

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

1098
PRINTED: 12/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505473	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/10/2013
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NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5520 BRIDGEPORT WAY WEST UNIVERSITY PLACE, WA 98467
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at University Place Care Center on 12/4/13, 12/5/13, 12/6/13, 12/9/13, and 12/10/13. A sample of 31 residents was selected from a census of 94. The sample included 20 current residents and the records of 11 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████ RN, MN ██████████ RN, BSN, MSN ██████████ RN, BSN ██████████ PhD, RN, MS, MSN, APFNS</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Long-Term Support Administration Residential Care Services, District 3, Unit A P.O. Box 45819, MS: N27-24 Olympia, WA 98504-5819</p> <p>Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p><i>[Signature]</i> 12/20/13 Signature Date</p>	F 000	<p><u>The following written allegation of compliance is intended to meet the requirements for a plan of correction under state and federal law and is not an admission that the survey findings are correct or that they rise to the level of deficiencies under applicable law.</u></p> <p>RECEIVED</p> <p>JAN 06 REC'D</p> <p>DSHS - ADSA RCS - REGION 5</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE LNHA	(X6) DATE 1/2/14
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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: A description of the manner of protecting personal</p>	F 156	<p>F-156</p> <p>Resident #11 and #101 have been discharged from the facility.</p> <p>Review of financial files was completed by Business Office.</p> <p>Key staff will be inserviced on SNFABN and NOMNC provision.</p> <p>Audits will be conducted by the Administrator or designee to determine ongoing compliance. Results will be forwarded to Quality Assurance Committee for review of trends/patterns.</p> <p>Correction Date: 1-24-14 and on-going</p> <p>Administrator or designee will be responsible for compliance.</p>	

~~Christine Patten~~, LNHA 1/2/14

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F 156	<p>Continued From page 2 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 such benefits.</p>	F 156		

~~Clayton Miller~~, LNHA 1/2/14

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F 156	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide Liability Notices & Beneficiary Appeal Rights forms to 2 of 4 sampled residents (#s 11 & 101) who were included in the Stage 2 review. The Notice of Medicare Non-Coverage (NOMNC) was not provided to resident #11 and the Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) was not provided to resident #101. This failure placed the residents at potential risk of not being able to exercise their rights regarding liability and appeal reviews of services not covered under Medicare.</p> <p>Findings Include:</p> <p>RESIDENT #11 On 12/10/13 Staff G stated Resident #11 was admitted on [REDACTED]/13 and discharged home on [REDACTED]/13. The resident had used 21 days of Medicare services with 79 days remaining. Staff G stated he/she was unable to identify documents in the residents record that of the Notice of Medicare Non-Coverage (NOMNC) had been issued when Medicare services ended.</p> <p>Pub 100-04-Medicare Claims Processing update (30/260.3.9-Notice Retention for the Notice of Medicare Non-Coverage) dated May 24, 2013 with an effective date of 8/26/13 requires the provider must retain the original signed NOMNC in the beneficiary's file.</p> <p>RESIDENT #101 On 12/10/13 Staff G stated resident #101 was</p>	F 156		
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~~XXXXXXXXXXXXXXXXXXXX~~, LNHA 1/2/14

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F 156	<p>Continued From page 4</p> <p>admitted to the facility on [REDACTED]/13 and discharged on [REDACTED]/13 to another care facility. During this admission, the resident was transferred to the hospital on [REDACTED]/13 and returned to the facility on [REDACTED] 13.</p> <p>The Notice of Medicare Non-Coverage (NOMNC) with an effective date of July 25, 2013 was signed by the resident's representative on July 23, 2013. The resident remained in the facility until discharge on [REDACTED]/13. The required Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) that must be provided when Medicare coverage ends and the resident wishes to remain in the SNF receiving custodial care, was not in the documents provided to the resident.</p> <p>Staff G stated when asked if form 10055 (SNFABN or denial letter) had been provided to the resident to explain costs and billing responsibilities stated, the resident's representative had signed the Advance Bed Placement Notice included in the admission packet when Resident #101 was admitted. The form lists the resident's private pay costs when Medicare coverage ends.</p> <p>Pub 100-04-Medicare Claims Processing update (30/261-Expedited Determination Notice Association with Advance Beneficiary Notices) dated May 24, 2013 with an effective date of 8/26/13 reports some situations may require two notices at the end of Medicare covered care. One included when the beneficiary's Part A stay is ending because skilled level care is no longer medically necessary and the beneficiary wishes to remain in the SNF receiving custodial care. The beneficiary must receive the Notice of Medicare Non-Coverage (NOMNC) two days</p>	F 156			

