| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505431 | A. BUILDING _____ B. WING _____ | 03/05/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| BOTHELL HEALTH CARE | 707 - 228TH SOUTHWEST BOTHELL, WA 98021 |

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 0584<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to provide safe, sanitary and homelike environment to include the safe and sanitary use of wheelchairs for one of two residents (Resident #392) and therapy equipment, standing frame and positioning pillows for one of one (therapy gym) reviewed for safe sanitary homelike environment. These failures placed residents at risk for cross contamination and a decrease in quality of life. Findings included .<br>RESIDENT #392 Review of the quarterly Minimum Data Set (MDS, a required assessment tool), dated 02/25/20 showed that Resident #392 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS further showed that Resident #392 used<br>a wheelchair for mobility and was able to make needs known. Multiple observation on 02/26/20, 02/27/20 and 03/02/20 showed Resident #392's wheelchair had green colored tape approximately four inches wrapped around both of the wheelchair armrests which had tattered edges; however, the left armrest had a clear colored tape covering the green tape which was lifted on the edges. During an interview on 02/26/20 at 11:18 AM, Resident #392 stated that this was the wheelchair that was provided by the facility and when he received the wheelchair it had the green tape around the armrests. During an observation and interview on 03/02/20 at 12:29 PM, Staff C, Assistant Director of Nursing Services (ADNS), removed the clear colored tattered tape from Resident #392's wheelchair and stated that it was not a cleanable surface. THERAPY EQUIPMENT An observation on 03/02/20 at 1:15 PM, showed that the therapy standing frame had black colored tape that was covered with green tape that had areas of lifted and tattered edges. In addition, there were multiple positioning pillows that showed fuzzy like material attached to Velcro tape located on areas on the pillows. During an interview 03/02/20 at 1:31PM, Staff N, Therapy Manager, stated that the tape/Velcro applied to the standing frame and the positioning pillows would not be a cleanable surface. During an interview 03/02/20 at 1:35 PM, Staff A, Administrator, stated that the tape/Velcro that had been applied to the standing frame, positioning pillows and the tape that was tattered on Resident #392's wheelchair armrests, would not be a cleanable surface. Reference WAC 388-97-0880(1) . |
| F 0645<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **PASARR screening for Mental disorders or Intellectual Disabilities**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR) assessment was accurately completed upon or prior to admission to the facility for one of five residents (Resident #17) reviewed for PASRRs. This failure had the potential to place the resident at risk for inappropriate placement and/or not receiving timely and necessary services to meet ones mental health (MH) care needs. Findings included . Review of Resident #17's quarterly Minimum Data Set (MDS, a required assessment tool) dated 12/04/19, showed that the resident admitted on [DATE] with [DIAGNOSES REDACTED]. The MDS showed that Resident #17 received antidepressant medication and was<br>able to make needs known. Review of the physician order [REDACTED].#17 was prescribed [MEDICATION NAME] (a medication<br>used to treat depression) for the [DIAGNOSES REDACTED].#17's electronic health record (EHR) and paper chart on 03/04/20 at approximately 11:30 AM showed no PASRR completed and dated prior to admission to the facility. Review of Resident #17's document titled, Pre Admission Screening and Record Review Form (PASRR), completed by the facility showed that it was undated as to when it was completed. During an interview on 03/04/20 Staff L, Social Services Supervisor (SSS), stated that she was unable to locate Resident #17's documentation of a PASRR provided by the hospital prior to admit. In addition, Staff L, SSS, stated that Resident #17's PASRR completed by the facility was incomplete due to it was not dated. During an interview on 03/04/20 at 1:54 PM, Staff B, Director of Nursing Services (DNS) stated that it was her expectation that PASRRs were received from the hospital prior to the admission of a resident and if not received, the hospital should be contacted to send one to the facility as soon as possible. In addition, Staff B, DNS, stated that PASRRs completed by the facility should be signed and dated. Reference WAC 388-97-1975 . |
