resident #59 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set, an assessment tool, dated 01/29/2020, showed the resident did not reject care and required extensive assistance with ADLs. On 03/02/2020 at 3:39 PM, the resident was observed unshaven with scruffy facial hair. On 03/03/2020 at 7:55 AM, the resident was observed being assisted into the dining room for breakfast with unshaven, scruffy facial hair. Resident #59's shower documentation showed the resident had received a shower on 03/03/2020. The resident's health record showed no documentation of the resident refusing showers or being shaved. On 03/04/2020 at 7:52 AM, the resident was observed sitting in a wheelchair in a dining room with scruffy facial hair. On 03/05/2020 at 8:04 AM, the resident was observed sitting in the dining room waiting for breakfast with unshaven, scruffy facial hair. At 2:33 PM, the resident was observed unshaven in his wheelchair in front of the 100 hall nursing station. On 03/06/2020 at 8:35 AM, Staff G, Certified Nursing Assistant, stated, On shower days, (residents) get their nails done and shaved if they want to. If they refuse, we try again later and always let the nurse know so they can follow up as well. We chart on our tablets. At 10:33 AM, Staff K, Registered Nurse (RN), stated, Yes, I work with (Resident #59); and no one has ever reported to me that he has refused anything. At 10:55 AM, Staff H, RN and Resident Care Manager, said shaving generally happened on shower days. Staff H said there was no documentation Resident #59 refused showers or being shaved. At 12:36 PM, the resident was observed with unshaven, scruffy facial hair in the 100 hall dining area. Reference WAC 388-97-1060 (2)(c) . |
| F 0684<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>. Based on observation, interview and record review, the facility failed to ensure care and services were provided to identify, assess, and monitor non-pressure skin issues for two of three sampled residents (#59 & 242) reviewed for non-pressure skin. This failure placed residents at risk for discomfort, a change in health status and a diminished quality of life. Findings included . 1) Resident #59 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS), an assessment tool, dated 01/29/2020, showed the resident required extensive assistance with activities of daily living (ADLs) and had no documented skin issues. Resident #59's March 2020 Treatment Administration Record (TAR) showed a treatment for [REDACTED]. The treatment was signed off as completed on 03/01/2020 and 03/03/2020 by licensed staff. The January 2020, February 2020 and March 2020 TAR showed there was no documentation of new skin issues on the TAR between January 2020 and March 2020. On 03/05/2020 at 2:35 PM, when asked if Resident #59 currently had any skin issues, Staff H, Registered Nurse (RN) and Resident Care Manager (RCM), stated, No, none that I am aware of. After reviewing Resident #59's medical record, Staff H was unable to locate documentation showing any skin impairment. At 2:37 PM, Resident #59's right inner ankle was observed, with Staff H, with a small, approximately 0.5 centimeter, round open area, without drainage and odor. The open area was surrounded by a circular area, that blanched in some areas, was the size of a quarter. There was no dressing in place. At 3:21 PM, Staff H said the procedure for a new skin impairment was to complete an incident report, including notification of the MD to inform, obtain orders, and the resident placed on alert. Staff H said the RCM should have been notified. Staff H said the process was not followed.<br><br>2) Resident #242 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #242's alteration in skin integrity care plan, revised 02/27/2020, documented bruising to the resident's bilateral upper extremities and bilateral hands. The care plan did not include bruising to the resident's abdomen. Resident #242's March 2020 TAR documented the resident had a skin check conducted on 03/01/2020. The TAR did not include monitoring of bruises on the resident's abdomen. On 03/02/2020 at 2:46 PM, Resident #242 was observed with multiple black and purplish bruises, varying in size, on the abdominal area. The resident said she believed the bruises on her stomach were due to [MED] and anticoagulant injections. On 03/06/2020 at 10:10 AM, Staff Q, RN, said monitoring of newly identified non-pressure skin issues, such as bruising, should be identified during weekly skin checks, then documented and monitored on the TAR. After reviewing Resident #242's March 2020 TAR, Staff Q was unable to find documentation of the resident's abdominal bruising. Staff Q said the resident had a scattering of approximately ten bruises over the resident's abdomen and stated, These should be documented. At 10:21 AM, Staff C, RN and RCM, said non-pressure skin issues, such as bruising, were to be identified and monitored on the TAR. Staff C said monitoring should be in place to determine if the identified skin issue had resolved or worsened. Staff C said Resident #242's abdominal bruising had not been identified and monitored. At 1:09 PM, Staff B, RN and Director of Nursing Services, said she would expect staff to identify and monitor residents' non-pressure skin issues on the TAR. Staff B said newly identified skin issues should be identified during weekly skin checks. Reference WAC 388-97-1060 (1) . |

