STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505473	A. BUILDING _____ B. WING _____	11/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PLACE CARE CENTER	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 000	INITIAL COMMENTS This report is the result of an unannounced Quality Indicator Survey conducted at University Place Care Center on 11/03/14, 11/04/14, 11/06/14, 11/07/14, and 11/10/14. The survey included night hours on 11/06/14 from 7:30 p.m. to 9:30 p.m. A sample of 27 residents was selected from a census of 98. The sample included 22 current residents, the records of five former and/or discharged residents. The survey was conducted by: Shelly Darnell, BSS Erika Hurley, MS Rebecca Kane, RN, MN Gilda Warden, EdD, RN-BC The survey team is from: Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, District 3 P.O. Box 45819 Olympia, Washington 98504-5819 Telephone: 360.664.8420 Fax: 360.664.8451 Signature 11/20/14 Date	F 000	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 RECEIVED DEC 08 2014 DSHS - ADSA RCS - REGION 5	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 12/2/2014

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 000	Continued From page 1	F 000		12/5/2014
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by:	F 157	Resident 222 was discharged to the hospital and resident 120 was discharged home. Resident Care Manager is provided with weight variance list weekly and in conjunction with Registered Dietitian will review weights for any weight loss trend or weight gain trend. RCM will notify MD immediately. DNS will monitor compliance via weekly weight loss meeting and any trends reported to QA committee for follow-up.	

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F 157	Continued From page 2 Based on observation, interview and record review it was determined the facility failed to notify the physician in a timely manner regarding significant weight loss for 2 of 4 current sampled residents (#222 & 120) reviewed for nutrition. Failure to notify the physician prevented residents from receiving professional care and services which could have prevented further weight loss and/or addressed possible reasons for the weight loss and given the physician the opportunity to implement immediate interventions. Findings include: 1)Resident #222 was initially admitted to the facility on [redacted] with diagnoses including [redacted] [redacted] The resident had a four day hospital stay outside the facility from [redacted] and was readmitted on [redacted] related to bleeding in her stomach. Several observations of Resident #222 over the course of the survey revealed a thin resident with bony prominences easily visualized and Resident #222's recorded facility weights showed a significant decline in weight since her readmission to the facility as follows: 9/23/14 147.6 pounds 9/30/14 147 pounds 10/10/14 133.6 pounds (readmission weight) 10/20/14 126.0 pounds 10/31/14 114.4 pounds 11/3/14 110.8 pounds	F 157		

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F 157	Continued From page 3 From 10/10/14 to 10/20/14 the resident lost 7.6 pounds, which was 5.7% of her body weight. The facility's Weight Monitoring Guidelines, bullet #5, stated, "The physician and responsible party will be notified regarding significant weight variances as indicated." The guidelines further indicate that 5% weight loss within 1 month is categorized as significant. The resident continued to lose weight through 11/03/14 resulting in a weight loss of 22.8 pounds, which was 17.1% of her body weight. Review of the medical chart revealed no communication to the physician to notify him/her of the weight loss until a fax communication dated 11/3/14 requested orders for an appetite stimulant. On 11/6/2014 at 1:20 p.m., the Registered Dietician (RD) indicated she was responsible for overseeing weights for all facility residents and communicating significant weight losses to the interdisciplinary team (IDT) during weekly meetings. The RD stated it would be at that point that the IDT team would notify the physician. The RD indicated that she normally did not communicate with the physician directly. On 11/7/14 at 12:33 p.m., when asked about Resident #222's weight loss, the Director of Nursing Services (DNS) stated, "Yes, the physician should have been notified sooner." The DNS indicated that the nursing department relied on the RD to alert them regarding a resident's weight loss so the physician could be notified in a timely manner.	F 157		

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F 157	Continued From page 4 2)Resident #120 was admitted on [redacted] for [redacted] The resident's MDS dated 10/24/14 indicated the resident required limited assistance with activities of daily living, including eating. Record review of the resident's weight flow sheet documented the resident weighed 216 pounds upon admission to the facility on [redacted] and weighed 200 pounds on [redacted] indicating a 16 pound (7%) weight loss in 18 days. The facility's policy entitled "Weight Monitoring Guidelines" directed staff to notify a resident's physician when a significant weight loss of five percent occurred in one month. The amount of weight lost by Resident #120 exceeded the five percent loss in one month requiring notification to the resident's physician. No documentation was found to show the resident's physician was notified of the significant and unplanned seven percent weight loss . Refer to F-325 for additional information related to weight loss.	F 157		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.	F 242	Residents 223 and 120 discharged. in-servicing scheduled for covering resident choices on a shower or tub bath by SDC. Resident preference will be added to Activity preference list. This will be completed by activity department.	12/1/2014 & ongoing

