

1113

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505478</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/20/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>CORWIN CENTER AT EMERALD HEIGHTS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>10901 - 176TH CIRCLE NORTHEAST REDMOND, WA 98052</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Emerald Heights - Corwin Center on 12/16/13, 12/17/13, 12/18/13, 12/19/13 and 12/20/13. A sample of 20 residents was selected from a census of 54. The sample included 16 residents, the records of four former and/or discharged residents and two supplemental residents.</p> <p>The survey was conducted by:</p> <p>, MSW , BSN , RN, BSN , MS, RD</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Adult Services Administration Residential Care Facilities Region 2, Unit E 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388</p> <p>Telephone: (253) 234-6000 Fax: (253) 395-5070</p> <p> Residential Care Services</p>	F 000		
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12-27-13  
Date

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  	TITLE  Health Services Administrator	(X6) DATE  1/10/14
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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 241 SS=D	<p><b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to ensure residents received care in a manner which upheld their right to dignity. Failure to ensure care was provided in a visually private area, failure by facility staff to knock prior to entering resident rooms, and failure to ensure residents were addressed prior to staff altering their environment placed resident's at risk to feel disrespected and to experience a decreased quality of life.</p> <p>Findings include:</p> <p><b>RESIDENT #37</b> Resident #37 was recently diagnosed with a [REDACTED]. According to the resident's Minimum Data Set assessment (MDS) dated 11/27/13, the resident was usually understood and able to understand others, however she had significant cognitive impairment including poor short term memory.</p> <p>On 12/19/13 at 9:00 a.m., the resident was observed lying in bed with her eyes closed with minimal response to verbal stimuli. Staff E was observed to expose the resident's abdomen and administer a subcutaneous injection into the resident's abdomen. Staff E failed to close the window blinds. The resident's window looked out</p>	F 241	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>F241—483.15(a) Dignity and Respect of Individuality</b> <b>Resident #37: Correction as it Relates to the Individual:</b> This resident expired on 24 Dec 2013. <b>Protecting Residents in Similar Situations:</b> Nurses will be inserviced on the need to assure privacy from all angles when administering medications if the resident has not given specific instructions or approval for medication and/or treatments to be administered in a place or manner that privacy cannot be provided. <b>Measures/System Changes that will Occur to Insure Sustained Solutions:</b> Medication administration will be randomly audited by the Pharmacy Nurse and facility nurse managers. Audits will be conducted during a 90 day period and findings will be reviewed by the QAPI Committee for 3 months to ensure compliance. Should the resident give instructions/permission for medication or treatment to be given in a manner that does not allow for privacy on an on-going basis, the instructions and or permissions will be care planned for that specific resident. <b>Date Corrective Action Completed:</b> 2Feb 2014. <b>Person Responsible to Ensure Correction:</b> Director of Nursing Services or designee.</p>	

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F 241	<p>Continued From page 2</p> <p>into an adjacent room, which left Resident #37 exposed to the resident, or any other visitors, to that room.</p> <p>On 12/19/13, Staff B stated the expectation was that all staff would knock on the resident's door, announce themselves and allow the resident the opportunity to invite them in. Staff B further explained if staff were to provide care that would be considered a matter of privacy or dignity, the staff would pull the curtain. When asked if the expectation would be that staff would close the window covering, Staff B replied that it was expected that residents be given privacy "all around".</p> <p>In an interview on 12/19/13 at 10:45 a.m., Staff E stated staff were expected to knock on the resident's door prior to entering, allowing the resident an opportunity to invite them in. When Staff E was asked why the window blinds were left open when Resident #37 was given an injection, Staff E, replied "you're right, I should have closed the window blinds, however those blinds are usually closed this early in the morning."</p> <p><b>RESIDENT #42</b> Resident #42 was admitted to the facility on [REDACTED]/13 with multiple medical diagnoses. According to the [REDACTED] completed on 10/06/13, the resident was capable of making his needs known. The MDS identified the resident with no cognitive impairment. While in an interview with Resident #42 on 12/19/13 at 2:04 p.m., a staff member was observed to enter the resident's room without knocking. Resident #42 stated, "I don't like when they just walk in here and turn the light off without talking to me." Resident #42</p>	F 241	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>Resident #42: Correction as it Relates to the Individual:</b> This resident's preferences will be honored by staff knocking on the door, announcing their names and requesting permission to enter the room.</p> <p><b>Protecting Residents in Similar Situations:</b> Staff will be inserviced on protocol for entering a resident's room.</p> <p><b>Measures/System Changes that will Occur to Insure Sustained Solutions:</b> Staff will be monitored by the hall charge nurse, nurse managers and other facility department heads to determine protocol is being observed. Audits will be conducted during a 90 day period and findings will be reviewed by the QAPI Committee for 3 months to ensure compliance.</p> <p><b>Date Corrective Action Completed:</b> 2 Feb 2014.</p> <p><b>Person Responsible to Ensure Correction:</b> Director of Nursing Services or designee.</p>	