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| F 0684<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 2) |
| F 0695<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide safe and appropriate respiratory care for a resident when needed.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>. Based on observation, interview and record review, the facility failed to ensure safe handling and storage of nebulizer machines (breathing machines) for 2 of 4 sampled residents (#243 & 48) reviewed for respiratory care. This failure placed residents at risk for potential infection and a decline in health status. Findings included . The facility policy entitled, Departmental (Respiratory Therapy) Prevention of Infection, Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol, revised April 2012, documented nebulizers were to be stored in a plastic bag and marked with the date and resident's name between uses. 1) Resident #243 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS), an assessment tool, dated 02/26/2020, documented the resident was cognitively intact and required extensive assistance with activities of daily living (ADLs). Resident #243's respiratory care plan, revised 0[DATE]20, noted interventions including medications per order and medical nebulizer. Resident #243's March 2020 Medication Administration Record [REDACTED]. On 03/02/2020 at 3:58 PM, Resident #243's nebulizer machine was observed sitting on top of the resident's nightstand. The hand held mouthpiece/mask was observed resting on top of the resident's nightstand, uncovered. On 03/03/2020 at 10:15 AM, the resident's nebulizer machine was observed sitting on top of the resident's nightstand. The hand held mouthpiece/mask was observed resting uncovered on top of the resident's nightstand. On 03/04/2020 at 3:33 PM, Resident #243's nebulizer machine was observed sitting on top of the resident's nightstand. The hand held mouthpiece/mask was observed uncovered on top of the resident's nightstand. On 03/05/2020 at 4:18 PM, the resident's nebulizer machine was observed sitting on top of the resident's nightstand. The hand held mouthpiece/mask was observed uncovered on top of the resident's nightstand. On 03/06/2020 at 1:33 PM, Resident #243's nebulizer machine was observed sitting on top of the resident's nightstand. The hand held mouthpiece/mask was observed uncovered on top of the resident's nightstand. 2) Resident #48 was admitted to the facility on [DATE]. The MDS, dated [DATE], documented the resident was cognitively intact and required extensive assistance with ADLs. Resident #48's March 2020 MAR indicated [REDACTED]. On 03/04/2020 at 10:05 AM, Resident #48's nebulizer machine was observed sitting on top of the resident's nightstand. The hand held mouthpiece/mask was observed uncovered resting on top of the nebulizer unit. On 03/05/2020 at 4:15 PM, the resident's nebulizer machine was observed sitting on top of the resident's nightstand. The hand held mouthpiece/mask was observed uncovered resting on top of the nebulizer unit. On 03/06/2020 at 1:35 PM, Resident #48's nebulizer machine was observed sitting on top of the resident's nightstand. The hand held mouthpiece/mask was observed uncovered on top of the nebulizer unit. On 03/06/2020 at 1:36 PM, Staff B, Registered Nurse and Director of Nursing Services, said she expected residents' nebulizer masks to be covered in the nebulizer container. After observing the nebulizer machines for Resident #243 and Resident #48, Staff B said the masks were not covered for both units. Staff B said she was not certain of the facility's policy for storing nebulizer units. On 03/09/2020 at 10:02 AM, Staff B indicated she located the facility policy for storing nebulizers. Staff B said nebulizers should be cleaned and stored covered/bagged after each use. Reference WAC 388-97-1060 (3)(j)(ix) . |
