STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CARE	**209 NORTH AHTANUM AVENUE WAPATO, WA 98951**

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E 000	Initial Comments This report is the result of an Emergency Preparedness Survey conducted at Emerald Care on 04/13/18. This inspection was conducted in cooperation with a representative of the Washington State Patrol, Office of the State Fire Marshal. The survey was conducted by: Melly Thompson, RN Barbara Maeir, DSFM The survey team is from: Department of Social & Health Services Aging & Long-Term Support Administration Residential Care Services, Region 1, Unit D 3611 River Road, Suite 200 Yakima, WA 98902 Telephone: (509) 225-2800 Fax: (509) 574-5597	E 000		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:	E 015		

LABORATORY D RECTOR'S OR PROV DER/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.

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E 015	Continued From page 1 (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	E 015		

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E 015	Continued From page 2 failed to ensure the development of Emergency Preparedness policies and procedures for the provision of subsistence needs which included pharmaceutical supplies and adequate alternate energy sources necessary to maintain temperatures and sewage waste disposal for residents. This failed practice placed all residents at risk for a potential delay in staff response to an emergency situation. Findings included: Review of the Emergency Preparedness documents did not show evidence of a policy and procedure for all the components of subsistence needs. During an interview on 04/13/18 at 2:20 PM, Staff G, Activities Director/Editor of Emergency Preparedness Program, stated there was no policy and procedure addressing pharmaceutical supplies and adequate energy sources to maintain temperatures and sewage waste disposal for the residents and staff.	E 015		
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during	E 018		

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E 018	Continued From page 3 an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of	E 018		

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E 018	Continued From page 4 evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop policies and procedures for a system to track the location of sheltered residents and on-duty staff during an emergency. This failure placed the facility at risk of not being able to address resident's safety and care needs during an emergency event. Findings included: Review of the Emergency Preparedness program did not show evidence of policies and procedures for a system to track the location of sheltered residents and on-duty staff during a man-made or natural disaster. In an interview on 04/13/18 at 12:49 PM, Staff A, Administrator, stated there were no policies and procedures developed for a tracking system.	E 018		
E 020 SS=C	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) [(b) Policies and procedures. The [facilities] must	E 020		

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E 020	Continued From page 5 develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes	E 020		

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E 020	Continued From page 6 staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop policies and procedures which identified safe evacuation and care needs of the evacuees, staff responsibilities, transportation, evacuation locations, and primary and alternate means of communication with external resources of assistance. This failed practice placed the residents at risk for harm, due to unmet safety and care needs. Findings included: Review of the Emergency Preparedness program binder did not evidence the required policies and procedures. During an interview on 04/13/18 at 12:49 PM, Staff A, Administrator, stated the facility was in the process of developing policies and procedures to cover safe evacuation and care needs.	E 020		
E 022 SS=C	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a	E 022		

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E 022	Continued From page 7 minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop policies and procedures for sheltering in place. This failure placed the facility at risk of not being able to address the safety and care needs of the residents, staff, and volunteers who remained in the facility during an emergency event. Findings included: Review of the facility Emergency Preparedness program did not show evidence of polcies and procedures for sheltering in place. On 04/13/18 at 12:54 PM, Staff A, Administrator, stated the facility was in the process of developing the required policies and procedures.	E 022		
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must	E 024		

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E 024	Continued From page 8 develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement policies and procedures to incorporate the use of volunteers or other staffing strategies to utilize in an emergency. The failure to have a system to register, screen, and assign duties to volunteer personnel placed the facility at risk of not having enough personnel to provide care during an emergency, or to have volunteers performing tasks outside the scope of their skills. Findings included: Review of the Emergency Preparedness program did not show evidence of policies and procedures for volunteer use in the event of an emergency.	E 024		

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E 024	Continued From page 9 During an interview on 04/13/18 at 1:09 PM, Staff A, Administrator, stated the facility was in the process of developing policies and procedures for volunteer use during an emergency.	E 024		
E 025 SS=C	Arrangement with Other Facilities CFR(s): 483.73(b)(7) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients.	E 025		

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E 025	Continued From page 10 *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that pre-arranged transfer and transportation agreements were in place with other facilities and transportation providers, to transport and receive residents in the event the facility was not able to provide care during an emergency. This failed practice placed residents at risk for harm, due to unmet safety and care needs. Findings included: Review of the Emergency Preparedness program did not show evidence of transfer and transportation agreements. During an interview on 04/13/18 at 1:10 PM, Staff A, Administrator, stated the facility was in the process of obtaining transfer and transportation agreements.	E 025		
E 029 SS=C	Development of Communication Plan CFR(s): 483.73(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	E 029		

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E 029	Continued From page 11 failed to develop an emergency preparedness communication plan that complies with Federal, State and local laws. This failed practice placed all residents and staff in potential danger of injury or death in the event of a man-made or natural disaster. Findings included: Review of the Emergency Preparedness program did not show evidence of the required communication plan. During an interview on 04/13/18 at 12:05 PM, Staff A, Administrator, stated the facility was in the process of developing a communication plan as part of the Emergency Preparedness program.	E 029		
E 030 SS=C	Names and Contact Information CFR(s): 483.73(c)(1) [(c) The [facility, except RNHCIs, hospices, transplant centers, and HHAs] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the	E 030		

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E 030	Continued From page 12 following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	E 030		

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E 030	Continued From page 13 failed to develop an Emergency Preparedness communication plan that contained names and contact information for staff, entities providing services under arrangements, resident's physicians, other facilities and volunteers. This failed practice placed residents and staff at potential risk of injury and/or death due to an inability to obtain necessary services, in the event of an emergency. Findings included: Review of the facility Emergency Preparedness program did not show evidence of a communication plan with the required components. On 04/13/18 at 12:07 PM, Staff A, Administrator, stated the facility was in the process of developing the communication plan with the required components.	E 030		
E 031 SS=C	Emergency Officials Contact Information CFR(s): 483.73(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, or local emergency preparedness staff.	E 031		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

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EMERALD CARE	**209 NORTH AHTANUM AVENUE WAPATO, WA 98951**

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E 031	Continued From page 14 (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop an Emergency Preparedness communication plan that included contact information for Federal, State, tribal, regional, and local emergency preparedness staff, or other sources of assistance, for use in the event of an emergency. This failed practice placed the facility at risk of not being able to coordinate resident care and safety needs, during an emergency event. Findings included: Review of the facility Emergency Preparedness program did not show evidence of a communication plan with all the required conact information for the required entities. During an interview on 04/13/18 at 12:19 PM, Staff A, Administrator, stated the facility was in the process of developing a communication plan with the required contact information for the required entities.	E 031		
E 032 SS=C	Primary/Alternate Means for Communication CFR(s): 483.73(c)(3)	E 032		

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	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

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E 032	Continued From page 15 [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure an Emergency Preparedness communication plan that included primary and alternate means for communicating with facility staff, Federal, State, tribal, regional, and local emergency management agencies. This failed practice placed the facility at risk of not being able to address resident care and safety needs during an emergency event. Findings included: Review of the Emergency Preparedness program did not show evidence of a communication plan which included primary and alternate means for communication with staff and all necessary agencies during an emergency. On 04/13/18 at 1:23 PM, Staff A, Administrator, stated the facility was in the process of developing the communication plan with all the required components.	E 032		

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	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

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E 033 SS=C	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).	E 033		