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F 241	<p>Continued From page 3</p> <p>further stated, "They told me this was my home, and yet the aides come in my room without knocking." Additionally, the resident stated staff would often come into his room and adjusted the furnace without asking his permission. Resident #42 stated " every one keeps telling me this is my home, so why do they (staff) just walk into my room without permission? Would you allow someone to come into your home and adjust your furnace without your permission? Then why is it okay for them (staff) to come in my home and adjust or turn the heat off without asking me? If he (the residents roommate) wants the heat turned off that would be fine, but they (staff) should ask my permission prior to adjusting the furnace in my room."</p> <p>In an interview on 12/20/13, Staff A stated staff were aware of Resident #42's preferences regarding the room temperature and the facility has "have tried working with him on several issues and we will continue to work with him to resolve his concerns." Staff A stated that because the resident often listened to his audio book with headphones on, he was unable to hear the staff when they enter. Additionally, she stated Resident #42's roommate preferred the room a little cooler and staff would often adjust the heat in order to try and accommodate both residents.</p> <p><b>RESIDENT #11</b> Similar findings were found for Resident #11. According to the 09/26/13 MDS, this resident was cognitively intact and able to make her needs known.</p> <p>On 12/17/13 at 9:48 a.m., during an interview, Resident #11 stated "a lot of the time they (staff) just walk in." On 12/20/13 at 9:30 a.m., Resident</p>	F 241	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b><u>Resident #11: Correction as it Relates to the Individual:</u></b> This resident's preferences will be honored by staff knocking on the door, announcing their names and asking permission to enter the room.</p> <p><b><u>Protecting Residents in Similar Situations:</u></b> Clinical staff will be inserviced on protocol for entering a resident's room.</p> <p><b><u>Measures/System Changes that will Occur to Insure Sustained Solutions:</u></b> Staff will be monitored by the hall charge nurse, nurse managers and other facility department heads to determine protocol is being observed. Audits will be conducted during a 90 day period and findings will be reviewed by the QAPI Committee for 3 months to ensure compliance.</p> <p><b><u>Date Corrective Action Completed:</u></b> 2 Feb 2014.</p> <p><b><u>Person Responsible to Ensure Correction:</u></b> Director of Nursing Services or designee.</p>		

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F 241	Continued From page 4 #11 again stated staff usually did not knock prior to entering her room and added "I don't care for that."	F 241	<i>This Plan of Correction is the center's credible allegation of compliance.</i>		
F 279 SS=E	<b>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</b>  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 that the facility failed to develop and/or revise comprehensive care plans for five (#s 74, 7, 9, 6 & 11) sampled residents of the 19 residents whose care plans were reviewed in Stage 2. Failure to establish care plans that accurately reflected residents' care needs related	F 279	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  <b>(from pg 6)</b> <b>F279—483.20(d), 483.20(k)(1) Develop Comprehensive Care Plans</b> <b>Resident #74: Correction as it Relates to the Individual:</b> This resident discharged 27 Sept 2013, prior to the survey. <b>Protecting Residents in Similar Situations:</b> On admission all residents will be assessed for dehydration by a review of their diagnoses, by an assessment of their skin turgor and mucous membranes and, if indicated by above, a period of monitoring intake and output. An <u>At Risk for Dehydration</u> care plan will be added to the resident record when the resident is determined to be at risk based on Nursing, Medical or Dietary indicators. <b>Measures/System Changes that will Occur to Insure Sustained Solutions:</b> The Dietitian will initially assess residents within 48 hours of admission. The Dietitian will calculate estimated fluid requirements and use pertinent documentation to complete a comprehensive assessment after 7 days. If the resident is determined to be at risk for insufficient fluid status, the <u>At Risk for Dehydration</u> care plan can be initiated at any time. Weekly audits will be completed by Nurse Managers to ensure the care plan is being followed, the accuracy/ completeness of the fluid assessment tools		