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F 242	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure 2 of 3 current sampled residents (#223 & 120) were given the choice to have a tub bath and a system was in place to ensure all residents were aware of and offered bathing choices. This failure created the potential for a diminished quality of life. Findings include: 1)Resident #223 was admitted on [redacted] with diagnoses including [redacted] According to the Admission Minimum Data Set, an assessment tool, dated [redacted] Resident #223 was cognitively intact and required extensive one person assistance with transfers and physical help with bathing. On 11/3/14 at 1:43 p.m., Resident #223 stated she had only been offered a shower, "I would prefer to take a hot bath. I have sciatica and the baths help my pain." 2) Resident #120 was admitted on [redacted] with diagnoses including [redacted] The resident's MDS, dated [redacted] indicated it was very important to the resident to choose between a shower, tub or bed bath and documented the resident required physical assistance with bathing. When asked if she was able to choose between a shower, tub, or bed bath, Resident #120 stated,	F 242	Upon completion this will be forwarded to RCM for follow up to ensure resident preferences are honored. ADNS will monitor for compliance and any trends reported to QA committee.	

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F 242	Continued From page 6	F 242		

"No, I don't think the tub is used. I don't know if it's because it doesn't work or if it's some other reason."

The facility's Shower Sheet, a tool used by staff to document the type of bath/shower given, included a space to document whether the resident was given a shower or bed bath. A tub bath was not listed as an option on the Shower Sheet.

All documentation on the Shower Sheet indicated the residents had received showers.

On 11/6/14 at 8:37 p.m., the tub in the 100/200 hall shower room was observed with a hand written note in the tub read, "Great chair no foot rest." The water knob was turned but no water flowed from the faucet.

At 8:40 p.m. the bath tub in the 300/400 hall shower room was tested and water did flow from the faucet.

On 11/7/14 at 10:49 a.m., Licensed Nurse (LN) B stated, "I know they can be done. I have to ask LN C why they don't really do tub baths. I've never seen it done."

At 11:30 a.m., Nursing Assistant (NA) B stated, "We don't do tub baths here. I'd have to ask the nurse first before I could do one." The NA indicated there was a tub in the shower room but it was not offered.

At 11:36 a.m., NA A stated if a resident didn't want a shower the other options would be a bed bath or sponge bath. The NA said she had never seen anyone do a tub bath and had never done one.

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F 242	Continued From page 7 At 12:03 p.m. LN A stated, if a resident didn't want a shower, a bed bath could be offered. When LN A was asked about the tub bath option she stated, "I'm not sure, we have the shower areas, but the tub, let me find an answer for you." After checking with LN C, LN A stated a tub was available between 100/200 hall and the other room just had showers. On 11/10/14 at 11:06 a.m., the Director of Nursing Services stated, I know at least one tub is working but not sure about the other.	F 242		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit;	F 272	Resident 76 expired. Wound Nurse is now responsible for accurately completing out skin section of MDS to ensure accuracy. Risk Management Nurse is responsible to monitor compliance and reporting trends to QA committee.	12/10/2014 & ongoing

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F 272	Continued From page 8 Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to accurately assess the resident's (Resident #76) skin conditions and associated special treatments and procedures. This failure placed the resident at risk of receiving inadequate care and services. Resident #76 was admitted on [redacted] with diagnoses including [redacted] The resident's Minimum Data Set (MDS), an assessment tool dated [redacted] indicated the resident was moderately cognitively impaired, required extensive two person assistance with bed mobility and transfers and was at risk for pressure ulcers. Record review showed a 9/17/14 Physician Order for treatment to an open area to Resident #76's	F 272		