~~Shirley A. Proctor~~, LNHA 1/2/14

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F 156	Continued From page 5 prior to the end of coverage. A SNFABN must also be delivered before custodial care begins. Review of the records revealed a Notice of Medicare Non-Coverage (NOMNC) Quality Improvement Organization (QIO) Agreement letter dated 07/29/13 upheld the determination to terminate services. The letter records the resident was notified of the determination by telephone on 7/26/13 that Medicare services would no longer be provided beginning 7/26/13. Records also revealed a Medicare Expedited Appeal Request response letter dated 8/9/13 stating the appeal decision was unfavorable. The resident remained in the facility after receiving the unfavorable decision. Neither a SNFABN nor Denial Letter as required were provided by the facility in the record of documents given to the resident to inform her/him of potential liability for payment for continued to stay in the facility.	F 156			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide care and services in a manner that promoted and protected resident dignity and	F 241	<u>F-241</u> Spoke with Resident # 7 and informed her of the interventions that have been implemented and she reports no further issues. Upon surveyor bringing the issue to light, Administrator placed signs on the doors to the restrooms in the shower rooms stating "Residents		

~~Cherish A. Miller~~, LVHA 1/2/14

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F 241	<p>Continued From page 6</p> <p>individuality for 1 of 20 Sampled Residents (#7) reviewed for care and services. This failure placed residents at risk for feelings of embarrassment, loss of dignity and diminished quality of life.</p> <p>Findings include:</p> <p>Resident #7 was admitted to the facility on [REDACTED]/13 with multiple medical diagnoses including [REDACTED] and [REDACTED]. Resident #7 required extensive staff assistance with dressing and bathing.</p> <p>On 12/6/13 at approximately 1:00 p.m., the Resident was observed and interviewed following a shower. The shower room used by the Resident had entrances from both the 100 and 200 hallways. Among others, Staff Z was observed to enter the shower room from the 100 hallway without knocking [no sign available to indicate use] and walk by several resident shower stalls to use the bathroom.</p> <p>Staff W, Z and BB stated resident shower bathrooms were used by staff members. Staff K stated employees had their own bathrooms and they should probably use those and not the residents' bathrooms.</p> <p>Resident #7 was asked about her privacy during showers and how she felt when staff members used the bathroom while she was showering. She stated: "Yes that happens a lot. When I was married I was too modest to undress in front of my husband. When you come to a place like this, you have to learn to let go of your modesty. I have learned to let it go--it doesn't bother me anymore."</p>	F 241	<p>Only" and began inservicing staff.</p> <p>Staff K, W, Z and BB have been inserviced on the location of staff restrooms. All other staff members have been inserviced on the location of staff restrooms.</p> <p>Ransom audits will be conducted by the DNS or designee to determine ongoing compliance. Results will be forwarded to Quality Assurance Committee for review of trends/patterns.</p> <p>Correction Date: 1-24-14 and on-going</p> <p>Director of Nursing or designee will be responsible for compliance.</p>		

~~Abuse at [REDACTED]~~, LNHA 1/2/14

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F 241	Continued From page 7 On 12/6/13 at approximately 2:30 p.m., interview with the Administrator and Maintenance Director revealed they were not aware of employees' practices of using resident common use shower room bathrooms or the lack of privacy/signage on the doors. They stated they would follow-up on this issue.	F 241		
F 285 SS=E	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority	F 285	F-285 Resident #175, 34, 110, and 92 have been discharged from the facility. Resident #130's PASRR is accurate and Level II evaluation has been completed. Audit was completed for residents and PASRR forms are in place and referred to Level II evaluation as needed. Facility will attempt to educate hospital on their responsibilities as it relates to PASRRs. Nurses who complete new admissions will be inserviced on reviewing and revising PASRRs as needed upon admission.	