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F 279	<p>Continued From page 5</p> <p>to dehydration, hospice and positioning devices placed residents at risk of unmet psychosocial care needs.</p> <p>Findings include:</p> <p><b>DEHYDRATION RESIDENT #74</b></p> <p>According to the admission Minimum Data Set (MDS) assessment, dated 09/02/13, Resident #74 admitted to the facility on [REDACTED]/13 for rehabilitation. This MDS also identified the resident with a recent diagnosis of dehydration. The Care Area Assessment, completed at the time of the initial MDS, indicated the resident had decreased skin turgor and dry mucus membranes. The resident was also prescribed a diuretic medication and had a hand tremor that might interfere with the resident's ability to eat and drink independently. The summary noted a care plan to address the resident's hydration status would be implemented.</p> <p>Review of the resident's comprehensive care plan revealed no dehydration care plan had been implemented. The only directive on the care plan that addressed the resident's hydration status stated "encourage fluid intake."</p> <p>Review of the Registered Dietitian's assessment noted the resident required 1500 cubic centimeters (cc) of fluids daily to maintain normal hydration status. This note identified the resident was offered 730 cc of fluid at meals. There was no indication in the resident's record the discrepancy between the recommended fluid intake and the fluids offered with meals was addressed, nor that a plan was implemented to ensure the resident received the fluids she was</p>	F 279	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <hr/> <p>and that appropriate followup is occurring. Staff will be inserviced about the policy for monitoring hydration. Audits will be conducted during a 180 day period and findings will be reviewed by the QAPI Committee for 6 months to ensure compliance.</p> <p><b>Date Corrective Action Completed:</b> 2 Feb 2014.</p> <p><b>Person Responsible to Ensure Correction:</b> Registered Dietitian.</p> <p><b>(from pg 7)</b> <b>Resident #7: Correction as it Relates to the Individual:</b> A Hospice care plan has been generated and placed in the resident's medical record.</p> <p><b>Protecting Residents in Similar Situations:</b> All residents receiving Hospice services have had their charts audited to ensure an updated Hospice care plan is present.</p> <p><b>Measures/System Changes that will Occur to Insure Sustained Solutions:</b> All residents will have a chart audit 72 hours after being placed on a Hospice to determine a personalized care plan is present addressing medications, services and supplies. The SSC will coordinate with the hospice provided to ensure that all required</p>		

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F 279	<p>Continued From page 6 assessed to require.</p> <p>During an interview on 12/19/13 at 9:30 the MDS Coordinator, Staff G, stated that if the care plan was not in the clinical record he did not know why one was not implemented.</p> <p><b>HOSPICE RESIDENT #7</b> Resident #7 was a [REDACTED] resident of the facility. The resident had a fall and sustained a fracture on 09/24/13. On 10/23/13 the resident was admitted onto [REDACTED] services.</p> <p>On 12/22/13 review of the resident's care plan found no specific information concerning what services were provided by [REDACTED]. The care plan in place on 12/22/13 noted the resident was on comfort care for [REDACTED] treatment, however there was no defined plan to show what services were provided by hospice and/or what the services the facility would be providing in order to ensure coordination of care.</p> <p>On 12/20/13 at 8:45 a.m., the Director of Nursing Services, Staff B, was asked about the care plan for [REDACTED]. She was not able to locate any information that identified what services would be provided by hospice. When asked how the care was coordinated between the two entities, she stated the hospice nurse visited the facility and verbally communicated information about the resident's care with facility staff. Staff B acknowledged a [REDACTED] care plan should have been in place.</p> <p><b>RESIDENT #9</b> Similar findings were identified for Resident #9 who admitted onto [REDACTED] services on [REDACTED]/13.</p>	F 279	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>documentation is present in the resident's chart. The QAPI Committee will review Hospice Care Plan audits for 3 months to ensure compliance. <b><u>Date Corrective Action Completed:</u></b> 2 Feb 2014. <b><u>Person Responsible to Ensure Correction:</u></b> DNS or designee.</p> <p><b><u>Resident #9: Correction as it Relates to the Individual:</u></b> A Hospice care plan has been generated and placed in the resident's medical record.</p> <p><b><u>Protecting Residents in Similar Situations:</u></b> All residents receiving Hospice services have had their charts audited to ensure an updated Hospice care plan is present. <b><u>Measures/System Changes that will Occur to Insure Sustained Solutions:</u></b> All residents will have a chart audit 72 hours after being placed on a Hospice to determine a personalized care plan is present addressing medications, services and supplies.</p>	

