STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505421	A. BUILDING _____ B. WING _____	**03/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WASHINGTON ODD FELLOWS HOME	**534 BOYER AVENUE WALLA WALLA, WA 99362**

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)
F 0660 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Plan the resident's discharge to meet the resident's goals and needs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of two residents (#3) reviewed for discharge to the community received a timely referral to home health for required nursing services. This failure put the resident at risk for unmet nursing care needs. Findings included . Resident #3. Review of the resident's medical record showed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident had a urinary catheter (a device used to drain the bladder), a [MEDICAL CONDITION] (an artificial exit from the colon created to divert waste through a hole in the colon and through the wall of the abdomen), and had an active discharge plan to return to the community. During an interview on 03/12/2020 at 8:00 AM, a collateral contact stated Resident #3 was discharged to home on 02/10/2020 without home health care as promised. (Resident #3) needed nursing services for his [MEDICAL CONDITION] and to flush his PICC line. (Peripherally Inserted Central Catheter- a long intravenous (IV) line inserted in a smaller vein in the upper arm and terminates in a larger vein in the chest near the heart.) The home health agency did not contact the collateral contact until 02/13/2020. Review of Resident #3's discharge plan (with canceled date of 02/20/2020) showed the goal Resident was previously residing at home and anticipates return. Review of the interventions showed Social Services will continue to coordinate with Rehab Therapies, and Nursing to clarify Discharge Plan as appropriate. Review of a 02/07/2020 physician order [REDACTED]. Review of the physician's exam and plan on the same date showed the resident would continue receiving IV magnesium and Home Health was needed for nursing services. Review of a 02/07/2020 nursing progress note written at 5:12 PM (a Friday) showed the resident's daughter was notified of the discharge order, however she was not comfortable with (Resident #3) coming home without having proper ostomy supplies and also Home Health not available to provide PICC line care over the weekend. Monday am the HH (home health) referral will be made by MSW (Masters Social Work). Review of the 02/10/2020 transfer and discharge report for Resident #3 showed the reason for transfer was (Resident #3) no longer needs the 24 hr (hour) nursing care that (the facility) SNF (skilled nursing facility) provides. (Resident #3) is being discharged to a lesser level of care. During an interview on 03/13/2020 at 1:10 PM, Staff D, Social Services, stated that she recalled Resident #3's discharge on 02/10/2020 and stated she made the referral to home health on that day. Staff D was unable to locate a copy of the referral faxed to home health and stated I do not keep them. During an interview of 03/13/2020 at 2:15 PM, a Home Health collateral contact stated the referral for Resident #3 was sent from the facility on 02/12/2020. Review of the referral fax cover sheet from the facility showed it was sent to the Home Health agency on 02/12/2020 at 1:19 PM. Reference: WAC 388-97-0080
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure two of three residents (#1, 4) reviewed for use and care of a catheter (a flexible tube inserted into the bladder to drain urine), received appropriate care and services to minimize the risk of associated urinary tract infections. This failure placed residents with catheters at risk for complications. Findings included . Record review of the facility's undated policy titled, Catheter Site Care showed that after perineal care, staff should remove gloves, perform hand hygiene and don a new pair of non-sterile gloves (prior to) clean the catheter from the insertion site to approximately six inches distally with hospital approved cleanser and washcloths. Record review of the facility's undated policy titled, Hand Hygiene Policy & Procedure showed staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following strong recommendations for hand hygiene in healthcare settings. Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: * Immediately before touching a patient *Before moving from work on a soiled body site to a clean body site on the same patient *After contact with blood, body fluids, or contaminated surfaces *Immediately after glove removal Resident #1. Review of the resident's medical record showed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of a 01/13/2020 comprehensive assessment showed the resident was cognitively intact, required extensive assistance from two staff for dressing and toileting. The resident had an indwelling urinary catheter and was always incontinent of bowel. Observation on 03/13/2020 at 7:50 AM showed Staff E and Staff F, both Nursing Assistants (NA), perform incontinent care, catheter care and assisted Resident #1 with dressing. During this process, Staff F, wearing disposable gloves, brought a basin of water and washcloths to the bedside. Staff F unfastened and lowered the front of the resident's incontinent brief and cleaned around the [MEDICATION NAME] (a surgically created opening in the abdominal wall through which urine passes) and catheter tubing. Wearing the same gloves, Staff F assisted the resident to turn on the left side and cleaned liquid bowel movement with more washcloths. Wearing the now soiled gloves, Staff F disconnected the catheter tubing from a large urine collection bag and attached the tubing to leg bag. During an interview on 03/13/2020 at 8:10 AM, Staff F acknowledged the failure to remove the soiled gloves and perform hand hygiene prior to changing the resident to a leg bag. Resident #4. Review of the resident's medical record showed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of a 01/27/2020 comprehensive assessment showed the resident was cognitively intact, required assistance from staff for toileting and personal hygiene. The resident had an indwelling urinary catheter. Observation on 03/13/2020 at 9:40 AM showed Staff G, NA, provide catheter care for the resident. During the process, Staff G, wearing disposable gloves, placed washcloths in the bottom of the resident's hand washing sink to wet with warm water, squeezed out the excess water and brought to the resident's bedside. Wearing the same gloves, Staff G provided perineal care and catheter care. With the same soiled gloves, the NA got the leg bag from the resident's bathroom, disconnected the catheter tubing from the large urine collection bag and attached the tubing to the resident's leg bag. During an interview on 03/13/2020 at 9:40 AM, Staff G stated she would always set the washcloths in the bottom of the sink to wet them and did not know she should not do it. Staff G also acknowledged she should have changed her gloves and performed hand hygiene before changing to the leg bag. During an interview on 03/13/2020 at 10:00 AM, Staff H, Registered Nurse (RN) and Charge Nurse, stated that gloves should be changed and hands washed when going from soiled to clean tasks. When informed of the observations where gloves were not changed prior to handling catheter tubing to change to leg bags, Staff H stated that is not appropriate. Reference: WAC 388-97-1060 (3)(c)

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.