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

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FORM APPROVED
OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	505387		C 07/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROVIDENCE MOTHER JOSEPH CARE	3333 ENSIGN ROAD NORTHEAST OLYMPIA, WA 98506

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F 000	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Survey conducted at Providence Mother Joseph Care Center on July 30, 2014. A sample of 3 current residents and 2 former residents was selected from a census of 144. The following complaints were investigated. 3029539 The survey was conducted by: Catherine Litsiba, R.N., B.S.N., Complaint Investigator The Complaint Investigator was from: Department of Social & Health Services Aging and Long-Term Support Administration/ALTSA Division of Residential Care Services P.O. Box 45819 Olympia, WA 98504-5819 Telephone: 360-664-8432 Fax: 360-664-8451	F 000	RECEIVED AUG 20 2014 DSHS/ADSA/RCS	
	Jean Pierce Date: 8-8-14 Residential Care Services			

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE Aug 15 2014

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ıer safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ›gram participation.

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F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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. 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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 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.	F 225	F 225 Resident #3 expired on [redacted] 14. To protect all Residents, the Long Term Care (LTC) Unit Managers will review all Resident care plans and Resident care profiles in CareTracker (CNA care plans) to ensure each Resident's transfer status is accurate and appropriate. The LNs will put all Residents with changes in transfer status on alert charting for a minimum of 72 hours. The LNs will also report changes in transfer status to on-coming LNs and CNAs prior to start of each shift. "Transfer Status Change x 72 hrs" has been added to the 24 hour Change in Status (alert charting) form (see Attachment #225-A). The LNs will be in-serviced related to these changes, to include daily documentation requirements. The LNs and CNAs were in-serviced 8/5/14 and 8/8/14 on the importance of following the care plan and Resident care profile for all transfers. They were also instructed that if a fall occurred during transfer, they are	

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F 225	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure an incident of possible neglect and/or abuse was reported to state survey office in accordance with 42CFR 483.13 (c) (i) (iii) (2) (3) (4) and failed to have evidence the incident of possible neglect and/ or abuse was thoroughly investigated to protect residents from further potential neglect and/or abuse while the investigation was in process for 1 of 5 (#3) residents reviewed for neglect and abuse. This failure placed the residents at risk for continued potential neglect and/or abuse. Findings include: Resident #3 was a long term resident of the facility. Resident had diagnoses to include Alzheimer's Dementia and [redacted] Resident was admitted to hospice services on [redacted]14 and expired in the facility on [redacted]14. Document review indicated on 7/5/14 Resident was noted to have bruising to her right arm. The documentation noted a decline in the resident's condition with increased weakness. Facility determined after investigation and assessment the resident now required 2 staff members to assist with transfers until the resident could be assessed by physical therapy. Resident's care plan was updated to reflect the change from a 1 person transfer to a 2 person transfer. The change in transfer status was also noted in the care tracker system (system used to notify the nursing assistants of the plan of care and any changes made).	F 225	responsible to document the transfer assistance that was being provided at the time of fall on the Unusual Occurrence Report (UOR) witness statement. The Unit Managers that are responsible for UOR summaries will investigate transfer status for any fall that occurred during transfer. Those findings will be documented in the UOR investigation summary. The LTC Nurse Managers will review the alert charting board each weekday and note any transfer status changes. They will be responsible to audit the nursing notes to ensure they reflect appropriate documentation (TCU transfer status is updated PRN on in-room white boards). This will be done for a period of 30 days. The LTC Nurse Managers will also be responsible to round weekly and question a sample of floor nurses and CNAs to ensure they are knowledgeable of current transfer status. This will be part of their regular daily rounding to ensure on-going compliance and sustain solutions.	