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F 279	<p>Continued From page 7</p> <p>Review of the comprehensive care plan found no information to identify what services were provided by hospice.</p> <p>After the interview on 12/20/13, Staff B contacted the [REDACTED] provider and obtained written care plans for the services provided by the hospice staff for both Resident #7 and #9. She stated the care plans should have been in the resident's records and should have been updated periodically.</p> <p>Failure to ensure care plans were updated to reflect who would provide specific services and care and how frequently the service was provided placed residents at risk for unmet care needs.</p> <p><b>POSITIONING DEVICES</b> <b>RESIDENT #6</b> In a staff interview during Stage 1, on 12/17/13 at 11:18 a.m., Staff B and C identified Resident #6 with a "positioning device" on the right side of her bed.</p> <p>Observation of the resident's bed revealed bilateral upper side rails (positioning devices).</p> <p>Review of the resident's comprehensive care plan revealed a "Turning / positioning in bed (bed mobility)" CP, dated 08/16/13, that identified the resident required extensive assistance of 1-2 staff to turn /reposition. The CP did not identify the use of positioning devices or side rails.</p> <p>The care guide located inside the resident's closet identified "Mobility Device: ARCO rail(s)". It did not provide any direction to staff regarding the resident's use of the rails, nor did it specify if the resident utilized one or both rails.</p>	F 279	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>The SSC will coordinate with the hospice provided to ensure that all required documentation is present on the resident's chart. The QAPI Committee will review Hospice Care Plan audits for 3 months to ensure compliance.</p> <p><b>Date Corrective Action Completed:</b> 2 Feb 2014. <b>Person Responsible to Ensure Correction:</b> DNS or designee.</p> <p><b>Resident #6: Correction as it Relates to the Individual:</b> This resident's care plan and care guide have been updated appropriately to include location, number, and use of the device.</p> <p><b>Protecting Residents in Similar Situations:</b> All residents with positioning devices in place have had their care plans and care guides updated to ensure information is accurate regarding the number, location and individualized use of the positioning device.</p> <p><b>Measures/System Changes that will Occur to Insure Sustained Solutions:</b> Staff will be inserviced on how to request devices. They will receive training in encouraging, and assisting residents with positioning devices. Audits will be conducted monthly to verify the</p>	

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F 279	<p>Continued From page 8</p> <p>In an interview on 12/20/13 at 8:50 a.m., Staff C reviewed the resident's care plan and stated the side rail CP must have been "thinned" from the chart. She also stated the Impaired Skin CP should have made reference to the side rail, but did not. She stated one care plan directed staff to "pad the positioning rail", but did not identify which rail nor did it provide direction for its use. Staff C stated the resident did not turn well and holds on to the rail occasionally.</p> <p>On 12/20/13 at 11:15 a.m. Staff C acknowledged the resident's care plan did not include sufficient information regarding the use of the side rails.</p> <p><b>RESIDENT #11</b> Similar findings were identified for Resident #11 when, on 12/17/13 at 11:23 a.m., Staff B and C identified the resident had a "positioning device" on the left side of her bed.</p> <p>Observation of the resident's bed confirmed a side rail was in the up position on the left side of her bed.</p> <p>Review of a care plan for bed mobility, dated 04/12/13, revealed the resident required limited assistance. The care plan went on to read "will turn and position self with the assistance of one person...". There was no mention or direction to staff regarding the side rail.</p> <p>The care directive located in the resident's closet read "Transfer device: arco rail(s); assist x1...". No specific instructions for the use of the side rail were present for staff to follow.</p> <p>Failure to ensure care plans were developed that</p>	F 279	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>positioning devices are in place as documented, are still needed, and that the care plans and care guides are accurate. Audits will be conducted during a 90 day period and findings will be reviewed by the QAPI Committee for 3 months to ensure compliance.</p> <p><b>Date Corrective Action Completed:</b> 2 Feb 2014. <b>Person Responsible to Ensure Correction:</b> Restorative Nurse Manager or designee.</p> <p><b>Resident #11: Correction as it Relates to the Individual:</b> This resident's care plan and care plan have been updated appropriately to include location, number and use of the device. <b>Protecting Residents in Similar Situations:</b> All residents with positioning devices in place have had their care plans and care guides updated to ensure information is provided regarding their location, number and individualized use of the device. <b>Measures/System Changes that will Occur to Insure Sustained Solutions:</b> Staff will be inserviced on how to request devices. They will receive training in encouraging, and assisting residents in the use of a positioning device. Audits will be conducted during a 90 day period and findings will be reviewed by the QAPI Committee for 3 months to ensure compliance. <b>Date Corrective Action Completed:</b> 2 Feb 2014. <b>Person Responsible to Ensure Correction:</b> Restorative Nurse Manager or designee.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505478</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/20/2013</b>
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F 279	Continued From page 9 provided staff specific information regarding the care and services residents were assessed to require placed the residents at risk for unmet care needs.	F 279	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>		
F 285 SS=D	<p>483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI &amp; MR</p> <p>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.</p> <p>A nursing facility must not admit, on or after January 1, 1989, any new residents with:</p> <p>(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;</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>(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority 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</p>	F 285			