| F 0698<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Past noncompliance - remedy proposed**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>. Based on interview and record review, the facility failed to ensure ongoing communication with [MEDICAL TREATMENT] staff and resident assessments before and after [MEDICAL TREATMENT] treatment were completed for one of one sampled residents (#2) reviewed for [MEDICAL TREATMENT] services. This failure placed residents at risk for medical complications [REDACTED]. Findings included . Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 03/02/2020 at 11:21 AM, the resident said she received [MEDICAL TREATMENT] treatment three times per week. The resident said when she went to treatments she did not take paperwork or packet of information with her. [MEDICAL TREATMENT] progress notes, dated 02/01/2020 through 03/03/2020, showed three of 14 times staff documented the resident assessment before and after [MEDICAL TREATMENT]. On 03/04/2020 at 1:50 PM, Staff S, Registered Nurse (RN), stated, For our [MEDICAL TREATMENT] residents, we do a weight check, vital signs, lung sounds and a fistula check and chart under the [MEDICAL TREATMENT] tab before the resident goes to [MEDICAL TREATMENT]. (Residents) do not take a binder or packet of information with them, just medications as needed and a sack lunch or snack. The transportation is already arranged and we just have them ready to go. If (the [MEDICAL TREATMENT] staff) have any questions, they call us. When (residents) come back, we do the same checks, vital signs, weights as ordered and their site; and document it under the [MEDICAL TREATMENT] tab. On 03/05/2020 at 8:40 AM, Staff U, RN and Resident Care Manager (RCM), stated, For residents on [MEDICAL TREATMENT], staff should be charting, both when they leave and when they return from [MEDICAL TREATMENT], in the [MEDICAL TREATMENT] progress notes. At 10:52 AM, Staff C, RN and RCM, stated, For our [MEDICAL TREATMENT] residents, the nurses should be documenting twice a day, once before they leave and once when they come back from [MEDICAL TREATMENT]. They should be charting under the [MEDICAL TREATMENT] tab which will automatically go into regular progress notes. We do not send any paperwork with them to [MEDICAL TREATMENT]. At 11:18 AM, Staff B, RN and Director of Nursing Services, stated, We do not have a specific policy or procedure to tell nurses what to do with [MEDICAL TREATMENT] residents. The expectation is they will do an assessment before leaving for [MEDICAL TREATMENT] and assess when they come back and document that assessment. I checked and we were not consistently doing that. Reference WAC 388-97-1900 (1),(6)(a-c) . |
| F 0732<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **Post nurse staffing information every day.**<br><br>. Based on interview and record review, the facility failed to maintain daily nurse staff posting records 11 of 18 months (October 2018 through March 2020) reviewed. This failure placed residents at risk of not being fully informed of the facility's staffing information and have readily available for review of facility's staffing records. Findings included . A review of the facility's daily nurse staff postings for the last 18 months, October 2018 through March 2020, showed the facility retained seven months of daily staff posting records. The facility was unable to provide documentation for 18 months of daily nurse posting records. On 03/09/2020 at 1:37 PM, Staff X, Staffing and Scheduling Coordinator, said the facility kept record of daily staff postings for seven months, and did not retain these records for 18 months. Staff X stated, I wasn't told I had to. At 1:41 PM, Staff A, Administrator, said he was unaware of how long the facility needed to retain daily staff postings. Staff A said he knew the facility was required to retain postings, but did not know the regulation specified 18 months. No Associated WAC . |

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| F 0757<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure each resident's drug regimen must be free from unnecessary drugs.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>. Based on interview and record review, the facility failed to ensure as needed (PRN) medications had adequate indications for use (parameters) for 2 of 5 sampled residents (#75 & 47) reviewed for unnecessary medications. This failure placed residents at risk for receiving incorrect dosages of medications, medical complications [REDACTED]. Findings included . 1) Resident #75 was admitted to the facility on [DATE]. The Minimum Data Set (MDS), an assessment tool, dated 02/05/2020, documented the resident was severely cognitively impaired and required extensive assistance with activities of daily living. Resident #75's March 2020 Medication Administration Record [REDACTED]. There was no indication at what level of temperature would be considered a fever.