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F 225	Continued From page 3 On 7/7/2014, according to the medical record, Resident #3 was being toileted by staff. During the transfer from the toilet to the wheelchair the resident became weak and fell forward bumping her head on the call light box on the wall. There was small amount of bleeding to the right lateral side of the eyebrow. The investigation completed by the facility indicated there was only one staff member transferring the resident. The conclusion was made the resident needed to be made a Maxi lift with 2 person assistance. Care tracker was updated to reflect the change. Resident #3 was made a 2 person transfer on 7/5/14. On 7/7/14 the care plan was not followed when resident was transferred with only 1 person. The investigator did not recognize the fact the care plan was not followed and therefore did not recognize and/or rule out the possibility of neglect and/or abuse. The incident was not thoroughly investigated and it was not reported to the state as required. During the exit interview the Director of Nurses had no explanation as to why it was not realized the resident was a 2 person transfer already at the time of the incident on 7/7/14.	F 225	Corrective action will be complete by 8/22/2014. The DNS will be responsible to ensure correction.	
F 309 SS=G	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	F 309 Resident #1 received medical treatment that resolved her infection and is now receiving prophylactic antibiotics. She currently has no signs or symptoms of infection or any complaints related to. LN A was removed from duty immediately after surveyor exit on 7/30/14 and is no longer in the employment of PMJCC.	

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F 309	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to comprehensively assess and ensure timely notification of a physician regarding a change in condition for 1 of 5 (#1) residents. Failure to communicate the resident's condition to a phsyician caused harm to Resident #1 when treatment was delayed and she was sent to the hospital for urinary tract infection. Findings include: Resident #1 was a long term resident of the facility. She had diagnoses to include chronic pain and anxiety. According to Minimum Data Set (MDS an assessment tool used by the facility) she was alert and oriented and able to make her needs known. She required the assistance of staff to meet her needs to include toileting and was generally incontinent. Document review indicated Resident was ordered Macrobid (anti-biotic) on 7/9/14 for a urinary tract infection (UTI). Macrobid was completed on 7/16. On 7/18 nursing documented, "Resident complaining of burning upon urination with abdominal pain. Urine is cloudy with clear coloring and has a strong odor. Resident ended a Macrobid therapy for UTI on 7/16. On routine pain management medication." There was no indication the physician was notified of the resident's complaint of pain with urination or the condition of the urine. After 7/18 there was no documentation of any assessment regarding urinary issues. On 7/22,	F 309	All Patients/Residents will continue to be put on alert charting for change in condition and be assessed and documented on each shift/PRN throughout shift. Any notification (fax) or call out to the physician will be put on the alert charting board to monitor for timely physician follow-up. The Long Term Care (LTC) physician group was notified not to remove faxes from the facility and of the need to address all calls/faxes timely as appropriate to the severity of the change in condition. The LTC practice of re-copying the 24 Change of Condition report (alert charting report) each night will be changed to a "running" report (current practice on TCU) to ensure that no transcription omissions/errors are made. Residents will not come off the report until the change of condition is resolved. The LNs will be in-serviced on changes made to the 24 Hour Change in Status (alert charting) report form and the new protocol.	

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F 309	Continued From page 5 according to nursing note written at 10:01, "MD (physician) called with new order to start Macrobid 100mg po (by mouth) BID (2 times a day) for 10 days for UTI. Obtain a UA (urine analysis) sample first prior to starting Macrobid therapy. UA with C&S (culture and sensitivity) order." There was no documentation to indicate why the physician was called for the order, as there was nothing in the documentation to indicate resident had any symptoms of a UTI. On 7/23, according to the documentation written at 00:01 the UA was collected and sent to the lab. Documentation also indicated the resident had no difficulty voiding and voided sufficient quantity. Macrobid was started as ordered. Documentation on 7/23 at 23:33 reported, "Resident very lethargic and slurring speech was unclear when RN (registered nurse) was giving 1600 (4p.m.) medications. RN called PCP (primary care physician) at 16:30 (4:30p.m.) and waited for return call back. Vital signs at 1600 BP (blood pressure) 110/80, P (pulse) 90, R (respirations) 20, SAT (oxygen saturation) 89-94%. At 1830 (6:30p.m.) retried calling PCP d/t (due to) no return call at this time. PCP returned call by 1900 (7p.m.) gave report to MD regarding resident lethargy and speech. On call PCP gave orders to hold all medication and to continue to monitor. Resident still unresponsive and her vitals at 2000 (8p.m.) was 112/68, P 70, R 18, SAT 85%. RN called PCP and got order to call 911 and send resident to ER (emergency room)." Resident was admitted to the hospital and diagnosed with a urinary tract infection and returned to the facility on [redacted] There was no documentation to indicate what	F 309	The LTC Nurse Managers will review the alert charting board each weekday (for one month) and make note of any "MD Notification" and check that timely follow up and documentation was completed. The Managers will continue to monitor a weekly sample for an additional sixty (60) days to ensure that the solutions are sustained. The facility initiated the use of InterAct III SBAR communication forms for physician notification on 5/19/14. The LNs have received on-going education on the use of these forms. After they complete the SBAR, it is then put in the Manager's box for end of month Quality Assurance (QA) review. The facility will continue to develop the SBAR QA data and outcomes to ensure on-going compliance. Corrective action will be complete by 8/22/14. It will be the responsibility of the DNS to ensure on-going correction.	