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F 285	<p>Continued From page 10 services, whether the individual requires specialized services for mental retardation.</p> <p>For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (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: Based on interview and record review, the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR) assessments were accurate upon admission to the facility or updated as needed for three sampled residents (#s 65, 11 &amp; 76) of the six residents whose PASRRs were reviewed. Failure to develop a system in which the facility ensured PASRRs were accurate placed residents at risk to not receive timely and necessary services to meet their mental health needs.</p> <p>Findings include:</p> <p><b>RESIDENT #65</b> Resident #65 admitted to the facility on [REDACTED]/13 with multiple diagnoses to include [REDACTED]. Review of the PASRR, completed 04/06/13 by the discharging hospital, revealed the resident's [REDACTED] diagnosis was not reflected.</p> <p>On 12/19/13 at 12:54 p.m. Staff H (Social Services) stated her practice was to review the PASRR annually for accuracy. She indicated if the</p>	F 285	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>F285—483.20(m), 483.20(e) PASRR Requirements for MI &amp; MR</b> <u>Resident #65: Correction as it Relates to the Individual:</u> This resident's PASRR will be reviewed and updated to accurately represent MI diagnosis and need for Level II evaluation. <u>Protecting Residents in Similar Situations:</u> PASRRs will be audited to ensure they are current for residents. <u>Measures/System Changes that will Occur to Insure Sustained Solutions:</u> PASRRs will be reviewed and updated as needed when a resident is admitted from the hospital. PASRRs will be completed with any new diagnosis of [REDACTED]. The SSC will review the PASRR with any change of condition for accuracy and updating. The PASRR will be reviewed during quarterly MDS reports, and during [REDACTED] medication rounds. PASRR completion audits will be reviewed by the QAPI committee for 3 months to ensure compliance. <u>Date Corrective Action Completed:</u> 2 Feb 2014. <u>Person Responsible to Ensure Correction:</u> Social Services Coordinator.</p>		

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F 285	<p>Continued From page 11</p> <p>resident admitted with an incorrect PASRR it would not be looked at or reviewed for a year.</p> <p><b>RESIDENT #11</b> Similar findings were found for Resident #11. This resident was admitted to the facility [REDACTED] 13 with a diagnosis for [REDACTED]. While the [REDACTED] diagnosis was accurately reflected on the PASRR, the form also indicated the resident would only need 30 days of care. At the time of the survey, this resident had been in the facility for over eight months. By coding Resident #11 as only needing 30 days of care, the resident was disqualified from being considered for a Level II evaluation. Failure to update the PASRR prevented the facility from determining if the resident needed a Level II evaluation.</p> <p><b>RESIDENT #76</b> Review of Resident #76's record revealed she admitted to the facility on [REDACTED] 13 after hospitalization for a [REDACTED]. On 10/31/13 her physician prescribed an [REDACTED] medication for "[REDACTED]". The facility implemented a Mood care plan that identified the resident had [REDACTED] that required treatment.</p> <p>The PASRR, dated 10/14/13 and completed by the discharging hospital, identified the resident with no mental illness, including anxiety. The facility failed to update the PASRR to accurately reflect the resident with anxiety.</p> <p>The facility failed to ensure a system by which newly admitted residents' PASRRs were reviewed to ensure accuracy. This placed all residents admitted to the facility at risk to not receive a Level II evaluation if required.</p>	F 285	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><u>Resident #11: Correction as it Relates to the Individual:</u> This resident's PASRR will be reviewed and updated to accurately represent MI diagnosis and need for Level II evaluation.</p> <p><u>Protecting Residents in Similar Situations:</u> PASRRs will be audited to ensure they are current for residents.</p> <p><u>Measures/System Changes that will Occur to Insure Sustained Solutions:</u> PASRRs will be reviewed and updated as needed when a resident is admitted from the hospital. PASRRs will be completed with any new diagnosis of [REDACTED]. The PASRR will be reviewed with any change of condition for accuracy and updating. The PASRR will be reviewed during quarterly MDS reports, and during [REDACTED] medication rounds. PASRR completion audits will be reviewed by the QAPI committee for 3 months to ensure compliance.</p> <p><u>Date Corrective Action Completed:</u> 2 Feb 2014.</p> <p><u>Person Responsible to Ensure Correction:</u> Social Services Coordinator</p>	