<br><br>2) Resident #47 was admitted to the facility on [DATE]. The MDS, dated [DATE], documented the resident was alert and oriented. Resident #47's March 2020 MAR indicated [REDACTED]. There was no indication what specific temperature would be considered a fever. On 03/05/2020 at 10:21 AM, Staff AA, Registered Nurse (RN), said he would administer PRN Tylenol for any temperature above 98.6 F. When asked where he would find specific direction, Staff AA stated, We follow the facility's standing orders. Staff AA provided an undated document entitled, CRM Physicians LLC, Nursing Standing Orders, which instructed PRN Tylenol/APAP is to be given for fever above 99 F. At 10:39 AM, Staff C, RN and Resident Care Manager, said the guidelines were for staff to administer PRN Tylenol for a temperature 2 degrees above the resident's baseline, and indicated staff would know what the resident's baseline temperature was. At 11:17 AM, Staff B, RN and Director of Nursing Services, said a fever was considered to be 2 degrees above the resident's baseline temperature. When asked how staff would know to give PRN Tylenol at 2 degrees above the resident's baseline temperature, Staff B stated, They just know it, like we know normal body temperature is 98.6 F. On 03/09/2020 at 11:43 AM, Staff R, Licensed Practical Nurse, said she would administer Tylenol for a temperature above 99 degrees. Staff R indicated there were no parameters in Resident #75's order for Tylenol specifying what temperature to administer the medication. Reference WAC 388-97-1060 (3)(k)(i) . |
| F 0761<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | **Ensure drugs and biologicals used in the facility are labeled in accordance with** |

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| F 0761<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | (continued... from page 3)<br>**currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>. Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were discarded when expired in 1 of 2 medication storage rooms reviewed for medication storage. This failure placed residents at risk of receiving expired medications, less effective medications and a diminished quality of life. Findings included . On 03/06/2020 at 1:31 PM, a brown paper bag with a resident's name was found on the shelf in the 300 Hall medication storage room. The bag contained several containers of prescription and over-the-counter medications including a bottle of [MEDICATION NAME] which expired on 03/03/2020; a bottle of [MED] with an expiration of 02/07/2020; and a bottle of [MEDICATION NAME] which expired 02/07/2020. At 1:44 PM, Staff Z, Registered Nurse (RN) and Resident Care Manager, said the resident (name on the paper bag) had discharged from the facility in October 2019. Staff Z said the medications should have gone home with the resident upon discharge. Staff Z said no individual staff was identified to be responsible for discarding expired medications and all nursing staff should monitor expiration dates. On 03/09/2020 at 11:24 AM, Staff B, RN and Director of Nursing Services, said her expectation was expired medications should be immediately disposed of, and all medication rooms and carts cleaned out weekly. Reference WAC 388-97-1300 (2) . |
| F 0812<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.**<br><br>. Based on observation, interview and record review, the facility failed to maintain clean and sanitary food storage and ice machine areas on 2 of 3 clean utility room pantry areas (100 hall and 300 hall) reviewed for food storage and distribution. This failure placed residents at risk for cross contamination and food borne illness. Findings included . On 03/05/2020 at 10:30 AM, the 100 hall clean utility storage area was observed. The refrigerator had multiple dried spills that were pink and brown colored on the bottom shelf and towards the back of the refrigerator. There was no documentation showing a cleaning schedule for the refrigerator. At 10:40 AM, the 300 hall clean utility storage area was observed. The refrigerator was observed to have multiple areas of dried matter inside the door, on the shelves and on the outside of the door. At 10:42 AM, the 300 hall utility room ice machine was observed to have an ice scoop dripping onto two folded washcloths that were stained a brown color. The surrounding floor had multiple paper towels and debris on it. At 10:45 AM, the 300 hall utility room coffee machine on the counter near the refrigerator had three boxes of tissue stacked on top of it. Part of the cardboard of the bottom box was observed to be stuck in patches to the top of the coffee machine. The counter around the coffee machine had multiple dried pink stains. There was no documentation showing a cleaning schedule for the refrigerator, ice machine area and coffee machine. At 11:00 AM, Staff J, Dietary Manager, said the dietary staff were responsible for stocking refrigerators and checking refrigerator temperatures. Maintenance staff were responsible for cleaning the ice machines and housekeeping staff were responsible for cleaning the refrigerators. Staff J stated, As far as I know, there is no check off list or cleaning schedule for the refrigerators. Staff J said he would expect all the clean utility areas to be maintained in a clean and sanitary manner. Reference WAC 388-97-1100 (3), 2980 . |