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F 309	Continued From page 6 was done for the resident between 4p.m. and 8p.m. There was no evidence of further assessment of the resident between 4p.m. and 8p.m. Resident #3 was interviewed in her room on 7/30. She was alert and oriented and in no obvious distress. When asked about her recent visit to the hospital she said she went because she had a UTI. She stated, "I had a UTI for a long time but I could not convince the staff of it." "I have chronic pain, and I am always in pain so they thought it was my normal pain and I could not convince them I was miserable." Resident also stated she had been recently treated for a "bladder" infection and when she complained of pain with urination she was told to wait and see if it got better. She said they finally sent her to the hospital because she became lethargic and they were concerned. She had no concerns regarding her care since return to the facility and denied current pain related to UTI. LN (licensed nurse) A was interviewed on 7/30 while at her medication cart. She stated she documented her assessment of the resident in the chart on 7/23. She stated she assessed the resident every hour and she had a fever because they already knew she had a UTI. She had no explanation why her assessments were not documented as she contended, or why she waited so long to re-call the PCP when she got no response after the initial call. In the exit interview on 7/30, LN B stated she had been there the evening when Resident #3 was sent to the hospital and had assessed the resident. She stated the resident was responsive but would not respond to LN A. LN B	F 309		

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F 309	Continued From page 7 acknowledged Resident was lethargic and had slurred speech. She admitted she did not document her assessment of the resident but would make a late entry. In the exit interview on 7/30, the DNS (Director of Nurses) said the documentation made by LN A was incorrect and did not reflect the resident accurately. She stated the resident was not unresponsive, she just did not respond to LN A. DNS and LN B indicated the lack of response from the resident was because of behaviors, "If she does not like you she will not talk to you, and LN A was a new nurse, so the resident did not respond to her."		F 323 Resident #3 expired on [redacted]14. To protect all Residents, the LTC Unit Managers will review all Resident care plans and Resident care profiles in CareTracker to ensure transfer status is current and appropriate. The LNs will put all Residents with changes in transfer status on alert charting for a minimum of seventy two (72) hours. The LNs will also report out to LNs and CNAs any changes in transfer status prior to start of each shift. "Transfer Status Change" has been added to the 24 hour Change in Status (alert charting) form (see Attachment #225-A). The LNs will be in-serviced related to these changes, to include daily documentation requirements.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		
	This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure adequate supervision, and failed to ensure revised care plans were carried out to prevent further occurrences of falls for 1 of 5 residents (#3). The facility also failed to ensure complete assessments of the residents were completed after falls to ensure there was no latent injury for 1 of 5 residents (#2).		The LNs and CNAs were in-serviced on 8/5/14 and 8/8/14 related to following the Plan of Care (POC) for all transfers and, if a fall occurred during transfer, to document the transfer assistance that was being provided on the Unusual Occurrence Report (UOR) witness statement.	

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F 323	Continued From page 8 These failures placed Resident #3 at risk for continued falls and Resident #2 at risk for unidentified injuries and complications related to the falls. Findings include: Resident #3 was a long term resident of the facility. Resident had diagnoses to include Alzheimer's Dementia and [redacted] Resident was admitted to hospice services on [redacted]/14 and expired in the facility on [redacted]/14. Document review indicated on 7/5/14 Resident was noted to have bruising to her right arm. The documentation noted a decline in the resident's condition with increased weakness. Facility determined after investigation and assessment the resident now required 2 staff members to assist with transfers until the resident could be assessed by physical therapy. Resident's care plan was updated to reflect the change from a 1 person transfer to a 2 person transfer. The change in transfer status was also noted in the care tracker system (system used to notify the nursing assistants of the plan of care and any changes made). On 7/7/2014, according to the medical record, Resident #3 was being toileted by staff. During the transfer from the toilet to the wheelchair the resident became weak and fell forward bumping her head on the call light box on the wall. There was small amount of bleeding to the right lateral side of the eyebrow. The investigation completed by the facility indicated there was only one staff member transferring the resident. The conclusion	F 323	The Unit Managers that are responsible for UOR investigations will ensure that the current plan of care was being followed at the time of any fall that occurred during transfer and will document those findings in the UOR investigation summary, ensuring that solutions are sustained. The LTC Nurse Managers will review the alert charting board each day and note transfer status changes and review the nursing notes to ensure the notes reflect appropriate documentation (TCU transfer status is updated daily on in room white boards). The LTC Nurse Managers will also be responsible to round weekly and question a sample of floor nurses and CNAs to ensure they are knowledgeable of current transfer status. This daily and weekly audit will occur for three (3) months. Resident #2 is at his normal baseline. Current neurological assessment is negative for adverse findings related to fall on 7/19/14. His forehead wound has resolved without complication.	

