

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

PRINTED: 03/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

732

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505346	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/21/2013
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NAME OF PROVIDER OR SUPPLIER  CHENEY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2219 NORTH 6TH STREET CHENEY, WA 99004
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INITIAL COMMENTS

F 000

This report is the result of an unannounced Off-Hours Quality Indicator Survey conducted at Cheney Care Center on 3/17/13, 3/18/13, 3/19/13, 3/20/13, and 3/21/13. The survey included data collection on 3/17/13 from 12:00 p.m. to 2:00 p.m. A sample of 38 residents was selected from a census of 52. The sample included 33 current residents and 5 former and/or discharged residents.

The survey was conducted by:

\_\_\_\_\_, BSW  
\_\_\_\_\_, RN  
\_\_\_\_\_, RN  
\_\_\_\_\_, RN

The survey team is from:

Department of Social & Health Services  
Aging and Long-Term Support Administration  
Division of Residential Care Services, District 1,  
Unit B  
316 W. Boone Avenue, Suite 170  
Spokane, WA 99201-2351

Telephone: (509)323-7303  
Fax: (509)329-3993

*K. K. [Signature]* 3/29/13  
Residential Care Services Date

RECEIVED  
APR 11 2013  
DSHS  
SPOKANE WA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rita A. Juarez</i>	TITLE Administrator	(X6) DATE 4/8/13
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156 SS=D	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>	F 156	<p><u>F 156 NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</u></p> <p>Resident # 56, 61, and 79 were all given a 3 day Notice of Medicare Provider Non-Coverage stating they would be coming off of Medicare because they no longer qualified for Medicare services. The one of 5 different Skilled Nursing Facility Advanced Beneficiary Notices had not been given as required.</p> <p>An in-service was given to the Multi-disciplinary team, medical records and bookkeeping staff on 3/20/2013 by a contracted expert MDS consultant. The staff demonstrated competency with the Medicare Denial Letter Process by listing which denial letters are used for Part A and Part B residents and ability to identify which residents require continued stay/ Advanced Beneficiary Notices when receiving Medicare services. The expert MDS consultant remains contracted with the facility as a resource for future ABN questions.</p>		

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F 156	<p>Continued From page 2</p> <p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by</p>	F 156	<p>On 4-5-2013 continued in servicing was provided via webinar.</p> <p>Compliance will be monitored by Medical Records, Social Service Director and Administrator on an ongoing basis.</p>	5-6-13
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F 156	<p>Continued From page 3 such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide required liability and/or appeal notices for 3 of 3 residents (#56, 61, 79) in a sample of 38. Findings include:</p> <ol style="list-style-type: none"> <li>1. Resident #56 was on Medicare A from 12/14/12 to 2/6/13. The resident was discharged from Medicare Part A services for coverage reasons and remained a resident in the facility. The facility issued a Notice of Medicare Provider Non-Coverage but did not issue a Skilled Nursing Facility Advanced Beneficiary Notice (SNF/ABN) or one of the 5 uniform Denial letters as required. These notices informed beneficiaries of the right to have a claim submitted to Medicare and advised them of the standard claim appeal rights that apply if the claim was denied by Medicare.</li> <li>2. Resident #61 was on Medicare A from 12/24/12 to 1/23/13. The resident was discharged from Medicare Part A services for coverage reasons and remained a resident in the facility. The resident did not receive the required SNF/ABN.</li> <li>3. Resident #79 was on Medicare A from 12/14/12 to 2/6/13. The resident was discharged from Medicare Part A for coverage reasons and remained a resident in the facility. The resident did not receive the required SNF/ABN. In an interview on 3/21/13 at 1:00 p.m., Staff #B confirmed the required SNF/ABN's were not</li> </ol>	F 156			

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F 156 F 279 SS=D	Continued From page 4 being completed as required. 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to develop a comprehensive care plan with measurable goals and interventions for facility staff to use in the management and treatment of behavioral, mental and/or emotional symptoms, and an indwelling Foley catheter for 3 of 25 residents sampled (# 8, 15, 17) reviewed for initial care plans in a sample of 38. This failure placed the residents at risk for not receiving	F 156 F 279			