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E 033	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a communication plan which included a method of sharing information and medical documentation for residents under the facility's care, to ensure that resident records were secure and readily available to support continuity of care during an emergency. This failed practice placed residents at risk of injury and/or death. Findings included: Review of the provided documentation did now show evidence of an emergency preparedness communication plan with the required components. On 04/13/18 at 1:24 PM, Staff A, Administrator, stated the facility had not developed an Emergency Preparedness communication plan with the required components.	E 033		
E 034 SS=C	Information on Occupancy/Needs CFR(s): 483.73(c)(7) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of	E 034		

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E 034	Continued From page 18 providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop an Emergency Preparedness communication plan that included a method for providing information about the facility's needs, current occupancy, and it's ability to provide community assistance during an emergency. This failed practice placed all residents, staff and community members at risk of harm, due to unmet care and safety needs, from under-utilized medical resources. Findings included: Review of the facility Emergency Preparedness program did not show evidence of a communication plan with the required components. On 04/13/18 at 1:28 PM, Staff A, Administrator, stated the facility had not developed an Emergency Preparedness communication plan.	E 034		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal,	E 035		

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E 035	Continued From page 19 State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement a plan to provide information about Emergency Preparedness to all residents, family members and/or representatives. This failed practice placed all residents and/or resident representatives at risk of not knowing how they (or a loved one) would be cared for during an emergency. Findings included: Review of the facility Emergency Preparedness program did not show evidence of a method for sharing information from the emergency plan. During an interview on 04/13/18 at 1:31 PM, Staff A, Administrator, stated the facility had not developed a method for sharing information from the emergency plan with residents and/or resident representatives.	E 035		
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and	E 036		

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E 036	Continued From page 20 the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement a training and testing program which would reflect the risks identified in the facility's risk assessment and be included in their emergency plan. This failed practice placed residents at risk of harm due to staff, contractors, and/or facility volunteers not	E 036		

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E 036	Continued From page 21 knowing how to proceed and/or care for residents during an emergency. Findings included: Review of the facility Emergency Preparedness program did not show evidence of a training and testing program developed specific to the facility's risk assessment as part of the emergency plan. During an interview on 04/13/18 at 1:34 PM, Staff A, Administrator, stated the facility had not developed and implemented a training and testing program based off of their facility risk assessment.	E 036		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles.	E 037		

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E 037	Continued From page 22 (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training.	E 037		

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E 037	Continued From page 23 *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt	E 037		

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E 037	Continued From page 24 reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop initial and annual Emergency Preparedness trainings. This failed practice placed residents and staff at risk of potential injury and/or death in the event of an emergency, related to the lack of staff training. Findings included: Review of the facility Emergency Preparedness program did not show evidence of a training program developed specific to the facility's risk	E 037		

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	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 037	Continued From page 25 assessment as part of the emergency plan. During an interview on 04/13/18 at 1:37 PM , Staff A, Administrator, stated the facility had not developed and implemented training consistent with staff responsibilites during an emergency.	E 037		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated,	E 039		

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E 039	Continued From page 26 clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to participate in a full-scale community-based, or an individual facility-based, emergency exercise. This failed practice placed the facility at risk of implementing non-working emergency plans, and placed all residents at risk for harm, due to unmet safety and care needs related to the lack of testing and analyzing the emergency plan. Findings included: Review of the provided documentation did not	E 039		

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E 039	Continued From page 27 show evidence of a full-scale community-based or individual facility-based emergency exercise in order to test and analyze the emergency plan. During an interview on 04/13/18 at 1:42 PM, Staff A, Administrator, stated the facility had not participated in a full-scale, community-based or in individual facility-based exercise.	E 039		
F 000	INITIAL COMMENTS This report is the result of an unannounced Long Term Care Off-Hours Survey and Complaint Investigation conducted at Emerald Care on 04/10/18, 04/11/18, 04/12/18, 04/13/18, 04/16/18, 04/17/18, 04/18/18, 04/19/18, 04/20/18, and 04/23/18. A sample of 44 residents was selected from a census of 69. The sample included 41 current residents and the records of three discharged residents. . The following complaints were investigated as part of this survey: #3506472 #3510251 The survey was conducted by: Melly Thompson, RN Cuca Botello, RN Jo Whitney, RN Glenda Valenzuela, RN Gwin Kaercher, BS The survey team is from:	F 000		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

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F 000	Continued From page 28 Department of Social & Health Services Aging & Long-Term Support Administration Residential Care Services, Region 1, Unit D 3611 River Road, Suite 200 Yakima, WA 98902 Telephone: (509) 225-2800 Fax: (509) 574-5597	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550		

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F 550	Continued From page 29	F 550		

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure staff 1) handled one of three residents (#18) in a dignified manner during care, 2) responded to one of three residents (#61) who requested the removal of a 1D, 1L picture (which was a facility protocol requiring the presence of two caregivers) from the room doorway, 3) attended to the needs of one of one 1D, 1L resident (#54) reviewed for 1D, 1L impairment during dining, and 4) responded timely to one of seven residents (#43) dependent on assistance for toileting. This failed practice placed all the identified residents at risk for a loss of dignity and feelings of embarrassment resulting in a diminished quality of life. Findings included:

HANDLING DURING CARE
Resident #18. Review of the medical record revealed the resident was admitted to the facility on 1D, /17 with diagnoses including 1D, 1L and 1D, 1L . The most recent comprehensive assessment dated 01/18/18 showed the resident required total assistance with most Activities of Daily Living (ADLs),

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EMERALD CARE	209 NORTH AHTANUM AVENUE WAPATO, WA 98951

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F 550	Continued From page 30 including positioning. On 04/11/18 at 1:19 PM, the surveyor was interviewing a resident in his room with the door closed. The door opened abruptly, Staff K, Nursing Assistant (NA), backed into the room, pulling Resident #18 in his wheelchair. The NA abruptly lowered the resident's wheelchair from a 1D, to a 1D, position, reached over the resident and placed her hands over the resident's chest area, grabbed his shirt and quickly pulled the resident up in his wheelchair. Staff K then immediately lifted the wheelchair and resident back up to a 1D, position. The NA did not explain the procedure to the resident prior or during care. During an interview on 04/11/18 at approximately 1:30 PM, Staff K stated the resident was dependent on staff for ADLs and required two person assistance. She decided to take him in his room and reposition him by herself because he was falling and there was no staff to help her. As the surveyor was interviewing Staff K about the observed interactions with Resident #18, she stated "...I know I was doing something that I was not supposed to do." Staff K was aware the resident needed to be frequently repositioned in his wheelchair due to a tendency to slip down in his chair. The NA demonstrated to the surveyor that the resident had an 1D, 1L in his wheelchair, but the 1D, was unplugged or disconnected, which was why the 1D, was not sounding off when she first observed the resident. FEELINGS OF BEING DEMEANED Resident #61. Review of the medical record showed the resident was admitted on 1D, /17 with diagnoses including 1D, and 1D, 1L	F 550		