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F 272	Continued From page 9 right buttocks. The resident's MDS, dated 9/21/14 failed to document the skin condition found on 9/17/14, and was not listed on the assessment as a pressure ulcer, other ulcer, wound, or skin problem. Special treatments or procedures were also not identified or included on the resident's MDS. On 11/10/14 at 11:00 a.m., Licensed Nurse (LN) E stated the other MDS nurse had completed the 9/21/14 MDS for Resident #76 and said, "I don't see that she marked the skin condition on the MDS. At 11:04 a.m., when asked why the resident's skin condition had not been documented on the MDS, LN F stated, "It's possible I didn't find the information or the wound nurse didn't have it documented in the skin section.	F 272		
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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to promptly implement measures to prevent skin break down	F 309	Resident 76 expired. In-servicing was provided 11/21 and to be repeated for 12/5 on skin checks. Wound Nurse to monitor treatment books weekly to ensure skin checks are completed. Risk management nurse to ensure compliance and report any trends to QA committee.	12/10/2014 ongoing

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F 309	Continued From page 10	F 309		

for a resident with documented risk factors and failed to conduct weekly skin assessments for 1 of 3 residents (#76) reviewed for skin impairment. This failure contributed to the resident acquiring skin damage and potential for decreased quality of life.

Findings include:

Resident #76 was admitted on [redacted] with diagnoses including [redacted]

The resident's Minimum Data Set (MDS), an assessment tool, dated [redacted] indicated the resident was moderately cognitively impaired and required extensive two person assistance with bed mobility and transfers and was at risk for pressure ulcers.

Record review showed a hand over/transfer form completed by a licensed nurse from the hospital which indicated Resident #76 had a spot on his coccyx at the time of transfer from the hospital.

The facility's admission charting on [redacted] documented "Redness to groin noted, small amount of redness noted to buttocks with a healed open area." The skin assessment/Skin Condition Sheet completed on [redacted] documented "a little bit of redness to coccyx."

The Braden Scale for Predicting Pressure Sore Risk was completed on 9/8/14 and documented a score of 14, which indicated the resident was at moderate risk for pressure ulcer development.

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F 309	Continued From page 11 The resident's temporary care plan, dated [redacted] identified [redacted] as problems the resident required interventions for. Although the resident had been identified as being at moderate risk for developing pressure ulcers and had redness to the skin, the initial/temporary care plan did not include specific interventions to prevent skin break down. The resident's plan of care, dated [redacted] for a self-care deficit related to [redacted] documented the resident required two person total assist with bed mobility and two person hoyer lift assistance with transfers from bed to chair. On [redacted], nine days after admission to the facility, the temporary care plan documented the resident had an open area to the right buttocks measuring 2.5 cm x 1.5 cm and excoriation to inner buttocks. The care plan documented interventions at that time ([redacted]) to prevent further skin break down including cleansing open area and applying [redacted] every three days, applying [redacted] to buttocks and peri area every shift, using a mattress overlay to bed and turning and repositioning the resident every two hours. On 11/07/14 at 11:32 a.m., Licensed Nurse (LN) D stated she considered the open area on the resident's skin moisture related because the resident's care directive indicated he was incontinent. Record review showed the resident had a urinary catheter in place and was usually continent of bowel. The record did not indicate the resident's skin was frequently exposed to moisture.	F 309		

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F 309	Continued From page 12 On 11/10/14 at 11:05 a.m., the LN F (MDS nurse) stated she had noted discrepancies whether the resident was continent or not based on inconsistencies of the care directive, nursing notes and bladder/bowel assessment. She stated prior to completing the MDS assessment she asked staff and the resident to determine if he was continent or not, and concluded he was continent of bowel and had a urinary catheter in place and was coded as continent. At 11:09 a.m., when asked how the resident's documented redness to the coccyx/buttocks was monitored, LN D stated it would have been monitored during a weekly skin check. LN D and the surveyor reviewed the resident's September Treatment Record. LN D stated a weekly skin assessment should have been done every Monday evening and acknowledged that it had not been done. The only skin assessment completed for Resident #76 was done on the first day the resident was admitted to the facility.	F 309		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325	Resident 222 was discharged to the hospital and resident 120 was discharged home. Medicare Unit residents will be weighed Weekly on scheduled days. RD will review weight report in conjunction with RCM will review the residents with any reportable trending and follow-up will occur in nutrition meeting weekly; DNS will monitor compliance and report any trends to QA committee.	12/11/2014 + ongoing

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F 325	Continued From page 13	F 325		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined the facility failed to have a system in place to recognize, evaluate, and address weight loss for 2 of 4 current sampled residents (#222 and 120) reviewed for nutrition. This failure caused a delay in notifying the physician and placed both residents at risk for further weight loss and decline in health.