| F 0880<br><br>**Level of harm** - Immediate jeopardy<br><br>**Residents Affected** - Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>. Based on observation, interview and record review, the facility failed to ensure infection control procedures, including hand hygiene, use of designated equipment and surveillance of infections, were being followed to prevent the spread of infectious diseases within the facility for six of 10 sampled residents (#9, 40, 10, 43, 76 & 78) and four of four observed staff (Staff EE, BB, DD & CC) reviewed for infection prevention and control. These failures placed residents at risk for an influenza outbreak and spread within the facility and a diminished quality of life. This failure resulted in an Immediate Jeopardy on 03/03/2020. The immediacy was removed on 03/05/2020 when the facility educated staff on hand hygiene and validated competencies in infection control practices. Findings included . The facility's policy and procedure entitled, Infection Prevention and Control Program, revised August 2016, showed the following steps to be taken for prevention of infection and outbreak management including: *Preventing the spread to other residents *Educating the staff and the public *Educating staff and ensuring they adhere to proper techniques and procedures The facility's policy and procedure entitled, Influenza, Prevention and Control of Seasonal (sic) policy and procedure, revised April 2013, showed the following hygiene practices staff were to follow: *Droplet precautions will be initiated for suspected or confirmed influenza. *Staff will wear a face mask when entering a room of a resident with suspected or confirmed influenza. *Face mask will be removed and staff will perform hand hygiene when leaving the room. The facility's policy and procedure entitled, Handwashing/Hand Hygiene, revised April 2012, showed when hand washing/hand hygiene should be performed including: *Before and after direct resident contact *Before and after entering isolation precaution settings *Before and after assisting a resident with a meal <HAND HYGIENE> On 03/02/2020 at 10:31 AM, Staff B, Registered Nurse (RN) and Director of Nursing Services, said the facility had one confirmed resident with Influenza A and one resident pending the results from a flu swab (used to test for Influenza). At 12:16 PM, Staff EE, Activities Director, was observed bringing a beverage into room [ROOM NUMBER] for two residents. Staff EE did not perform hand hygiene after leaving the room. At 12:23 PM, Staff EE was observed stirring Resident #359's coffee in the 100 Hall dining room. Staff EE coughed into her right sleeve and left the dining room without performing hand hygiene. Staff EE returned to the dining room, put sugar into Resident #30's coffee, picked up Resident #30's spoon and stirred the coffee. On 03/03/2020 at 7:58 AM, Staff EE was observed to scratch her face and reach into a cupboard for brown sugar and syrup for Resident #17. Staff EE did not perform hand hygiene after touching her face. At 8:02 AM, Staff EE was observed wheeling Resident #22 into the dining room, adjusted the leg rest on the wheel chair, handed a creamer to Resident #292, rubbed Resident #22's back and then left the dining room. No hand hygiene was performed. Between 8:29 AM and 8:32 AM, Staff EE was observed entering three rooms on 100 Hall (room [ROOM NUMBER], 106 and 113) to deliver newspapers. Staff EE was observed opening blinds, moving bedside tables and touching bed linens in the resident's rooms. Staff EE was not observed to perform hand hygiene before entering or after exiting the rooms. At 9:17 AM, Staff EE said it was a good idea to wash hands anytime before entering and exiting a resident room. On 03/03/2020 at 3:28 PM, a Droplet Precautions sign was observed on the wall outside of room [ROOM NUMBER] included the following directions: *Steps before care: mask for staff and visitors upon entry into the room *Steps after care: Perform hand hygiene using proper handwashing techniques. At 3:28 PM, Staff BB, Social Services, was observed standing approximately three feet inside the doorway of room [ROOM NUMBER] (with the Droplet Precaution sign), talking to Resident #9 (positive for Flu) and Resident #76. Staff BB was holding a clipboard and was not wearing personal protective equipment (PPE). Resident #9 was sitting in her wheel chair interacting with Staff BB. The privacy curtain was not completely pulled between Resident #9 and Resident #76's sides of the room. At 3:33 PM, Staff BB