| F 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br><br>Based on observation, interview and record review facility failed to ensure safe use of a stove in one of four halls (200 hall) was nonoperational when left unattended. This failure placed residents at risk for avoidable injuries and environmental hazards. Finding included . Review of the facility's policy titled, Use of Stove in OT Kitchen, dated October 2018, showed, The stove is for the use of the activity department staff for food activities and for Therapy sessions only. Staff will supervise the operation of the stove in a safe manner. Policy explanation and compliance guideline: 1. Maintenance Director is responsible for unlocking and relocking the stove at the electrical panel. 2. While the stove is unlocked and in use the activity staff/therapy staff are to be present at the stove. Staff is not to leave the stove unattended at any time that it has been unlocked. Staff will remain at the stove until the maintenance director relocks the stove. 3. Immediately upon completion of the food activity the staff will turn the stove off and notify the maintenance director to relock the stove at the electrical panel. 4. A log is maintained by the maintenance director of the lock/unlocking activity. An observation on 02/26/20 at 9:41 AM, showed that the stove in the activity/occupational (OT) gym was warm to the touch and the oven was set on bake at 200 degrees. The top burners on the stove were able to be turned on and was operational. In addition, there was one female resident that sat in the activity room and was left unattended.<br>An observation and interview on 02/26/20 at 11:57 AM, showed that the stove was warm to the touch; however, the stove would not turn on. Staff F, Activity Supervisor (AS), stated that they had just had an activity were they cooked pig in the blanket (hot dog with a roll around it). During an interview on 02/26/20 at 2:06 PM, Staff J, Maintenance Director, stated that the facility had a process on ensuring that the stove was turned on just prior to the activity and shut off right after the activity, In addition, when asked what happened on 02/26/20 when the stove was found on with only one resident in the activity/OT room and no staff members, Staff J, Maintenance Director, stated that the stove had been left on all night because, they had an activity with the residents to celebrate Mardi Gras. Review of the maintenance log for January and February 2020 showed that on 02/25/20 showed that the stove was unlocked, making the stove operational at 9:03 AM and had not been turned off until the following morning on 02/26/20 at 8:55 AM. During an interview on 02/28/20 at 12:31 PM Staff A, Administrator, stated that she had been notified that the stove had been left on all night. Staff A, Administrator, further stated that it was her expectation that the stove would be turned on by the maintenance department at the breaker box just prior to an activity, never be left unattended while it was on and be shut back off at the break box with a lock when the activity was completed. In addition, Staff A, Administrator, stated that the stove should never be |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505431 | A. BUILDING _____ B. WING _____ | 03/05/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| BOTHELL HEALTH CARE | 707 - 228TH SOUTHWEST BOTHELL, WA 98021 |

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 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | (continued... from page 1)<br>left unattended. Reference WAC 388-97-1060(3)(g) . |
| F 0693<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, the facility failed to provide the necessary care and services related to the use of Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube that passed into a person's stomach through the abdominal wall, to provide a means of feeding, hydration and administering medications) for one of two residents (Resident #79) reviewed for tube feeding. This failure placed the resident at risk for medical complications [REDACTED]. Findings included . Review of Resident #79's quarterly Minimum Data Set (MDS, a required assessment tool) dated 02/11/20, showed that the resident admitted on [DATE] with [DIAGNOSES REDACTED]. The MDS showed that Resident #79 received nutrition through a feeding tube and was able to make needs known. Review of Resident #79's physician order [REDACTED]. It further showed<br>that the feeding tube marking was placed at button 4 and to notify the physician if abnormal findings. During an observation and interview on 03/04/20 at 10:43 AM, Staff D, Registered Nurse (RN), was checking placement of Resident #79's feeding tube and checked the feeding tube marking which showed a marking of 6. When asked about Resident #79's marking showing 6 instead of 4, Staff D, RN, stated that she would have to follow up on the issue. Review of Resident #79's medical record on 03/04/20 at approximately 11:15 AM, showed no documentation related to the resident's feeding tube marking documented as being 6 (instead of 4 per physician's orders [REDACTED]. During an interview on 03/04/20 at 3:47 PM, Staff D, RN, stated that Resident #79's feeding tube marking has been at 6 since about January 2020. In addition, when asked why the physician was not notified of the change in Resident #79's feeding tube markings, Staff D, RN, stated that she probably overlooked it because the resident showed no signs and symptoms of respiratory distress; however, she should have notified the physician. During an interview on 03/04/20 at 4:02 PM, Staff B, Director of Nursing Services (DNS), stated that her expectation was that nurses follow physician's orders [REDACTED].#79's physician orders, Staff B, DNS, stated that the order indicated to notify the physician for abnormal findings and that was her expectation. Reference WAC 388-97-1060 (3)(f) . |