1) Resident #222 was initially admitted to the facility on [redacted] with diagnoses including [redacted] The resident had a four day hospital stay outside the facility from [redacted] and was readmitted on [redacted] related to an ulcer and bleeding in her stomach.

The resident's Minimum Data Set (MDS), an assessment tool dated 10/22/14, indicated that the resident needed set-up and supervision or cuing during meals.

Several observations of Resident #222 over the course of the survey revealed a thin resident with bony prominences easily visualized.

Resident #222's recorded facility weights showed a significant decline in weight since her readmission to the facility as follows:

9/23/14 147.6 pounds

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505473	A. BUILDING _____ B. WING _____	11/10/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY PLACE CARE CENTER	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 325	Continued From page 14 9/30/14 147 pounds 10/10/14 133.6 pounds (readmission weight) 10/20/14 126.0 pounds 10/31/14 114.4 pounds 11/3/14 110.8 pounds From 10/10/14 to 10/20/14 the resident lost 7.6 pounds, which was 5.7% of her body weight. From 10/10/14 to 11/03/14 the resident lost 22.8 pounds, which was 17.1% of her body weight. The facility's Weight Monitoring Guidelines documented the residents would be weighed upon admission for three days and then weekly until determined stable. This policy was not followed for Resident #222. Review of the meal monitoring documentation from 10/10/14 to 10/31/14 indicated that the resident had a poor appetite much of the time, often refusing meals altogether, or eating 25% or less. Review of the interdisciplinary team (IDT) notes, labeled "Weekly Care Management Note," for 10/22/14 and 10/29/14 do not document any identification of the resident's significant weight loss or a plan to address resident's weight loss. Review of the nursing progress notes from 10/10/14 to 11/3/14, revealed no documentation regarding the resident's weight loss, appetite, and/or refusal of meals. The "Medicare Charting Guide," a document outlining areas that nurses should be charting about, did not have weight loss highlighted as an area to address. Review of the Nutritional Assessments and	F 325		

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F 325	Continued From page 15 Nutritional Progress Notes, shows no documentation between 10/14/14 and 11/03/14 regarding resident's weight loss or nutritional status. The note from 10/14/14 indicates that food preferences will be re-started (from prior to hospitalization) and sugar free health shakes will be added with meals. On 11/07/14 at 11:40 a.m., the Registered Dietician (RD) indicated that she was aware of resident's weight loss and was monitoring the interventions of sugar free health shakes and maximizing food preferences. When asked about the 7.6 pound weight loss between 10/10/14 and 10/20/14, The RD stated, "I was watching to see if those interventions worked. I also thought that weight (10/20/14) might have been an error." Review of the weight record showed no re-weight taken near 10/20/14. When the RD was asked if other interventions should have been implemented at that point and the physician notified regarding the weight loss, the RD stated, "I think in retrospect that, maybe, you are correct." 2)Resident #120 was admitted on [redacted] for [redacted] The resident's MDS dated [redacted] indicated the resident required limited assistance with activities of daily living, including eating. Record review of the resident's weight flow sheet documented the resident weighed 216 pounds upon admission to the facility on [redacted] and weighed 200 pounds on [redacted] indicating a 16 pound weight loss in 18 days. The facility's Weight Monitoring Guidelines	F 325		

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F 325	Continued From page 16 documented the residents would be weighed upon admission for three days and then weekly until determined stable. This policy was not followed for Resident #120. Record review showed weights were not taken for the resident for 13 days between [redacted] and [redacted] and a nine pound loss occurred. On 11/06/14 at 5:20 p.m., the RD stated the resident had not triggered for a significant weight loss. The RD stated it could be because she is a large lady or the computer software program may not have flagged it because she had not been in the facility for 30 days. When asked about weight loss percentage for Resident #120, the RD calculated the resident's weight loss and stated,"It's seven percent, you are right." The RD stated, "I should have picked up on that between [redacted] and [redacted] It's my fault. I should have noted the weight loss." Refer to F-157	F 325		