~~Administrative~~, LNHA 1/2/14

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F 285	<p>Continued From page 8</p> <p>has determined prior to admission--</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>For purposes of this section:</p> <p>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).</p> <p>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR) assessments were accurately completed prior to admission to the facility for 2 of 3 Sampled Residents (#'s 175 and #130) and 3 of 11 former Residents (#'s 34, 110 and 92) reviewed for PASRRs. Failure to ensure PASRR's were done and/or accurately completed, placed residents at risk for inappropriate placement and/or not receiving timely and necessary services to meet their mental health [MH] and/or developmental disability [DD] care needs.</p> <p>Findings include:</p> <p>According to the most recent December 2012 State PASRR form, "hospital staff members will</p>	F 285	<p>Audits will be conducted by the Social Services or designee to determine ongoing compliance. Results will be forwarded to Quality Assurance Committee for review of trends/patterns.</p> <p>Correction Date: 1-24-14 and ongoing</p> <p>Administrator or designee will be responsible for compliance.</p>

~~Chantal A. Miller~~, LNHA 1/2/14

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F 285	<p>Continued From page 9</p> <p>initiate the PASRR process and when necessary, coordinate services with the designated MH PASRR evaluator or DD program manager to complete Level II evaluations [a comprehensive evaluation conducted by an an independent/state contracted mental health professional to determine if residents require mental health or DD services] prior to admission to nursing facilities." The form further indicated: "The nursing facility [NF] is responsible for assuring the form is complete and accurate at the time of, or before, admission. The NF must maintain and update this form as necessary."</p> <p>1) Resident #175 was admitted from the hospital to the facility on [REDACTED]/13 with multiple medical diagnoses that included [REDACTED] and [REDACTED] indicators. These indicators required a Level II evaluation. The hospital failed to perform the PASRR evaluation. The facility completed the PASRR and requested a Level II on 10/14/13. As of 12/6/13, the required Level II evaluation had not been done.</p> <p>2) Resident #130 was admitted from the hospital to the facility on [REDACTED]/13 with multiple medical diagnoses including "[REDACTED]" as noted on the physician's admission record. The hospital PASRR dated 2/1/13 was inaccurate and failed to indicate [REDACTED] that required a Level II evaluation.</p> <p>The facility completed a PASRR on 5/18/13 that indicated [REDACTED] and the need for a Level II evaluation. The independent [outside] evaluator completed the Level II evaluation on 10/3/13, resulting in a 9 month delay in referrals for mental health services after admission.</p>	F 285			

Christine [REDACTED], LNHA 1/2/14

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F 285	Continued From page 10 At noon on 12/6/13, during interview with Staff H regarding the PASRR process, it was learned the facility had repeated problems obtaining completed and/or accurate PASRR's from the hospital and obtaining timely PASRR/DD evaluations. Staff H showed a documentation log of PASRR process problems that evidenced the facility's inability to obtain accurately completed PASRRs and obtain independent [outside] mental health evaluations and services in a timely manner. 3) Former Resident #34 was admitted to the facility from the hospital on [REDACTED]/13 with multiple medical diagnoses including [REDACTED] and [REDACTED] failure ([REDACTED]). The hospital PASRR dated 8/20/13 was inaccurate and failed to indicate [REDACTED] which would indicate a need for a Level II evaluation. Further review of the Resident's PASRR Advanced Categorical Determinations (ACD's) included a severe medical condition ([REDACTED]) and may have allowed the resident to remain in the facility without the need for a Level II. The resident was discharged on [REDACTED]/13 without an accurate PASRR. 4) Former Resident #110 was admitted to the facility from the hospital on [REDACTED]/13 with multiple medical diagnoses including [REDACTED] disorder. The hospital PASRR dated 7/17/13, indicated a 30-day stay which would not require a Level II evaluation. The facility Social Services (SS) staff completed a PASRR on 7/29/13 and requested a Level II evaluation. The Resident was discharged within 30 days on [REDACTED]/13 making a Level II evaluation unnecessary. 5) Former Resident #92 was admitted to the	F 285			

~~Christine [REDACTED]~~, LNHA 1/2/14

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5520 BRIDGEPORT WAY WEST UNIVERSITY PLACE, WA 98467		
(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 285	Continued From page 11 facility from the hospital on [REDACTED]/13 with multiple medical diagnoses including [REDACTED], [REDACTED] and [REDACTED] disease ([REDACTED]). The hospital did not complete a PASRR. Facility staff completed the PASRR on 9/2/13 but failed to indicate [REDACTED] or the [REDACTED]s [REDACTED], [REDACTED] to indicate whether a Level II evaluation was required and the resident may remain in the facility without a Level II.	F 285			

~~Alvina [REDACTED]~~, LNHA 1/2/14