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F 550	Continued From page 31 The most recent comprehensive assessment dated 03/19/18 showed the resident was cogntively intact. On 04/11/18 at 10:41 AM, Resident #61 stated there was an incident that took place a few weeks prior where a staff person called her a deragatory name and the facility "took the aide's (nursing assistant) side..." After the incident, the resident stated staff placed a '1D, 1L picture" on the outside of her room door which meant the resident required two-person attendance at all times. "...the 1D, 1L picture is demeaning. I asked them to take it down twice." In an interview on 04/19/18 at 4:49 PM, Staff C, Social Services Director (SSD), stated the resident did request to have the 1D, 1L picture removed because it was a dignity issue for the resident. However, the picture was not removed since it was a facility practice whenever there was a staff to resident conflict. On 04/19/18 at 12:24 PM, Resident #61 further explained she did not like the '1D, 1L " picture because, "...it makes me feel horrible, like I am dirty...like it's a bad thing (if the picture was placed on a resident's room door)." Observation outside the resident's room after the interview revealed a picture of 1D, 1L next to the resident's door, visible to anyone passing the resident's room. Review of the resident's 03/26/18 comprehensive care plan showed a Mood/Behavior focus with an intervention which read, "...3/27 Two caregivers at all times (1D,)..." ASSISTANCE WITH DINING	F 550		

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F 550	Continued From page 32 Resident #54. Per record review, the resident admitted on 1D, /18 with diagnoses including 1D, 1L and recent 1D, 1L. The comprehensive assessment dated 01/22/18 showed he had no memory loss, adequate hearing and speech to understand and be understood by others. He was dependent on the assistance of others for all cares (including eating) due to 1D, 1L weakness and the 1D, 1L. The care plan dated 02/05/18 showed the resident's recent 1D, 1L affected his participation and involvement in daily activities. 1D, 1L related to concerns about his medical condition lead to calling out for assistance often related to the 1D, 1L. He verbally abused staff; they were directed to determine the source causing the distress and engage in conversation. He needed one-to-one assistance in the dining room to eat. On 04/10/18 at 12:30 PM, Resident #54 sat in his wheelchair at a table in the dining room with two other residents. "Who will take my order?" "Where is (Staff Y, Nursing Assistant (NA)?" (Staff Y was cueing and assisting others at a near by table in the dining room). The other two residents sitting with Resident #54 were non-verbal. "We want a candy bar, and popcorn - I will buy." At 12:50 PM (20 minutes after the resident began calling out for staff assistance) Staff W, Occupational Therapist, went to Resident #54 and accepted the money he handed to her and purchased his choice of soda pop from the vending machine in the room. Staff W stated the resident needed watching because he was not a good eater.	F 550		

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F 550	Continued From page 33 When each resident had a meal tray delivered a staff member sat at the corner of the table between the two other residents. Resident #54 asked what it (the meal) was and told he had tuna (sandwich); hearing this the resident then asked for the alternative meal of hamburger gravy on mashed potato. The sandwich on a plate was left at the table. When the resident's chosen meal was delivered to the table in a bowl, he located and picked up a fork with his right hand and stabbed at the table in front of him (the sandwich plate). After unsuccessful efforts to find the food, the staff person at the table told him the bowl was on his left side. Resident #54 using his fork attempted to eat the meal without assistance, losing interest because of unsuccessful efforts to find food and feed himself. During a second lunch observation on 04/16/18 at 12:22 PM, Staff Z, Activity Assistant, brought Resident #54's tray to the table, telling the resident of its arrival. Resident #54 reached for his coffee cup. A tablemate sitting on his right helped the resident to find the empty coffee cup. Resident #54 requested a "cappuccino." Staff Z brought out a hot drink cup, sat it to the right near the tablemate. The tablemate picked up the cup and drank the coffee. Staff Z observed the tablemate drinking the coffee and took the cup away. Resident #54 asked again for a cup of coffee. When Staff Z brought another cup, he said, "here you go" then walked away. Resident #54, now with coffee, had not received any guidance/cuing about what food or where the food was on the tray or plate. Resident #54, speaking to no-one states, "I am supposed to have spaghetti." The tablemate	F 550		

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F 550	Continued From page 34	F 550		

responded to the resident's question telling him he received spaghetti. The following dialog was overheard without staff intervention. "It is right there." "Where?" "On the plate." "Where, on the plate, I 1D, 1L , I am 1D, ." Resident #54 sat waiting for an answer.

The tablemate looked for her own meal as the three others at the table were already served. The tablemate attempted to help Resident #54 by putting on his shirt protector across his chest and around his neck; he pushed her efforts away. A resident at a nearby table sees/overhears the interaction and calls out to bring attention to the actions between the two residents. The tablemate hears and stops her efforts with the shirt protector without staff intervening or attention to the situation.

Resident #54 with fork in hand, attempted to stab at the food on his plate without direction or guidance. The tablemate picked up a glass of juice and put it up to Resident #54's lips. He pushed her away and with apparent frustration he pushed his wheelchair away from the table.

Staff M, Licensed Practical Nurse (LPN), approached Resident #54 asking if he would eat if taken back to the table. "No, I do not want the tray." The tablemate at this point had drank from Resident #54's glass of juice and started to eat off his meal tray. Staff M returned to the table directing the tablemate to go to her assigned table that had direct supervision. Staff M brought a new meal, food in a bowl and new flatware. At 12:38 PM, nearly 40 minutes after initially served, Staff M sat next to Resident #54 offering the one-to-one assistance required with each meal. As Staff M sat and assisted Resident #54, she

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F 550	Continued From page 35 referred to him as "dear" instead of using his name. On 04/17/18 at 8: 00 AM, Resident #54 was waiting for breakfast sitting calmly at the table with two other residents, without conversing. The resident stated, "others come in, move him around and don't explain." They say "it is right there" and he said, "I am 1D, they say they did not know that." He reported he "eats better with a fork than a spoon - but needs to know where the food on the tray is." Resident #54 recollected the incident at lunch the previous day; "That lady she tried to help me. I did not know her and did not want her help... would have pushed her away if not removed. Then the other lady came and helped." The resident stated that he knew he had a problem getting angry at people and was trying to do better. He knew he needed and wanted assistance at meals in the dining room. PERSONAL CARE Resident #43. Review of the medical record showed the resident was admitted to the facility on 1D, /17, with diagnoses including 1D, 1L with 1D, 1L . The comprehensive assessment dated 03/01/18 showed the resident required a two person physical assist for transfers. Additionally, the resident's in room care directives showed an intervention to "offer toileting after every meal, to assist her to stay continent of bowel." On 04/16/18 at 8:50 AM in the 300 hall, Resident #43 approached Staff M LPN and stated "I have went on myself and I need help." Staff M called down the hall to Staff N, NA; "she needs immediate help" pointing to Resident #43. Staff N	F 550		

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F 550	Continued From page 36 proceeded to go into another resident's room with a 1D, 1L lift where she remained for approximatly 15 minutes. Resident #43 stated to the Staff M several more times, "I need help." Staff M replied, "I'm sorry honey I need to finish this" as she continued to prepare medications. On 04/16/18 at 9:05 AM (15 minutes later), Staff O (Housekeeping Supervisor) walking by Resident #43 stopped and pointed out to Staff M an area (approximately 15 by 12 inches) of 1D, 1D, 1L leaking under the resident's wheel chair. Staff O obtained yellow cones and placed them around the resident; there was a strong 1D, 1L . The resident stated to Staff M, "I'm so sorry I just couldn't hold it." On 04/16/18 at 12:44 PM, Staff N stated she had reviewed the resident's in-room care directives to provide individualized care. Reference: WAC 388-97-0180 (2-3)	F 550		
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve	F 609		