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F 329 SS=D	<p><b>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure three of five residents (#s 76, 7 &amp; 9) reviewed for unnecessary medications were free of unnecessary medications related to administering medications in accordance with physician's orders, adequate indications for use, monitoring and lack of gradual dose reductions. These failures resulted in Resident #76 receiving</p>	F 329	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>(from pg 12) <u>Resident #76: Correction as it Relates to the Individual:</u> This resident's PASRR will be reviewed and updated to accurately represent MI diagnosis and need for Level II evaluation. <u>Protecting Residents in Similar Situations:</u> PASRRs will be audited to ensure they are current for residents. <u>Measures/System Changes that will Occur to Insure Sustained Solutions:</u> The PASRR will be reviewed and updated PASRRs as needed when a resident is admitted from the hospital. PASRRs will be completed with any new diagnosis of [REDACTED]. The SSC will review the PASRR with any change of condition for accuracy and updating. The PASRR will be reviewed during quarterly MDS reports, and during [REDACTED] medication rounds. PASRR completion audits will be reviewed by the QAPI committee for 3 months to ensure compliance. <u>Date Corrective Action Completed:</u> 2 Feb 2014. <u>Person Responsible to Ensure Correction:</u> Social Services Coordinator</p>		

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F 329	<p>Continued From page 13</p> <p>medications that were unnecessary and placed Resident #s 7 and 9 at risk to receive unnecessary medications.</p> <p>Findings include:</p> <p><b>FACILITY POLICY</b> The facility's Psychotropic Medication and Behavior Review policy, dated 11/10, detailed that "Trial dose reductions will occur as follows:... Hypnotics: dose reduction will be attempted quarterly unless determined to be clinically contraindicated... Clinically Contraindicated is defined as the continued use is in accordance with relevant current standards of practice and the physician has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function... or the resident's target symptoms returned or worsened after the most recent attempt at tapering the dose...".</p> <p><b>RESIDENT #76</b> According to the admission Minimum Data Set (MDS) assessment, dated 10/22/13, Resident #76 had diagnosis that included [REDACTED] and [REDACTED]. Review of physician's orders revealed the resident received several medications to treat these diagnosis. A 10/16/13 physician's order (PO) directed staff to administer [REDACTED] twice a day. Staff were directed to hold the medication if the resident's systolic blood pressure (SBP) was less than 120 or her heart rate was less than 65.</p> <p>Review of the November 2013 Medication Administration Record (MAR) revealed staff frequently held the evening [REDACTED] dose</p>	F 329	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><u>F329—483.25(l), Drug Regimen is Free From Unnecessary Drugs)</u> <u>Resident #76: Correction as it Relates to the Individual:</u> Resident's medications have been reviewed and modified as per physician orders. Blood pressure parameters are being monitored. A sleep monitor has been instituted in association with the [REDACTED] order. <u>Protecting Residents in Similar Situations:</u> All residents receiving medication with parameters are being monitored for compliance. All residents on [REDACTED] with parameters are being monitored per orders with hours of sleep being recorded if indicated. <u>Measures/System Changes that will Occur to Insure Sustained Solutions:</u> Nurses are being inserviced regarding the need to follow parameters associated with medication, when to notify the physicians and proper documentation. MAR's and charts will be audited for 90 days with the results to be reviewed by the QAPI Committee for 3 months to ensure compliance. <u>Date Corrective Action Completed:</u> 2 Feb 2014. <u>Person Responsible to Ensure Correction:</u> DNS or designee.</p>	

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F 329	<p>Continued From page 14</p> <p>however staff did not consistently document the vital signs to reflect why this was done. For example, on 11/06, 13 and 14/13 staff noted they held the dose but did not record the vital signs. Alternately, on 11/02 and 03/13 staff noted they gave the dose but did not record the vital signs. On 11/07, 23 and 24/13 staff noted the administration of the medication despite recording a SBP less than 120. On 11/11 and 17/13 staff noted they held the medication despite recording a SBP of 120 or greater and no documentation of the HR.</p> <p>Similar findings were noted in October and December when the [REDACTED] was administered despite staff noting the resident's SBP was less than 120 (10/17, 23, 24, 26, 12/07 and 09/13) or when the medication was held without monitoring of the vital signs (12/08 and 18/13).</p> <p>A 10/16/13 PO for [REDACTED] three days a week was also in place with directions for staff to hold the dose if the SBP was less than 120. Staff noted they held the dose on 12/18/13 without evidence of monitoring of vital signs. Staff noted they administered the medication on 10/23 and 24, despite an SBP less than 120.</p> <p>The resident also received the [REDACTED] medication [REDACTED] from 10/16/13 until it was discontinued on 11/13/13. The PO included directions to staff to hold the medication if the resident's SBP was less than 120. Staff noted they administered [REDACTED] on 10/23, 24 and 11/01/13 despite a SBP of less than 120.</p> <p>The facility administered multiple doses of medications despite physician's orders to hold them. In addition, failure to monitor vital signs</p>	F 329	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>		