was observed asking Resident #76 if her coffee was OK, told the residents she would visit with them later and left the room. Staff BB did not perform hand hygiene before leaving the room. Staff BB left room [ROOM NUMBER] and pushed through the closed fire door between 100 and 200 Hallways. Staff BB walked down 100 Hallway to the front of the facility, passing two wall mounted hand sanitizers along the way. Staff BB did not perform hand hygiene. At 4:50 PM, Staff BB said she had been trained on isolation precautions and the signs outside the room told staff what they were to do. When asked about performing hand hygiene when leaving room [ROOM NUMBER], Staff BB stated, I just really didn't think that I needed to wash. At 3:34 PM, Staff M, RN and Infection Preventionist, said staff should wash their hands before serving a meal and between assisting residents especially if touching the chair, table or other residents. Staff M said the expectation was all staff would use hand sanitizer going in and out of rooms and wash their hands with soap and water if they came into contact with body fluids. At 5:25 PM, Staff M said the expectation was for staff to perform some sort of hand hygiene every time entering and leaving a room with isolation precautions, even if not interacting with the affected resident. On 03/03/2020 at 4:22 PM, Staff DD, Certified Nursing Assistant (CNA), was observed entering Resident #343's room. No hand hygiene was observed. Staff DD adjusted the resident's bed linens. Staff CC, CNA, was in the room at the time and left to go to the nurse station. No hand hygiene was performed. Staff CC returned to the room without performing hand and transferred Resident #343 to bed. At 4:55 PM, Staff DD said hand hygiene should be done before entering and before |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505389 | A. BUILDING _____ B. WING _____ | 03/09/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| AVAMERE REHABILITATION OF CASCADE PARK | 801 SOUTHEAST PARK CREST AVENUE VANCOUVER, WA 98683 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0880<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Some | (continued... from page 4)<br>leaving a resident's room. Staff DD said she had not worked the three days prior and had not received any education regarding the influenza outbreak. At 5:00 PM, Staff CC said hand hygiene should be done before and after entering and exiting resident rooms. On 03/03/2020 at 5:03 PM, Staff M said three residents were now positive for Influenza A: *Resident #40, room [ROOM NUMBER]-2, was the first resident with confirmed Influenza A. The resident was diagnosed at the hospital on [DATE]. Resident #40 was admitted to the hospital and was not currently in the facility. *Resident #9, room [ROOM NUMBER]-2, was the second resident with confirmed Influenza A. The resident was diagnosed at the hospital and sent back to the facility on Droplet Precautions. *Resident #10, room [ROOM NUMBER]-1, was confirmed positive for Influenza A on 03/02/2020. At 5:10 PM, Staff M said staff were trained on 03/02/2020 on flu personal PPE and hand hygiene. Staff M said the education was facility wide for all staff. Staff M said the education did not include return demonstration or a post-test to validate understanding of flu PPE and hand hygiene. Review of the In-service Attendance Record, dated 03/02/2020 at 10:45 AM, 2:00 PM and 3:35 PM, showed Staff BB and Staff DD were not educated on flu PPE. There was no documentation night shift staff had received education regarding the flu outbreak or hand hygiene until 03/04/2020. On 03/03/2020 at 5:20 PM, Staff M said the roommate (Resident #76) of a resident on droplet precautions (Resident #9) should wash their hands before coming out of their room. On 03/05/2020 at 3:48 PM, Resident #76 was observed coming out of her room without performing hand hygiene first. Resident #76's roommate was positive for influenza A (Resident #9). Staff did not encourage Resident #76 to perform hand hygiene when she was observed to be outside of her room. On 03/06/2020 at 12:20 PM, Staff M said the facility tried to keep the roommate of a resident on droplet precautions in their room. Staff M said staff tried to encourage Resident #76 to perform hand hygiene before coming out of her room. At 12:30 PM, Staff M said the facility had five confirmed residents with influenza A. Staff M said all five residents lived on the 200 hall with rooms in close proximity: *Resident #9 in room [ROOM NUMBER]-2 *Resident #78 in room [ROOM NUMBER]-2 *Resident #10 in room [ROOM NUMBER]-1 *Resident #40 in room [ROOM NUMBER]-2 *Resident #43 in room [ROOM NUMBER]-1 <Designated Equipment> On 03/03/2020 at 5:30 PM, an isolation cart was observed outside of room [ROOM NUMBER]. A Droplet Precautions sign was on the wall outside the