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F 609	Continued From page 37 abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to report to the State Agency allegations of potential verbal abuse and mistreatment made by one of six residents (#61) reviewed for allegations documented in a grievance form. This failed practice placed the resident at risk for unidentified abuse, resulting in potential continued mistreatment and a diminished quality of life. Findings included: According to the "Nursing Home Guidelines - The Purple Book," Sixth Edition, dated October 2015, "Staff to Resident incidents of abuse/neglect...should be reported to the Department of Social Health Services (DSHS) Hotline number, logged within five days, and Police or 911 called." Resident #61. Review of the medical record showed the resident was admitted on 1D, /17 with diagnoses including 1D, and 1D, 1L The most recent comprehensive assessment	F 609		

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F 609	Continued From page 38 dated 03/19/18 showed the resident was cognitively intact. During an interview on 04/11/18 at 10:41 AM, Resident #61 stated there was an incident that occurred a few weeks back which resulted in a staff person calling her a derogatory name. She stated she spoke to Staff C, Social Services Director, about the incident. Review of the facility grievance log showed a grievance dated 12/21/17 with a statement from the resident that a caregiver "...yanked her leg (during care) and...walked out..." The facility completed an investigation regarding the allegation of the grievance. The investigation included a statement from the resident that she no longer wanted the same caregiver to assist her with Activities of Daily Living. An additional grievance dated 03/26/18 showed Resident #61 alleged a caregiver called her a derogatory name, "B----h." The facility completed an investigation but did not report the allegation as required. Interviewed on 04/20/18 at 1:04 PM Staff B, Director of Nursing Services, stated she did not report the allegations reported by Resident #61 to the State as required. Reference: WAC 388-97-0640(5)(a)	F 609		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 610	Continued From page 39 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure investigations were completed for two of five allegations of possible abuse/neglect (#s 38, 219) reported as grievances. This failed practice placed the residents at risk for potential abuse/neglect. Findings included: Resident #38. Review of the medical record showed the resident was readmitted on 1D, /17 with diagnoses including 1D, 1L [redacted]. The most current comprehensive assessment dated 02/21/18 documented the resident was cognitively intact. Review of a grievance dated 06/27/17, documented the resident reported a staff person expected her to do things she was unable to do and the resident alleged the staff person (caregiver) spoke to her in a rude voice. Resident #219. Review of the medical record	F 610		

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EMERALD CARE	**209 NORTH AHTANUM AVENUE WAPATO, WA 98951**

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F 610	Continued From page 40 showed the resident was admitted to the facility on 1D, /17 with diagnoses including 1D, 1L The most recent comprehensive assessment dated 02/21/18 documented the resident with an intact cognition. Review of a grievance dated 01/22/18 documented the resident's family member reported an incident to Staff C, Social Services Director. The grievance documented the incident occurred the day prior. The resident used his call light to request assistance for toileting. The resident reported the caregiver "...entered the room with an attitude" stating, 'What do you want?" The resident reported he had to wait approximately 45 minutes because the caregiver had to wait for her partner. Review of the resident's medical record did not show evidence of an investigation of the 01/22/18 grievance (potential neglect) reported by a family member. During an interview on 04/20/18, Staff B, DNS, stated she was responsible to go through the grievances and determine if an allegation needed to be investigated to rule out abuse and/or neglect. She stated she did not complete investigations for the grievances documented for Resident #s 38, 43 and 219. Reference: WAC 388-97-0640 (6)(a)(b)	F 610		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review	F 644		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CARE	209 NORTH AHTANUM AVENUE WAPATO, WA 98951

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F 644	Continued From page 41 (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a Pre-admission Screening and Resident Review (PASRR) Level 1 was completed prior to admission for one of five sampled residents (#62) reviewed for unnecessary medication administration. This placed the resident at risk for not being given the most appropriate setting for their needs and receive the services they needed in that setting. Findings included: Resident #62. Per medical records the resident was admitted on 1D, /18 with diagnoses including 1D, 1L [redacted] The resident was transferred to the hospital on 1D, /18 for treatment of a 1D, fracture. The resident was re-admitted to the facility on 1D, /18 without a PASRR. On 04/18/19 at 11:30 AM Staff C, Social Services Director, stated the resident had been living in an	F 644		

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	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

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EMERALD CARE	209 NORTH AHTANUM AVENUE WAPATO, WA 98951

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F 644	Continued From page 42 Assisted Living Facility before coming to the nursing home. She added she had not realized a PASRR had not been completed by the previous facility prior to 1D, /18. She also acknowledged she had not obtained a PASRR from the hospital when the resident came back to the facility from the hospital on 1D, /18. Review of the resident's medical record showed a PASRR dated 1D, /18 two days after the resident had been admitted and while the resident was in the hospital. The resident was transferred to the hospital on 1D, /18. Review of the facility PASRR policy with a revision date of 11/25/15, showed the facility was to "ensure all residents have a valid Pre-Admission Resident Review prior to admission to the facility..." Reference: WAC 388-97-1915 (4)	F 644		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		

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	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CARE	**209 NORTH AHTANUM AVENUE WAPATO, WA 98951**

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F 656	Continued From page 43	F 656		

required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to develop/implement a person-centered comprehensive care plan for three of forty-four sampled residents (#s 27, 18, 22) reviewed for care plans. This failed practice placed the residents at risk of unmet needs. Findings included:

Resident #27. Per medical records he was admitted on 1D, /18; his diagnoses included a wound to the 1D, 1L and 1D,

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CARE	209 NORTH AHTANUM AVENUE WAPATO, WA 98951

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F 656	Continued From page 44 The comprehensive assessment dated 02/05/18 showed the resident was cognitively intact and required extensive assist for bed mobility, transfers, dressing, toilet use and personal hygiene. Impairment on 1D, 1L was coded for the functional limitation in Range of motion and identified his pain level at 8 out of 10 (moderate to severe pain). On 04/11/18 at 10:29 AM Resident #27 stated he had been found '1D, 1L sometime in January of this year." He stated that the skin on his 1D, 1L was torn off, his 1D, hurt and sometimes he had trouble picking up things. On 04/16/18 at 4:00 PM, the resident stated he was not having much pain but was having difficulty making 1D, as his 1D, felt weak. The 1D, 1L was covered with a 4 x 4 inch gauze, the 1D, 1L appeared edematous (swollen) and slightly darker in color than the 1 1D, On 04/17/18 at 10:21 AM, Staff L, Licensed Practical Nurse (LPN), Treatment Nurse, provided wound care to the resident's 1D, 1D, 1L Observed a two inch linear scab to his 1D, 1L , without drainage, some redness and discoloration was present on the surrounding skin. On 04/17/18 at 10:15 AM, Staff Q, LPN, stated the resident does complain of 1D, pain and he provided the resident with pain medication; "It seems to be effective." He added, he documented the level of pain and the medication effectiveness on the resident's Medication	F 656		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CARE	**209 NORTH AHTANUM AVENUE WAPATO, WA 98951**

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F 656	Continued From page 45	F 656		

Administration Record (MAR). For any additional pain issue, such as the site of pain, he would document in the nursing progress notes.

Review of the February, March, and April 2018 electronic MAR's showed the resident was given pain medication. Sixteen doses of pain medication had been admininstered in February, 14 doses of pain medication in March, and 23 doses of pain medication in April. Review of the resident's plan of care did not include the resident's wrist and hand pain.

The nursing progress notes dated 02/05/18 showed the resident complained of 1D, 1L pain and identified the 1D, 1L as warm to the touch and "a bit swollen." The 02/11/18 nursing progress notes showed the resident again complaining of 1D, 1L pain.

