

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

PRINTED: 05/17/2013
FORM APPROVED
OMB NO. 0938-0391

1011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505325	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/14/2013
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NAME OF PROVIDER OR SUPPLIER ISLAND HEALTH & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 835 MADISON AVENUE NORTH BAINBRIDGE ISLAND, WA 98110
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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
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Island Health and Rehabilitation Center on May 14, 2013. A sample of 3 current residents and 1 former resident was selected from a census of 51.</p> <p>The following complaints were investigated. 2798583 2802492 2802426</p> <p>The survey was conducted by: [REDACTED], R.N., B.S.N., Complaint Investigator The Complaint Investigator was from: Department of Social & Health Services Aging and Long-Term Support Administration/AL TSA Division of Residential Care Services P.O. Box 45819 Olympia, WA 98504-5819 Telephone: 360-664-8432 Fax: 360-664-8451 <i>[Signature]</i> Date: 5/17/13 Residential Care Services</p>	F 000	<p>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report.</p> <p style="text-align: center;">RECEIVED MAY 29 REC'D DSHS - ADSEA RCS - REGION 5</p>	5/23/13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 5/23/13
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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 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F 225	<p>F - 225 (D)</p> <p>I. How the nursing home will correct the deficiency as it relates to the resident:</p> <p>Residents 1 and 2 no longer reside at the facility. Resident # 1 discharged home with physician orders and resident # 2 transferred to another skilled nursing facility. Both allegations have been investigated and reported to the state hotline per state and federal regulations.</p> <p>II. How the nursing home will act to protect residents in similar situations:</p> <p>The facility interviewed current residents, or resident's legal representative where applicable, to discover if they had concerns. The facility followed up appropriately with investigation and state notification per state and federal regulation for reportable findings.</p>	5/23/13	

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F 225	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure an allegation of neglect and/or abuse was immediately reported to state survey agency in accordance with 42CFR 483.13 (c)(i)(iii)(2)(3)(4) and failed to have evidence the allegation of neglect and/or abuse was thoroughly investigated to protect residents from further potential neglect while the investigation was in process for 2 of 4 (Resident #1 & Former Resident #2) residents reviewed for neglect and abuse. This failure placed the residents at risk for continued potential neglect and/or abuse.</p> <p>Interviews took place 5/14/2013 unless otherwise noted</p> <p>Findings include:</p> <p>Resident #1 had diagnoses to include [REDACTED] with [REDACTED]. Resident #1 had increased [REDACTED] and [REDACTED] and had medication changes. Resident #1 required assistance with her activities of daily living.</p> <p>According to facility investigation completed 5/1/13 Resident #1 was provided toileting assistance by four staff members. Resident #1 was screaming the entire time. After the toileting was completed Resident #1 was taken to the community room and was quiet for a while. She came out of the community room and pointed at three employees in the nurses' station and said, "You raped me." Two of the three employees had been involved in the early toileting of the resident.</p>	F 225	<p>III. Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <p>Supervisors and line-staff have been re-educated regarding reporting guidelines, the need to immediately report allegations of neglect and/or abuse to the state, the requirement to investigate allegations at the time of discovery, to protect the resident/s, and to document the allegation as well as the facility investigation and actions taken.</p> <p>IV. How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <p>Facility actions in relation to resident concerns of neglect and/or abuse will be reviewed weekly during morning manager meeting to ensure that appropriate steps were taken by the staff at the time of the allegation. Findings will also be reviewed during the next three scheduled QA meetings to ensure that ongoing compliance is sustained.</p>	5/23/13

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F 225	<p>Continued From page 3</p> <p>During the facility investigation it was noted staff did not report the allegation of rape to the state agency because they knew it had not occurred since there were multiple witnesses to the toileting process. The Director of Nursing Services (DNS) then reported it to the state agency.</p> <p>According the written report by the Administrator, staff were educated about reporting and notification requirements even if incident was unsubstantiated.</p> <p>Former Resident #2 was admitted to the facility [REDACTED]/13 with diagnoses to include [REDACTED] and [REDACTED]. She was assessed by the facility as being alert and oriented with confusion at times.</p> <p>Review of the medical record indicated allegations of neglect were made, "...was not receiving care she needed highlighting that her foot was worse." "...nothing had been done right." "...accusations that we are not doing our job ..." "It's been a month and you still don't know what's wrong with (Resident #2), you are doing nothing."</p> <p>The documentation indicated staff tried to inform Resident #2 that her foot was better and things were being done for the resident.</p> <p>Resident #2 was transferred out of the facility on [REDACTED]/13 by the family to another skilled nursing facility.</p> <p>There was no investigation or report made of the</p>	F 225	<p>V. Dates when corrective action will be completed: May 23, 2013</p> <p>VI. The title of the person/s responsible to ensure correction:</p> <p>Administrator, Director of Nursing, Educational Training Director</p>	5/23/13	

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F 225	Continued From page 4 allegations. In an interview with Social Service Director, she stated Resident #2's friend was upset because of a missing purse, which was later found, and when she and the Director of Nurses spoke to him things snow balled. She did not recognize the statements as allegations of neglect at the time because the issues were addressed and were unfounded. In an interview with Licensed Nurse (A) she said the allegations were unfounded and were dealt with at the time and thus did not need to be reported. In a telephone interview with Director of Nurses on 5/15/13 she said she felt the issues did not have credence and so had not reported them. She also said, "In hindsight I should have reported it." She admitted she probably needed some more education regarding reporting guidelines.	F 225		5/23/13	