room. A stethoscope was sitting on top of the isolation cart. At 5:50 PM, an isolation cart was observed outside of room [ROOM NUMBER]. A Droplet Precautions sign was on the wall outside the room. A blood pressure cuff and stethoscope were sitting on top of the isolation cart. At 5:52 PM, Staff GG, RN, said the equipment (on the isolation carts) was for use on residents who had the flu or were being tested for the flu. Staff GG said the equipment should be cleaned and stored inside the isolation cart, not on top of it. At 6:00 PM, an isolation cart was observed outside of room [ROOM NUMBER]. A Droplet Precautions sign was on the wall outside the room. A stethoscope was sitting on top of the isolation cart. At 6:05 PM, Staff M said the dedicated vital sign equipment should be cleaned between use and stored inside the isolation cart, not on top of it. <Surveillance> Review of the facility's infection surveillance documentation showed the monthly line listing did not include the residents affected by the Influenza outbreaks in the facility in January 2020 and March 2020. On 03/06/2020 at 1:00 PM, Staff M said it was her understanding that only infections requiring antibiotics needed to be on the line list. Reference WAC 388-97-1320(1)(a), (1)(c), (2)(a) . |
| F 0883<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Develop and implement policies and procedures for flu and pneumonia vaccinations.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>. Based on interview and record review, the facility failed to ensure residents and/or resident representatives were educated on the risks and benefits, and the consents and declinations, of the influenza and/or pneumonia vaccines for five of five sampled residents (#49, 12, 66, 75 & 47) reviewed for immunizations. This failure placed residents at risk of not being fully informed before making decisions regarding immunizations and receiving vaccines. Findings included . 1) Resident #49 was admitted to the facility on [DATE]. Resident #49's immunization status was documented as Influenza 09/30/2019 historical, and [MEDICATION NAME] 07/28/2016 historical. No documentation of the risks and benefits of the influenza and/or pneumococcal vaccines and signed declination/consent was located in the resident's medical record.<br><br>2) Resident #12 was admitted to the facility on [DATE]. The resident's immunization record documented the resident declined an influenza vaccine and was ineligible for a pneumococcal vaccine. No documentation of the risks and benefits of the influenza and/or pneumococcal vaccines and signed declination/consent was located in the resident's medical record.<br><br>3) Resident #66 was admitted to the facility on [DATE]. Resident #66's immunization record documented PCV 13 (Pneumococcal conjugate vaccine) given 09/23/2015 historical, and PPSV23 (Pneumococcal [MEDICATION NAME] vaccine) given 03/04/2019 historical. No documentation of the risks and benefits of the influenza and/or pneumococcal vaccines and signed declination/consent was located in the resident's medical record.<br><br>4) Resident #75 was admitted to the facility on [DATE]. The resident's medical record documented the resident's representative consented to an influenza vaccine on 10/04/2019. No documentation the resident received the influenza vaccine was located in the medical record. Resident #75's Immunization record documented the resident refused the pneumococcal vaccines. No documentation was located in the medical record showing the resident received the risks and benefits of the pneumococcal vaccines and when the resident declined the vaccination. On 03/09/2020 at 10:35 AM, Staff M, Staff Development and Infection Control Preventionist, said Resident #75 refused the pneumococcal vaccine in 2015, and the consent form documenting the resident's declination of the vaccine should be in the resident's medical record. Documentation of the risks and benefits of the influenza and/or pneumococcal vaccines and signed declination/consent was not located in the resident's medical record.<br><br>5) Resident #47 was admitted to the facility on [DATE]. The resident's immunization record documented the resident received the influenza vaccine on 12/04/2019 historical, the PCV 13 on 02/07/2019 historical, and had not received the PPSV23. No documentation of the risks and benefits of the influenza and/or pneumococcal vaccines and signed declination/consent was located in the resident's medical record. On 03/04/2020 at 3:53 PM, when asked how influenza and pneumococcal vaccines were documented if resident already had them, Staff M stated, As historical, and I write the date they told me they got it. When asked if date provided by residents were verified, Staff M stated, No, I take their word for it. Reference WAC 388-97--1340 (1), (2), (3) . |