| F 0695<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Some | **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 Continuous Positive Airway Pressure (C-PAP) therapy had ordered settings for three of four residents (Resident #s 1, 11 and 81) reviewed for respiratory services. This failure placed resident at risk for medical complications, unmet needs, and a diminished quality of life. Findings included . RESIDENT #1 Review of the admission Minimum Data Set (MDS, A required assessment tool), dated 02/20/20 showed that Resident #1 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS showed Resident #1<br>required a C-PAP at night and was able to make needs known. Review of the physician order [REDACTED].#1 showed no order for C-PAP settings. Review of the care plan dated 02/14/20 for Resident #1 showed that this resident required a C-PAP per physician's orders [REDACTED]. An observation on 02/28/20 at 9:45 AM, showed that a C-PAP machine was placed on Resident #1's bedside table. During an interview 02/28/20 at 10:31 AM, Staff M, License Practical Nurse/Resident Care Manager (LPN/RCM) was unable to locate the setting for Resident #1 C-PAP machine. When asked how the nurses would know if the C-PAP settings were accurate if this was not identified in the physicians order, Staff M, LPN/RCM, stated that it should have been in the physician orders [REDACTED]. RESIDENT # 11 Review of the annual MDS dated [DATE] showed that Resident #11 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS showed Resident #11 required a C-PAP at night and was able to make needs known. Review of the physician order [REDACTED].#11 showed no order for C-PAP settings. Review of the care plan dated 11/02/18 for Resident #11 showed that this resident required a C-PAP per physician's orders [REDACTED]. An observation on 03/02/20 at 9:00 AM, showed that a C-PAP machine was placed on Resident #11's bedside table. RESIDENT # 81 Review of the annual MDS dated [DATE] showed that Resident #81 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS showed Resident #81 required a C-PAP at night and was able to make needs known. Review of the physician order [REDACTED].#81 showed no order for C-PAP settings. An observation on 03/02/20 at 11:00 AM, showed that a C-PAP machine was placed on Resident #81's bedside table. During an interview on 02/28/20 at 10:53 AM, Staff B, Director of Nursing Services, (DNS), stated that it was her expectation that the physician orders [REDACTED].#s 1, 11 and 81 so that the staff could ensure the C-PAP machines had accurate settings. Reference WAC 388-97-1060(3)(j)(vi) . |
| F 0758<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to monitor target behaviors related to the use of [MEDICAL CONDITION] medications (mood and behavior-altering medications) for one of five residents (Resident #31) reviewed for unnecessary medication use. This failure placed the resident at risk for unnecessary use of medications, a missed opportunity for a gradual dose reduction and a diminished quality of life. Findings included . Review of the facility's policy and procedure titled, Use of [MEDICAL CONDITION] Drugs, dated November 2017, showed that Residents are not given [MEDICAL CONDITION] drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication. Review of Resident #31's admission Minimum Data Set (MDS, a required assessment tool) dated 12/23/19, showed that the resident admitted on [DATE] with [DIAGNOSES REDACTED]. According to the MDS, Resident #31 had cognitive impairment and exhibited episodes of depressed mood, low energy, poor appetite and increased sleepiness. The MDS further showed that the resident received antipsychotic, antianxiety and antidepressant medications. Multiple observations throughout the day on 03/02/20, 03/03/20 and 03/04/20, showed Resident #31 either in bed asleep or up in her wheelchair dozing off. Further observation showed the resident with no behavioral issues. Review of Resident #31's active physician orders [REDACTED]. Review of Resident #31's Medication Administration Record [REDACTED]. During an interview on 03/03/20 at 2:30 PM, Staff K, Licensed Practical Nurse (LPN), stated that licensed nurses documented the monitoring of target behaviors in the MAR. Staff K, LPN, stated that she was unable to locate documentation of target behavior monitoring for Resident #31. During an interview on 03/03/20 at 3:01 PM, Staff C, Assistant Director of Nursing (ADON), stated that the target behavior monitoring for Resident #31 was initially ordered on [DATE]; however, the order was discontinued on 01/03/20. Staff C, ADON, stated that the expectation was to monitor target behaviors for residents on [MEDICAL CONDITION] medications and that the monitoring of target behaviors should have been continued for Resident #31. Reference WAC 388-97-1060(3)(k)(i) . |
| F 0812<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Many | **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 and interview review, the facility failed to store food safely in two of three refrigerators and one of one dry storage room in the kitchen. The facility also failed to distribute and serve food in a sanitary manner in the kitchen. This placed residents at risk of cross contamination and food-borne illness. Findings included . An observation on 02/26/20 at 8:42 AM, showed the walk in kitchen refrigerator had containers of buttermilk ranch dressing, chipotle dressing and blue cheese dressing opened and not dated. One reach in refrigerator had three serving pitchers labeled, one with ranch and two with blue cheese dressing. Serving pitchers were not dated. An observation on 02/26/20 at 8:50 AM, showed two opened, undated, bags of dry cereal on a shelf in the dry storage area. An observation on 03/02/20 at 11:47 AM, showed that dietary staff were preparing lunch trays for the residents. An observation on 03/02/20 at 11:50 AM, showed |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **505431** | A. BUILDING _____ B. WING _____ | **03/05/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **BOTHELL HEALTH CARE** | **707 - 228TH SOUTHWEST BOTHELL, WA 98021** |