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F 323	Continued From page 9 was made the resident needed to be made a Maxi lift with 2 person assistance. Care tracker was updated to reflect the change. Resident #3 was made a 2 person transfer on 7/5/14. On 7/7/14 the care plan was not followed when resident was transferred with only 1 person. Resident #2 was a long term resident of the facility. He had diagnoses to include dementia, [redacted] and chronic pain. According to the MDS he was dependent on staff for cares, was cognitively impaired and was a fall risk. Resident could answer basic yes and no questions. He had physician orders to include Coumadin (anti-coagulant) secondary of a history of blood clots. On 7/19/14 the resident had a fall from his wheelchair. Document review indicated he had hit his head and had red area on his forehead measuring 2.5cm x 2.5cm. Documentation indicated neurological checks were started and his care plan was updated to include, "tilt wheelchair when left alone in his room."	F 323	The LNs were in-serviced on 8/5/14 and 8/8/14 on the importance of completing the entire neurological assessment, flow sheet, and documentation of findings. "Neuro checks x 72hrs" will be added to the Change in Status Report (alert charting) to ensure that the nurses are reporting out at end of each shift to on-coming shift (see attachment #225-A). The LNs will be in-serviced on changes made to the 24 Hour Change in Status (alert charting) report form and the new protocol. The neuro flow sheets will be kept in the MAR as the first sheet filed behind the Resident tab while in progress. When complete they will be put in the Unit Manager's box. The Unit Manager will audit for completion before filing in the medical record.	
	Review of the neurological flow sheet for the Resident #2 indicated neurological assessment was not completed. There was no indication the resident's level of consciousness had been assessed after the first 45minutes. There was no indication the resident's pupil response was ever assessed. (Both the level of consciousness and pupil response are important areas of assessment for neurological change and possible injury).		Staff will be educated that all tilt-in-space (TIS) and Bentley wheel chairs (which are used for pressure release, positioning, and comfort) will be assessed, reclined, and care planned per the following interventions as applicable:	

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F 323	Continued From page 10 Nursing documentation in the progress notes 7/19 - 7/21 indicated resident's neuro's (neurological assessment) were "WNL" (within normal limits). There was nothing to indicate how this was determined or what the normal limits were. Review of the care plan on 7/30 indicated the care plan and care tracker had been updated to reflect staff should tilt resident's wheelchair when left alone in his room. The plan of care did not indicate how far the chair should be tilted. Resident #2 was interviewed in his room on 7/30. He was in his bed in no apparent distress. He was asked simple yes and no questions. He denied pain and he denied concerns with his safety and/or his care. In an interview with LN B on 7/30 she stated she would fix the care plan to indicate the amount of tilt to be provided by the staff.	F 323	• Tilt-In-Space/Bentley wheel chair for positioning, pressure relief, and safety. • Consent signed. • Recline to position required to obtain goals. • Provide positioning that allows for Patient/Resident choice and comfort. • Notify LN if Patient/Resident is unsafe or states they do not want to be in chair. • Resident confused. Do not leave in upright position if unattended (out of sight of staff). • "Other Patient/Resident specific interventions as required." All Patients/Residents in a TIS or Bentley wheel chair will be reassessed and their care plans and care profiles will be reviewed and updated to reflect the above interventions. Therapy staff will continue to assess and document need for TIS and Bentley wheel chair use and notify nursing when a TIS or Bentley wheel chair has been ordered. See attached page (12).	