On 04/17/18 at 12:15 PM, Staff I, LPN, Resident Care Manager (RCM), stated the resident's plan of care did not include his 1D, 1L pain.

Resident #18. Review of the medical record revealed the resident was admitted to the facility on 1D, 17 with diagnoses including 1D, 1L and 1D, 1L . The most recent comprehensive assessment dated 01/18/18 showed the resident required total assistance with most Activities of Daily Living (ADLs), including positioning.

The resident's comprehensive care plan dated 01/18/17 documented a focus for Activities of Daily Living Self Care Performance. The resident required two person assistance for transfers with a 1D, 1L lift and two person assistance for mobility as the resident was unable to

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EMERALD CARE	**209 NORTH AHTANUM AVENUE WAPATO, WA 98951**

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F 656	Continued From page 46 move/reposition independently. An observation on 04/11/18 at 1:19 PM showed Staff K, Nursing Assistant (NA), wheeling the resident in his wheelchair into his room and repositioned the resident in his wheelchair by herself. The NA grabbed the resident's shirt from the chest area and pulled him up in the wheelchair. On 04/11/18 at approximately 1:30 PM the NA stated the resident required two person assistance for the repositioning. Staff K stated she did not implement the resident's plan of care because there was no one available to help her. During an interview on 04/18/18, Staff I, LPN/RCM, stated the RCM's would intiate the care plans on admission and print out a kardex of resident care directives for NA's to follow that were placed in each resident's closet. Resident #22. Review of the resident"s medical record showed the resident was admitted on 1D, /14 with diagnoses including 1D, 1L and 1D, 1L Resident #22's care plan and in-room care directives, updated on 10/27/17, showed the resident had a directive to be up in her wheelchair daily around 2:00-2:30 PM and laid back down from 3:00-3:30 PM. Observation of Resident #22 from 2:00 PM to 4:00 PM on 04/10/18, 04/11/18 and 04/17/18 showed she was not up in her wheelchair as directed. On 04/10/18 Staff M, LPN stated that the resident	F 656		

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EMERALD CARE	**209 NORTH AHTANUM AVENUE WAPATO, WA 98951**

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F 656	Continued From page 47 "gets up daily." On 04/18/18 Staff J, LPN/RCM stated that the resident was care planned to "be up daily." Reference: WAC 388-97-1020(1) (2) (a)(b)	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CARE	**209 NORTH AHTANUM AVENUE WAPATO, WA 98951**

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F 657	Continued From page 48 Based on observation, interview and record review, the facility failed to ensure the care plan was revised to accurately reflect the current status for one of one resident (#30) reviewed for 1D, 1L This failed practice placed the resident at risk for unmet care needs. Findings included: Resident #30. Review of the medical record showed the resident was readmitted on 1D, /18 with diagnoses including 1D, 1L . An observation on 04/11/18 at 9:31 AM showed the resident sitting in his wheelchair in his room, watching television. The resident's 1D, 1L was wrapped up with an ace bandage. During an interview on 04/11/18 at 9:35 AM, Resident #30 stated he 1D, 1L the 1D, 1D, 1L near the nurse's station a few weeks prior. The resident stated he was told he was not able to go to a family function because he had to go to 1D, 1L treatment. He had injured his 1D, 1D, and that is why it was wrapped up. During the same interview, Resident #30 stated he had 1D, 1L treatment three days a week and the facility provided him with a sack lunch to take with him. The resident reported he had been experiencing some 1D, 1L so he was told that he could no longer eat lunch at the facility on his treatment days due to several incidents of 1D, 1L episodes before or during his 1D, 1L treatment. The resident stated the treatment had to be stopped and cut short if he had a 1D, 1L episode. He stated the facility was working with the 1D, 1L center to try to figure out how to best meet his nutritional and toileting needs.	F 657		

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EMERALD CARE	209 NORTH AHTANUM AVENUE WAPATO, WA 98951

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F 657	Continued From page 49 Review of the 01/26/18 comprehensive care plan did not document interventions in regard to how the facility was ensuring the resident was offered an early lunch or snack on 1D, 1L treatment days. The care plan did not reflect how to ensure the resident's nutritional, toileting and 1D, 1L treatment needs were met related to the impact of the resident's 1D, 1L The same care plan did not reflect a history of the resident 1D, 1L as he had reported and per the incident that occurred a few weeks prior. On 04/18/18 at 1:27 PM, Staff I, LPN/RCM, stated the resident had a diagnosis of chronic 1D, 1L She stated the resident had missed several 1D, 1L treatments due to his 1D, 1L or due to his refusal to go. She explained that was why the resident had been hospitalized a couple of times recently; 1D, 1L . In regard to the resident 1D, 1L the 1D, 1L , the RCM stated the resident had a tendency to escalate quickly when he got upset. He would not direct anger towards other residents or staff, but would curse "under his breath..." During an interview on 04/19/18 at 10:04 AM, Staff C, Social Services Director (SSD), stated she spoke with the resident the day prior about his 1D, 1L injury. She stated the resident reported a history of doing the same thing at other facilities when he was upset. She stated all administrative staff and nursing staff were responsible to update the care plans as needed. Reference: WAC 388-97-1020(3)(c)(d)	F 657		
F 689	Free of Accident Hazards/Supervision/Devices	F 689		

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F 689 SS=G	Continued From page 50 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure all measures to reduce the risk of falls and prevent injury were implemented for two of eight residents (#62, 43) reviewed for accidents and incidents. Failure to identify risks factors and develop a supervision plan to mitigate risks resulted in a fall with significant injury to Resident #62. Findings included: Resident #62. Per medical records the resident was admitted on 1D, /18 with diagnoses including 1D, 1L , 1D, 1L and 1D, 1L (medical condition that causes 1D, 1L , and 1D, 1L 1D, 1L and/or 1D, 1L). The resident fell on 1D, /18 which resulted in a 1D, fracture. She was transferrred to the hospital for treatment and was re-admitted to the facility on 1D, /18. The comprehensive assessment dated 03/07/18 showed the resident required extensive assist for bed mobility, transfers, dressing, and eating. She required total assist for toilet use, personal hygiene and locomotion while in her wheelchair.	F 689		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CARE	209 NORTH AHTANUM AVENUE WAPATO, WA 98951

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F 689	Continued From page 51 The resident's Functional Safety Assessment dated 1D, /18 showed the resident's 1D, 1L and 1D, 1L medications affected the resident's activities of daily living. The resident's functional safety assessment also identified a concern related to the resident not being able to move independently. The recommendations made were use of a wheelchair and a 1D, . The potential risks were identified as "Increase injury: from trying to clib [sic] over rails/getting limbs caught in rails, tipping over wheelchair, incident of falls and other accidents, strangulation, choking or death." Per the resident record, prior to admission multiple Physician's Notes and health histories had been provided to the facility identifying the resident leaned forward and slid out of her wheelchair landing on her 1D, 1L . The Health History dated 02/13/18 showed the resident "has pretty severe 1D, 1L and 1D, ." The physician added any change for this resident was difficult for her. He recommended keeping her schedule regimented and gentle re-direction was best for the resident. The nursing progress notes dated 1D, /18 at 1:49 PM showed the resident had increased agitation and distress related to "move (new admit to facility) the resident was striking out at "passersby, rambling intelligibility." The nurse obtained an order for 1D, 1L medication and admininstered the medication to the resident. Per the resident's March 2018 Medication Administration Record (MAR) the resident had been administered both an 1D, 1L and 1D, 1L medication prior to the fall on 1D, /18. Review of Medscape Medical literature on 04/25/18 showed a warning that these	F 689		

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EMERALD CARE	**209 NORTH AHTANUM AVENUE WAPATO, WA 98951**

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F 689	Continued From page 52	F 689		

medications may cause dizziness, unsteadiness, and somnolence (excessive sleepiness), "which may lead to falls and consequently, fractures or other injuries." A review of the resident's record did not reveal any monitoring for the adverse side effects of the medications after they were administered.