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F 279	<p>Continued From page 5</p> <p>consistent care from all staff.</p> <p>Findings include:</p> <p>1. Resident #8 was admitted to the facility on [REDACTED]/11. Diagnoses included [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. The resident required assistance with activities of daily living (ADL's), and meal assistance (feeding). The minimal data set assessment (MDS) completed on 12/18/12 section D, staff assessment of the resident's mood; included Resident #8 had numerous incidents of poor appetite, and low energy. Record review of the resident's medications included daily use of an [REDACTED]. Record review of the resident's March 2013 behavior monitoring indicated no reported behaviors. The resident was observed on 3/18/13 in the day room dressed appropriately, talking and laughing with activity staff. Record review of the resident's care plan did not include measureable goals and interventions related to mood or medications. In a confirming interview with Staff #B on 3/21/13 she confirmed the care plan was not available. The resident's daily medication regime included an [REDACTED] for diagnosed [REDACTED]. The facility failed to include in the comprehensive care plan measurable goals and interventions for staff to follow related to the daily use of medication and evaluation of mood. This failure placed the resident at risk for inconsistent care from all staff.</p> <p>2. Resident # 15 was admitted to the facility on [REDACTED]12. Diagnoses included [REDACTED], [REDACTED], and [REDACTED]. The resident ambulated independently</p>	F 279			

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F 279

Continued From page 6  
with a walker and required minimal assistance with ADL's.  
The minimal data set assessment (MDS) completed on 12/26/12 section D, resident mood interview; included Resident #15 had a score of zero symptoms reported.  
Record review of the resident's medications included daily use of an [redacted] and [redacted] medication and occasional use of an [redacted] medication.  
The resident was observed on 3/18/13 in the day room with her walker. She was asking surrounding staff why she was there in the facility. Staff were heard to tell the resident it was because her sister brought her to the facility.  
Staff # E stated to surveyor in an interview on 3/18/13 that the resident was "confused today". She said the resident becomes confused as to why she is there and how she got there to the facility.  
A record review on 3/21/13 of the residents chart included a room care plan for staff and a blank care plan with no measureable dates or goals. The review of the care plan on the computer did not include goals or interventions for mood and/or medications.  
In a confirming interview with Staff #B on 3/21/13 she confirmed the care plan was not available. The resident's daily medication regime included an [redacted] and [redacted] and occasional use of an [redacted] medication. The facility failed to include in the comprehensive care plan measurable goals and interventions for staff to follow related to the daily use of medication and evaluation of mood until it was discovered by surveyor. This failure placed the resident at risk for inconsistent care from all staff.

F 279

F279 DEVELOP COMPREHENSIVE CARE PLANS

Resident # 8, 15, and 17 have a comprehensive care plan with measurable objectives and timetables to meet these resident's medical, nursing, mental, and psychosocial needs as identified in their comprehensive assessment.

All other residents' charts will be audited for completeness of records and care plans will be updated to reflect their plan of care.

The Multi-disciplinary team will be responsible for the initiating, reviewing, and updating all residents care plans. The MDS Coordinator will be responsible to monitor for compliance.

5-6-13

*[Handwritten signature]*

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F 279 Continued From page 7  
3. Resident #17 had diagnoses that included [REDACTED], [REDACTED] and [REDACTED]. Per record review, the resident was alert and oriented and able to make her needs known. She required extensive assist with most activities of daily living.  
Per record review, progress notes documented the resident was readmitted to the facility on [REDACTED]/13 from the hospital with an [REDACTED] in place.  
Per record review, there was no care plan initiated for the resident's [REDACTED].  
Per interview on 3/21/13 at 2:30 p.m., Staff # A confirmed the resident did not have a care plan in place for her [REDACTED].

F 279

F 280 SS=D 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  
  
The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  
  
A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

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F 280	Continued From page 8  This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to review and revise the plan of care for 1 of 25 residents (#81) reviewed for care planning in a sample of 38 related to [REDACTED]. Findings include: Resident #81 had diagnoses that include [REDACTED] and [REDACTED] with [REDACTED]s. Per record review, the resident had memory problems and was unable to make his needs known. He required extensive assist with activities of daily living. Per record review, nurses notes dated 3/15/13 documented that the resident had an indwelling [REDACTED] placed after he had no results from a straight [REDACTED] (a [REDACTED]). Per record review, the resident's plan of care included goals and interventions for [REDACTED]. The care plan did not have revisions that reflected his change in status which now included an indwelling [REDACTED]. In an interview on 3/21/13 at 2:30 p.m., Staff #A confirmed the resident's care plan had not been up dated to include the [REDACTED].	F 280	<u>F280 RIGHT TO PARTICIPATE PLANNING CARE- REVISE CP</u>  Resident # 81 is not capable of making his needs known and has the tendency to demonstrate negative behaviors towards staff when they are performing activities of daily living. The MD wanted to rule out a urinary tract infection. This resident has a urological medical condition that makes him prone to urinary tract infections. The order was to catheterize the resident, assess the urine, and obtain a specimen. The straight catheter was unsuccessful so a Foley catheter was placed. Once the urine for culture and sensitivity was collected and the urine assessed the Foley catheter was to be discontinued. The care plan for this resident has been updated.  All other residents' with catheters will be reviewed and assessments will be performed to comply with this citation.  The Multi-disciplinary team will be responsible for the initiating, reviewing, and updating all residents care plans. The MDS Coordinator will be responsible to monitor for compliance.	5-6-13	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309			