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F 329	<p>Continued From page 15</p> <p>when ordered placed the resident at risk to receive medications the physician ordered to be held. These failures resulted in, and placed the resident at risk to receive, unnecessary medications.</p> <p>According to the 10/22, 29 and 11/12/13 MDS assessment, Resident #76 had no trouble falling or staying asleep but did feel tired or have little energy several days a week.</p> <p>Review of physician's orders revealed Resident #76 received the [REDACTED] medication [REDACTED] every night for [REDACTED]. The order was originally implemented on 10/19/13 with increases in the dosage on 10/22 and 29/13. Additionally, on 10/29/13 the physician ordered staff administer Melatonin if the [REDACTED] was not effective.</p> <p>The Mood Care Plan, updated 12/12/13, noted the resident experienced [REDACTED] and [REDACTED]. Identified goals included the resident would "nap 1-2 hours each day as necessary for increased fatigue and will sleep 5-8 hours per night 5-7 days per week with staff interventions."</p> <p>Review of the resident's record revealed staff did not monitor the resident's hours of sleep.</p> <p>In an interview on 12/20/13 at 12:05 p.m., Staff C acknowledged there was no sleep monitor for the resident. She stated staff monitored the care plan goal, and the effectiveness of the medication use, by assessing the resident's alertness the next day, not by tracking the resident's hours of sleep. Based on the ongoing assessment that the resident had little energy and was tired, Staff C was unable to explain how staff determined the</p>	F 329	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	

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F 329	<p>Continued From page 16</p> <p>current dose of medication was effective, or alternatively, given the assessment that the resident had no trouble falling or staying asleep, how staff determined the medication was necessary.</p> <p><b>RESIDENT #7</b> According to MDS dated 07/09/13, Resident #7 was independent with all activities of daily living. The resident experienced a fall on 9/24/13 and suffered a fractured arm. The MDS dated 10/02/13 identified the resident experienced a significant decline in condition. She was placed on [REDACTED] services for [REDACTED] on 10/30/13.</p> <p>Review of the clinical record found that at the time of the fall the resident received a [REDACTED] medication "[REDACTED]." The August and September MARs indicated the resident received a 5 mg dose of [REDACTED] routinely each evening. In addition, the resident had an additional 5 mg dose that could be self administered if the initial dose was not effective. The MAR for September and October found there was no sleep monitor in place, despite the resident's use of a [REDACTED] medication to [REDACTED].</p> <p>Review of Pharmacy Consults found in June 2013 the pharmacy recommended a gradual dose reduction (GDR) of the [REDACTED] medication. However the physician declined the recommendation and noted a GDR attempt at that time "was likely to impair the resident's function... as documented below...". The patient specific rationale provided stated "per resident decision." There was no clinical rationale for why a dose reduction should not be attempted.</p>	F 329	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>Resident #7: Correction as it Relates to the Individual:</b> Resident is no longer on [REDACTED] or iron. [REDACTED] side effects to be monitored have been added to the MAR and care plan. Her orders have been reviewed to ensure that all medications indicated for a GDR have been addressed with a GDR and that such is documented.</p> <p><b>Protecting Residents in Similar Situations:</b> All psychoactive medications have been reviewed and GDRs started if indicated. All pharmacy recommendations regarding incompatible drug administration have been reviewed and implemented if not already in place.</p> <p><b>Measures/System Changes that will Occur to Insure Sustained Solutions:</b> All residents on [REDACTED] meds will have GDR trials as indicated per regulation. Residents will be educated as to the need to attempt to decrease the amount of medication they are taking and the policy modified to indicate this approach. Nurses are being inserviced regarding the need to follow GDR regulations. MARs and care plans are being updated with side effects to monitor when any resident is on an [REDACTED].</p> <p style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;"><b>JAN 13 2013</b></p>		