The two fall investigations dated 1D, /18 showed the resident fell twice within a 15 minute span. In each of the unwitnessed fall investigations the resident was found lying in her room. The first fall showed no injury, the second fall the resident complained "of pain with movement." An X-Ray was ordered and the resident was diagnosed with an 1D, 1L fracture and transferred to the hospital.

On 04/18/18 at 11:00 AM Staff T, Social Service Assistant, stated the resident "has been aggressive since she was admitted, on the first day I had to bring her into our office to help calm her and she tried to hit me when I attempted to drink water."

04/18/18 at 11:20 AM Staff B, Director of Nursing Services (DNS), stated the nurses were aware of the resident's fall history and her behaviors. She added she was responsible for completing the fall investigations in the facility. She added the resident 1D, constantly, has had six falls since admit and four resident- to- resident altercations. "I feel that the resident needs a more structured activity and one- to- one. We have noticed that when she is at the nurses station and there is a lot of noise around her she will get agitated." She added the resident's 1D, 1L had been changed from as needed to routine to see if the resident's behavior improved. "She is sleeping

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EMERALD CARE	209 NORTH AHTANUM AVENUE WAPATO, WA 98951

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 53 well and eating well. It is during the day that we need to offer more structured activities." On 04/18/19 at 11:30 AM Staff C, Social Service Director stated the resident is busy all day, "she self propels throughout the facility." On 04/19/18 at 10:08 AM Staff D, Licensed Practical Nurse (LPN) Charge Nurse, stated when the resident fell the first time on 03/07/18 a Nursing Assistant (NA) came and notified her of the resident's fall. She added "I assessed the resident, performed range of motion and checked for pain the resident was agitated, she did not verbalize pain, we than transferred the resident back to her wheelchair." She added she was unable to recall if the resident was left in the room or brought out to the front desk. LN added the fall intervention plans were to apply a 1D, 1L on the resident's wheelchair. but before completing the plans the resident fell a second time." She stated she had been called "back again to the resident's room." Staff D, stated the resident had complained of pain after the second fall so she obtained an order for an X-Ray and the resident was transferred to the hospital to repair her 1 fractured 1D On 04/19/18 at 11:32 AM Staff B, DNS, stated she had reviewed the two NAs witness statements and she acknowledged there was no documentation showing "anyone was with her on the first or second fall." She added someone should have been with her after she had her first fall, "We should have been watching her a little closer." She added nursing staff were aware of her fall history and knew the resident had been experiencing increased agitation and confusion due to her 1D, 1L and new environment.	F 689		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CARE	**209 NORTH AHTANUM AVENUE WAPATO, WA 98951**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 54	F 689		

Review of both Report of Resident Occurrence reports dated 03/07/18 and signed by two different NAs with times of occurrence of 4:30 PM and 4:40 PM showed the resident was in her room, staff were walking by her room and saw her on the floor. Both NAs documented the cause of her falls were related to the resident attempting to get out of her wheelchair.

On 04/19/18 at 2:19 PM Staff U, NA, stated she has worked for the facility for about two years and is familiar with the resident. She stated she was aware of the resident having two falls on 1D, /18. She added she attended to the resident's second fall. "I was walking by her room when I saw her on the floor, the resident was alone in her room. Since she was a new resident we had not been given instruction on her cares just that she was a 2 person assist for transfers."

The resident was observed on 04/19/18 from 10:00 to 10:15 AM self-propelling throughout the facility constantly speaking in an 1D, 1L manner. She was observed again between 2:20 PM and 2:30 PM, she was in her wheelchair self propelling, speaking loudly in an 1D, 1L manner and was not able to focus on being interviewed.

Resident #43. Review of the resident's medical record showed she was admitted to the facility on 1D, 17 with diagnoses including 1D, 1L 1D, 1L and 1D, 1L .

The comprehensive assessment dated 03/01/18 showed the resident required a two-person physical assist for transfers.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CARE	**209 NORTH AHTANUM AVENUE WAPATO, WA 98951**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 55 A progress note dated 03/10/18 showed the resident had a non-injury fall during a transfer. The NA stated she was trying to transfer the resident from the wheel chair to the bed and the resident slid to the floor. Review of the facility incident report dated 03/10/18, and updated on 03/16/18, showed that the NA involved was from an agency and not a routine caregiver. She did not review the residents closet care plan prior to attempting to transfer the resident from the wheel chair to the bed. This failure to follow the care directive resulted in the resident's fall. On 04/19/18 at 8:50 AM, Staff B, DNS, stated that the agency NA was "supposed to be" with a staff person for two days as part of her orientation to the facility. She further stated that the agency NA attempted to lay the resident down without reviewing Resident #43's in-room closet care plan. Reference: WAC 388-97-1060 (3) (g)	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 695		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CARE	209 NORTH AHTANUM AVENUE WAPATO, WA 98951

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 56	F 695		

Based on observation, interview and record review, the facility failed to ensure one of one resident (#48) with a change in [redacted] care, received care and services according to professional standards of practice. This deficient practice placed the resident at potential risk for failed therapy and/or infection due to the lack of coordinated care. Findings included:

Resident #48. Per the comprehensive assessment dated 02/19/18 showed diagnoses including [redacted]. The resident made decisions involving her daily care. Listed treatments included using [redacted] therapy.

The care plan dated 02/19/18 listed the resident's need for [redacted] how much, how to position the resident and symptoms of [redacted] to monitor. Nurses changed the [redacted] every week, cleaned the [redacted] weekly and record the [redacted] levels. Initiated on 06/18/12, the plan recorded the resident had [redacted], received [redacted] and noted "(the resident) refuse to wear a [redacted]."

On 04/18/18 at 4:15 PM, Resident #48 stated she used [redacted] from a [redacted] (a device that [redacted] to [redacted]) at the foot of the bed. Wires and [redacted] connected the [redacted] to a [redacted] machine set-up on a rolling bedside table also at the foot of the bed.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CARE	209 NORTH AHTANUM AVENUE WAPATO, WA 98951

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 57	F 695		

The 1D, machine had a 1D, 1L and a 1D, leading to a 1D, Resident #48 reported the 1D, was new for her and the additional box between the 1D, and the 1D, 1L recorded when the 1D, was on and for how long. She watched the 1D, level in the 1D, 1L so it did not dry out during the night after she put the 1D, on; she refilled it with 1D, 1L stored in the closet. With the addition of the 1D, machine there were "too many cords" and "she can't get up."