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 0812<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | (continued... from page 2)<br>Staff P, Dietary Aide (DA), opened the freezer with a gloved hand, removed items from the freezer, and placed the items on the cart next to the steam table. Without removing gloves or hand hygiene, Staff P, DA, then picked up trays, put them on top of the steam table, put plate covers on each plate of food, and then placed trays onto food carts. An observation on 03/02/20 at 12:00 PM, showed Staff P, DA, removed gloves, washed hands, pushed the food cart out the door, put on new gloves, opened the refrigerator door with gloved hands, then returned to the tray line and continued to set up trays. Staff P, DA, then left the tray line wearing gloves, went into the dry storage room, returned with a box, placed it on a cart next to the tray line and continued to set up trays on top of the steam table. No hand hygiene or glove changes were done after multiple surfaces were touched with gloved hands. An observation on 03/02/20 at 12:05 PM, showed Staff Q, Cook, used a gloved hand to place a bun onto each plate then used utensils to place other food onto the plates. Staff Q, Cook, left the tray line, removed gloves, washed hands, returned with a set of tongs and put the tongs into the pan of buns on the steam table. Staff Q, Cook, then put on gloves, touched the steam table counter with gloved hands, used utensils to put food on plates, used a gloved hand to put buns on the plates, then used tongs with a gloved hand to put buns on plates. The handle of the tongs was dropped onto the buns after each use. No hand hygiene or glove changes were done after steam table counter were touched with gloved hands. During an interview on 03/02/20 at 12:30 PM, Staff O, Dietary Manager (DM), stated that all food should be dated when opened and when placed into storage or serving containers. Staff O, DM, also stated gloves should be removed and hands washed when surfaces were touched before returning to serving or handling food. During an interview on 03/04/20 at 03:01 PM, Staff A, Administrator, stated she expected food items to be dated when opened and for staff to follow all sanitary precautions. Reference WAC 388-97-1100(3) . |
| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Provide and implement an infection prevention and control program.**<br><br>Based on observation and interview, the facility failed to ensure safe and clean laundry storage environments were maintained for three of three observations (clean linen room, and soiled linen room). This failure placed residents' and staff at risk of potential cross contamination, healthcare associated infections and a decreased quality of life. Findings included . Observation on 03/03/20 at 11:08 AM, the clean linen room attached to the laundry room showed a large cardboard box placed directly on the floor to the left of the entrance, next to a desk, that contained 80 rolls of toilet paper. Under the desk on the floor was a cardboard box that was opened at the top and showed a container of bleach in the box. In addition, under the folding table was a cardboard box of gloves that was half way on a wooden pallet and half on the floor and under two metal shelves were one cardboard box on the floor that was opened at the top that contained cloth like items and two cardboard boxes on the floor that contained 10 boxes of exam gloves in each. The soiled linen room attached to the laundry room showed two large cardboard boxes (one stacked on top of the other) placed directly on the floor, in front of wooden cupboards, that contained contour sheets. During an observation on 03/04/20 at 9:42 AM, the clean linen room attached to the laundry room continued to show cardboard boxes placed directly on the floor located next to the desk, under the desk, under the folding table, and under two shelves. In addition, in the soiled linen room, there were two large stacked cardboard boxes placed on the floor in front of the wooden cupboards. During an interview and observation on 03/04/20 at 9:56 AM, in the clean linen room attached to the laundry room, Staff E, Housekeeping/Laundry Supervisor (HLS), stated that the boxes located next to and under the desk, under the folding table and under the shelves should not be placed directly on the floor. Staff E, HLS, stated that the boxes should be paced on wooden pallets or put away off the floor. After entering the soiled linen room attached to the laundry room, Staff E, HLS, stated that the stacked boxes located in front of the cupboards may have been delivered on Monday (03/02/20) and should have been opened up and items put away and the boxes discarded. During an interview and observation on 03/04/20 at 10:09 AM, in the clean linen room and soiled linen rooms attached to the laundry room, Staff A, Administrator, stated that the cardboard boxes should not have been placed on the floor because it was an infection control issue. Reference WAC 388-97-1320(3) . |