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F 309	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide the necessary care and services for 2 of 3 residents (#6, 81) related to monitoring of non-pressure related skin issues. Findings include: 1. Resident #81 had diagnoses that include [REDACTED] and [REDACTED] with [REDACTED]. Per record review, the resident had memory problems and was unable to make his needs known. He required extensive assist with activities of daily living. Per record review, the resident had a fall on 3/14/13 and sustained a small laceration on top of his head and a skin tear on his posterior wrist. Review of the resident's plan of care revealed the resident was to have skin assessments weekly, the staff were to chart alterations in skin and note the color, odor, measurement, and amount of drainage if any. Per record review, the resident had his last skin assessment on 3/17/13 and there was no documentation found in the nurses' notes in regard to his newly developed skin issues nor was there documentation on his treatment record (TAR) or in the facilities alert charting. Per observation on 3/19/13, the resident was sitting in the common area in his reclined wheel chair. The resident was noted to have a dry, scabbed area on his wrist. The resident was unable to explain how he received it. Per interview on 3/21/13 at 1:00 p.m., Staff #F stated that if a resident had a new skin issue they</p>	F 309	<p><u>F309 PROVIDER CARE/SERVICES FOR HIGHEST WELL BEING</u></p> <p>Resident # 81 had a fall sustaining a small laceration of his head and skin tear on his left wrist. Both areas of injury had scabbed over and showed no signs or symptoms of infection.</p> <p>Resident #6 has a long history of right great toe skin issues due to bone deformity and poor circulation. At the time of this review the resident's toe had a small intact scab with no signs or symptoms of infection.</p> <p>All residents' skin will be checked and appropriate treatment plans will be initiated as needed. All licensed nurses will be in serviced on receiving, transcribing, and processing Physician orders.</p> <p>The DNS will be responsible to monitor for compliance on an ongoing basis.</p>	5-6-13
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 10</p> <p>were to fill out an in house form, place the information on their alert charting and chart on it each shift. If a treatment was necessary then they would also place in on the TAR.</p> <p>Per interview on 3/21/13 at 2:30 p.m., Staff #A stated if an area was found on the skin assessment it was to be placed on alert charting and then followed until it resolved.</p> <p>2. Resident #6 had diagnoses including history of a [REDACTED]. Per record review, the resident had [REDACTED], some difficulty making daily decisions, no behavior, and required extensive assistance with most activities of daily living. The resident had a chronic red area on the [REDACTED] and a [REDACTED] on the [REDACTED] due to bony deformity and poor circulation.</p> <p>The resident's care plan for the [REDACTED] foot skin problems included relieving pressure to the [REDACTED] foot and weekly monitoring.</p> <p>Per review of the weekly skin assessment and nurse's note dated 3/3/13, the [REDACTED] scab had changed and was softening. Additional record review revealed a licensed nurse notified the physician and requested a skin treatment order for the [REDACTED].</p> <p>A nurse's note dated 3/9/13 noted the physician had not responded to the request for treatment and was contacted again.</p> <p>Per record review, the physician ordered the skin treatment on 3/12/13 but the order was not transcribed on the March 2013 treatment record and the resident was not receiving the skin treatment.</p> <p>Review of the resident's skin assessment dated 3/17/13 noted the measurements for the areas on the [REDACTED] and [REDACTED]. There was no mention of a skin treatment or evaluation of</p>	F 309			

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

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F 309	<p>Continued From page 11 healing or worsening.</p> <p>On 3/20/13 at 3:00 p.m., Staff #A and the surveyor observed the resident's [REDACTED] foot. The [REDACTED] had a red area with intact skin. The 5th toe had a small intact scab with dry wound margins. There was no observable skin treatment applied to either toe. Staff #A confirmed the skin treatment had not been initiated per the physician order and the resident's skin problems had not worsened.</p> <p>Failure to initiate and evaluate a skin treatment ordered by the physician placed the resident at risk for worsening skin problems.</p>	F 309		