At night, she stated that she requested and received assistance to get into bed and position comfortably for the night. She then asked a nursing assistant to move the 1D, on the rolling table closer to put on the 1D, and turn the machine on; "it was all preset." The nurses were not helping/checking on the resident or use of the 1D,

Per chart notes, the resident completed a physician ordered sleep study on 03/27/18. On 04/02/18, the sleep study center recommended a 1D, (1D, 1L is a mode of 1D, 1L used in the treatment of 1D, 1L) and would contact the supplier to set-up the machine pending insurance coverage. Received on 04/03/18, the sleep study interpretation included, "Close clinical follow-up for efficacy and compliance monitoring with further adjustments as clinically indicated is recommended. Will likely require 1D, 1L . Consider overnight 1D, 1L at first follow-up." On 04/09/18, the supplier confirmed the appointment for the 1D, fit and set-up on 04/11/18. The chart note on 4/11/18 showed supplier "technician set-up the 1D, discussed setting and use with resident. Settings

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CARE	**209 NORTH AHTANUM AVENUE WAPATO, WA 98951**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 58 sheet placed in chart. Resident uses 1D, 1L (type of 1D,)." On 04/20/18, the Product Information for 1D, in the resident's paper record showed the prescribed settings for the machine. It included detailed cleaning recommendations of the 1D, 1D, and 1D, 1L It included how often the 1D, and 1D, need replacement. On 04/20/18, review of Resident #48's administration records (medication and treatment) failed to find documentation of the new therapy for the treatment of the resident's 1D, 1L condition. The plan of care was not updated. There was no monitoring of the resident's tolerance and compliance to the 1D, therapy nor assessment/evaluation of the effectiveness of the therapy. On 04/20/18 at 10:30 AM, Staff I, Resident Care Manager, stated the Charge Nurse or Licensed Nurse taking the order for a new treatment would update the care plan and add onto the administration record what tasks would be completed and when. A new therapy was monitored with alert charting per the 8-hour shift report. At approximately 10:35 AM on 04/20/18, Staff D, Charge Nurse, stated that someone using a 1D, needed to have listed interventions to refill the 1D, 1L with 1D, 1L (not 1D, 1L) to ensure a sufficient supply was purchased and available in the building, to clean the 1D, and monitor the effectiveness of the treatment since it was started. Staff D looked for, but did not find, interventions or monitoring recorded in the resident's electronic record.	F 695		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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EMERALD CARE	209 NORTH AHTANUM AVENUE WAPATO, WA 98951

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 59 Reference: WAC 388-97-1060(3)(j)(vi)	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure pain management was provided for one of five sampled residents (#119) reviewed for unnecessary medications and one of two sampled residents (#50) reviewed for pain, who required services consistent with professional standards of practice. Failure of the facility to complete a comprehensive pain assessment placed the residents at risk for adverse side effects from the medications being administered to the residents. Findings included: Resident #119. Per medical records the resident was admitted on 1D, /18. The resident's medical diagnoses included 1D, 1L [redacted]. The comprehensive assessment dated 1D, /18 showed the resident was cognitively impaired, he required extensive assist for all activities of daily living.	F 697		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CARE	209 NORTH AHTANUM AVENUE WAPATO, WA 98951

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 60	F 697		

Review of the resident's hospital records revealed a Physician's Note dated 02/05/18 noting the resident "was at home ...and he apparently fell down and could not get up." He had a history of 1D, 1L and and 1D, 1L and weakness of the 1D, 1L .

The February 2018 Medication Administration Record (MAR) showed the resident was admininstered 1D, 1L (pain medication) as needed for a total of 11 times for pain. The March 2018 MAR showed the resident had been given 1D, 1L for a total of 17 times for pain.

Review of the resident's medical record revealed a Physician's order dated 03/05/18 for 1D, 1L 10 mg 1D, 1L medication used for 1D, 1L) to be given in the morning for pain 15 minutes prior to therapy for seven days. The 1D, 1L was admininstered routinely in the morning for pain from 03/06/18 to 03/12/18. The resident's medical record did not reveal the resident had been monitored for adverse side effects such as 1D, 1L (often associated with 1D, 1L use).

On 04/20/18 at 3:57 PM Staff I, Licensed Practical Nurse (LPN), Resident Care Manager (RCM), stated "the resident was not complaining of pain but the family... called and told us the (resident) had pain." "I would check the resident and he did complain of 1D, 1L I think the 1D, was helping him." She added she discussed the concern with the resident's physician and the decision was made to try 1D, 1L prior to his therapy as "his 1D, 1L might be painful." The 1D, 1L was

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CARE	209 NORTH AHTANUM AVENUE WAPATO, WA 98951

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 61 discontinued because "he did not need it as it was mainly his 1D, 1L ." Staff I stated she had not completed a pain assessment prior to the administeration of the 1D, 1L She added sometimes the Director of Nursing Services will complete the pain assessment. Staff I reviewed the resident's medical record and stated she did not see a pain assessment. Per telephone interview on 04/09/18 at 8:45 AM, the resident's family member stated the family had concerns about the administration of 1D, 1L to the resident. Resident #50. Per medical records the resident was admitted on 1D, /13 with diagnoses including 1D, 1L The comprehensive assessment dated 03/07/18 showed the resident was cognitively intact. The medical record revealed the resident was administered an anti-inflammatory medication routinely for 1D, pain and 1D, (pain medication) as needed for mild pain. On 02/18/18 Staff V, LPN, documented on the progress notes that during the evening medication pass Resident #50 approached her and complained of "having 1D, pain." She documented the facility has a standing order for 1D, 1L (a medication that 1D, 1L . This medicine is used to relieve 1D, pain caused by 1D, that does not respond to oral treatment and also treats	F 697		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CARE	209 NORTH AHTANUM AVENUE WAPATO, WA 98951

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 62 [redacted]). The resident's medical record did not reveal a diagnoses of heart disease. On 04/16/18 at 12:02 PM Resident #50's Nurse Practitioner, stated "I saw her today and reviewed her medications and she does not have an order for [redacted]." She added if the nurses administered [redacted] they need to document on the resident's MAR that the medication was administered. On 04/16/18 at 12:47 PM Staff V, LPN, stated she recalled administering the [redacted] She thought she had taken a [redacted] and listened to the resident's heart, "but I do not know what happened to the notes." She added the facility did not have a formal process for assessing the resident's heart for the nurses to complete before or after administering the [redacted] She also was unable to recall if she documented the resident's level of pain. She acknowledged she had not documented the administration of the [redacted] on 02/18/18. Review of the Physician's Protocols dated 09/01/17 showed the protocols included ...'[redacted] as needed for [redacted] pain. May repeat every five minutes times 3. Notify the Provider if no relief. Take [redacted], & complete a thorough [redacted] assessment before and after administration." Review of the Pain Assessment and Management Policy dated 01/18/18 included "...A pain scale was to be used to describe the resident's pain level." Additionally, the policy included a comprehensive list of elements that were to be	F 697		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CARE	209 NORTH AHTANUM AVENUE WAPATO, WA 98951

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 63 included in the resident's pain assessment such as "...location of pain, pain intensity, qualities of pain ...." The protocol further instructed that the resident's pain is to be documented on the resident's MAR and "...documentation will continue every four hours." On 04/16/18 at 12:15 PM Staff B, DNS, stated that when the 1D, 1L is administered per the physician's protocol, the nurses are to add the 1D, 1L order to the resident's MAR. Review of the resident's medical record did not show the resident's 1D, assessment nor any vitals (1D, 1L) on the day the 1D, 1L was administered. There was also no monitoring of the medication adverse side effects such as flushing of the face or neck, headache, irregular heartbeat, nausea, or vomiting. Reference: WAC 388-97-1060 (1)	F 697		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CARE	**209 NORTH AHTANUM AVENUE WAPATO, WA 98951**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 64 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of seventeen residents (Resident #54) receiving 1D, 1L medications had an identified need	F 758		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CARE	209 NORTH AHTANUM AVENUE WAPATO, WA 98951

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F 758	Continued From page 65 for a newly started medication evidenced by a set goal for the therapy, target symptom monitoring and non-medicinal interventions to promote effective sleep. This deficient practice placed the resident at risk for unnecessary medication use. Findings included: Resident #54. Per the medical record the resident admitted into the facility on 1D, /18. The admission assessment dated 1D, /18, showed the resident had multiple diagnoses including 1D, 1L He had 1D, 1L with no memory loss. He was dependent on the assistance of staff for all activities of daily life due to the recent 1D, . Medication orders included 1D, 1L (an 1D, 1L) daily. Behaviors of refusal of care, refusal of medications, withdrawn, and change in sleep pattern were listed as indicators of 1D, 1L for Resident #54. Staff interventions in the event of behaviors were 1:1 conversation, visits with family/friends, offering drink or snack, change of position and/or offering an activity. New admission data collection included documenting how many hours the resident slept every night for 14 days. This started for Resident #54 on 1D, /18 and ended on 1D, /18. The record showed Resident #54 slept 1 hours at first, increased to 1 hours on 1D, and by 1D, , he slept 1 hours nightly. On 02/01/18, the facility 1D, 1L medication committee reviewed Resident #54 for the use of the 1D, 1L , 1D, 1L . The chart note by Staff I, Resident Care Manager/committee	F 758		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CARE	209 NORTH AHTANUM AVENUE WAPATO, WA 98951

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F 758	Continued From page 66	F 758		

member, entered at 1:36 PM showed the resident had taken the medication for a while, it was effective and he had no symptoms of 1D, 1L Additionally, Staff I recorded, "Review of hours of sleep with noted sleep disturbances." Staff I noted a new order to start 1D, 1L (another 1D, 1L) at bedtime related to 1D, 1L Later that day at 5:32 PM, a chart note recorded Resident #54 signed the informed consent form (lists risks and benefits of 1D, 1L therapy) for the 1D, 1L The new medication started on 02/01/18.

The plan of care initiated on 01/29/18 listed a resident focus area of mood/behavior related to the diagnosis of 1D, 1L . Goals of listed interventions included improved mood state, no symptoms of 1D, 1L . "Monitor/record/report" as needed for changes in mood patterns, symptoms of 1D, 1L , and/or sad mood per facility behavior monitoring protocols. An individualized goal/target to measure if the resident had less 1D, 1L or the achievement of productive sleep was not listed; non-medicinal interventions to promote sleep were not listed.

Record review on 04/19/18 at 1:30 PM by Staff D, Charge Nurse, stated monitoring of sleep occurred under "change in sleep pattern" on the target behavior monitor for the 1D, 1L

The behavior monitors did not record any change in sleep pattern. A 02/20/18 chart note showed Resident #54 refused the bedtime dose of 1D, 1L because he reported he had slept all day. Although the record included intermittent notes about the lack of "behaviors (1D, 1L ,

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	505265	A. BUILDING _____ B. WING _____	C 04/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMERALD CARE	**209 NORTH AHTANUM AVENUE WAPATO, WA 98951**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 67 refusals)" tracking/monitoring of 1D, 1L went unnoted. On 04/20/18 at 10:25 AM, Staff I reviewed the facility documentation and addition of 1D, 1L on 02/01/18. She stated that sleep monitoring should have continued; "it slipped through." Noting a change in a sleep pattern did not provide documentation if the new medication for sleep disturbance was effective or not Reference: WAC 388-97-1060 (3)(k)(i)(4)	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review the facility failed to ensure food safety	F 812		

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F 812	Continued From page 68	F 812		

systems were in place to include cleanable surfaces for food preparation and food serve out areas, proper dishwashing sanitation, and food handling practices to prevent cross contamination. This failed practice placed all the residents in the facility at risk for foodborne illness. Findings included:

On 04/13/18 at 10:00 AM, the food preparation counter had a two inch circular area of missing surface laminate, exposing the raw wood (an uncleanable surface). The right corner edge of the food preparation counter had multiple missing pieces of laminate measuring one and half inches, exposing the raw wood.

The front section of the steam table (food serve out area) had a 30 inch long by quarter inch wide strip of missing laminate exposing the wood counter. The 30 inch strip of missing laminate caused the remaining laminate on the front section of the steam table to separate from the wood counter, hence black debris was observed between the wood surface and the laminate. The steam table counter had an approximate 18 inch rubber baseboard unattached and lying on the floor

On 04/13/18 at 10:15 AM the high temperature dishwashing machine's control box readout displayed "177" degree Farenheit during the rinse cycle.

On 04/13/18 at 10:33 AM, Staff R, Facility Chef, stated he was responsible for monitoring the dishwashing machine temperature logs. He added he was concerned about the temperature of the rinse cycle as "it is supposed to be 180."

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F 812	Continued From page 69	F 812		

Review of the February, March, and April 2018 High Temperature Dish Machine Temperature Log the rinse cycle was consistently below the manufacturers recommended rinse temperature. For example from April 1 to April 12, the rinse cycle was below 180 degrees Farenheit 27 times for all three meals.

On 04/13/18 at 10:40 AM, Staff R, stated he had not noticed, nor had he been informed, by his staff that the rinse cycle was not reaching the correct temperature. After reviewing the Dishwashing Temperature Log, he added he was concerned about the "147 degree rinse cycle temperature documented on April 11 and 12, and the lack of multiple temperatures not documented, stating "I find it hard to believe." He added he had no other sanitation methods for checking the water temperatures on the dishwasher.

During lunch preparation on 04/13/18 at 11:24 AM Staff S, Dietary Aide (DA), stood in front of the food preration counter. She placed an approximate 7 inch paring type of knife on the un-cleanable surface (2 inch wood exposed circular area), she then picked up the knife and was about to cut the ham for the salad when she was stopped by the Surveyor. she stated "oh I did not realize I had placed the knife on that surface (referring to the un-cleanable surface)."

On 04/13/18 at 11:46 AM, the technician that services the dish machine stated he was "not sure the temperature gauge on the hot temp dishwasher is reading correctly." He added he had instructed "the kitchen staff to wash the dishes in the three compartment sink, wash, rinse and sanitize and then put the dishes through the

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F 812	Continued From page 70 hot temp dishwasher, until a dishwashing representative "comes next week to repair the washing machine." On 04/13/18 at 12:13 PM Staff S, was observed standing in front of the food preparation counter. She donned gloves and opened a large plastic container full of sour cream. She placed two ounce plastic cups on metal trays. With gloves on, she then left the food preparation counter and went to the middle wood cabinet in the kitchen. She touched the outside facing of the drawer that was worn and unvarnished with small striations that were not cleanable. She returned to the food prep area and proceeded to scoop out the sour cream and place the sour cream inside the plastic cups. Prior to completing the task she stated she was missing a few more plastic cups, she then placed the 6- two ounce plastic cups on the metal trays and she re-arranged the cups placing her fingers inside the cups. She did not remove her gloves and wash her hands during the entire process. On 04/16/18 at 1:53 PM the dishwashing machine service technician stated "the hot temperature water meter had to be recaliberated." He added the meter had been set to have the wash cycle be longer from 40 seconds to a minute and reset the booster temp to 192 "this will affect the final rinse and help maintain the temperature stay at 180 or above." Reference: WAC 388-97-1100(3) Food Code Chapter 246-215-04555 (1)	F 812		