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NAME OF PROVIDER OR SUPPLIER  CORWIN CENTER AT EMERALD HEIGHTS			STREET ADDRESS, CITY, STATE, ZIP CODE 10901 - 176TH CIRCLE NORTHEAST REDMOND, WA 98052	
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F 329	<p>Continued From page 17</p> <p>On 12/20/13 at 11:15 a.m., the Resident's physician and the ADNS, Staff L, were interviewed. The physician stated the resident had been taking the [REDACTED] medication, [REDACTED], for "a long time". He stated he had discussed a dose reduction with the resident after receiving the pharmacy consult, however no change in the medication was made because the resident declined a GDR of the medication. He was unable to provide any indication a GDR had previously been attempted or failed. He stated the medication was discontinued while the resident was hospitalized in September, and the facility had not re-started it.</p> <p>In addition, a pharmacy recommendation, dated 06/24/13, identified the facility administered an Iron supplement and Tums at the same time. The pharmacy recommended the medications be administered two hours apart due to interaction between the two which effected the absorption of the Iron. The facility noted "resident would like no changes to her regime" and no changes were made in how the medications were administered.</p> <p>Failure to ensure a gradual dose reduction of the hypnotic medication was attempted per regulation, and without monitoring of the resident's sleep to determine the effectiveness and/or continued need of the medication placed the resident at risk to receive an unnecessary medication. Failure to ensuring the times of administration of the iron and Tums was spaced to optimize the absorption of the supplements placed the resident at risk for unnecessary drugs.</p> <p>Review of the December MAR revealed the resident's current drug regime included [REDACTED] and [REDACTED]</p>	F 329	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>MAR's and charts will be audited for side effect monitoring and the quarterly [REDACTED] review will continue to include monitoring of GDR's and any possible side effects of [REDACTED] medication. Audits will be conducted during a 90 day period and will be reviewed for compliance by the QAPI Committee for 3 months to ensure compliance. <u>Date Corrective Action Completed:</u> 2 Feb 2014. <u>Person Responsible to Ensure Correction:</u> DNS, SSD or designee.</p> <p>(from pg 19) <u>Resident #9: Correction as it Relates to the Individual [REDACTED]</u> side effects to be monitored have been added to the MAR and care plan. <u>Protecting Residents in Similar Situations:</u> All hospice resident's medications have been reviewed. Hospice services have been contacted to discuss the need for monitoring for side effects of [REDACTED] medication. This facility will ensure that it is either on the hospice care plan or on the facility care plan. Side effects to be monitored have been placed on the MAR.</p>	

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F 329	Continued From page 18 medications were currently being administered. The MAR did include a behavior monitor, however there was no description of the potential adverse side effects associated with any of the [REDACTED] medications that were being administered. There was no indication the resident was monitored for side effects of the medications.  RESIDENT #9 According to the significant change MDS assessment, dated 08/30/13, Resident #9 had a [REDACTED] and [REDACTED] services were initiated.  Review of the resident's record found a 10/14/13 PO for an [REDACTED] medication. The December MAR noted the resident received a routine dose of the medication in the evening. The facility had a behavior monitor in place, but there was no indication the resident was monitored for side effects of the medication.  On 12/20/13 at 8:15 a.m., Staff K, Licensed Nurse, verified there were no potential adverse side effects identified that could be associated with the use of the medication nor any indication staff monitored for adverse side effects.	F 329	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  <u>Measures/System Changes that will Occur to Insure Sustained Solutions:</u> AIMS are initiated for all [REDACTED] meds and reviewed every 6 months with changes in resident's medication and conditions addressed as they occur. Quarterly psychotropic rounds will continue to include monitoring of any possible side effects of [REDACTED] medication. A random audit of the AIMS and [REDACTED] rounds will occur for 90 days and will be reviewed by the QAPI Committee for 3 months to ensure compliance. Nurses are being inserviced on protocol to monitor side effects of [REDACTED] medications. <u>Date Corrective Action Completed:</u> 2 Feb 2014. <u>Person Responsible to Ensure Correction:</u> DNS, SSD or designee.		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364	(from pg 20) <u>F364—483.35(d)(1)-(2) Nutritive Value/Appear, Palatable/Prefer Temp Resident #45: Correction as it Relates to the Individual</u> Staff assisting this resident with her intake have been inserviced and are being monitored to ensure that the resident		

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F 364	<p>Continued From page 19</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure two residents (#s 45 and 53) who required a drinkable puree diet were provided meals in a palatable manner. Failure to provide menu items separately prevented foods from having a distinguishable taste and odor. This placed residents at risk for less than adequate nutritional intake, weight loss and a diminished enjoyment of their meals.</p> <p>Findings include:</p> <p>Review of the facility's menu revealed the lunch meal on 12/16/13 included salmon asparagus and brie quiche and green beans.</p> <p>Observation of lunch service in the Assisted Dining Room on 12/16/13 at 12:17 p.m. revealed Resident #45 received her entree. It was served on a plate with two distinctly colored and portioned pureed food items. Staff E identified them as quiche and green beans. Staff E then scraped both food items into a mug, added milk and mixed it together. She assisted the resident to drink the mixture from the mug. Staff F mixed Resident #53's quiche with milk in a mug and fed the resident. At 12:42 p.m. Staff E put the remainder of Resident #53's green beans and quiche in a mug, mixed it with milk and then fed her with a spoon. At 12:46 p.m., Staff F mixed Resident #45's pureed lemon bar with water and assisted the resident to drink the mixture. At 12:52 p.m., Staff E was observed to do the same for Resident #53's dessert.</p>	F 364	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Is getting her courses mixed individually with appropriate liquids. As the resident is nonverbal, staff are monitoring for physical signs of meal dissatisfaction and alternatives are being requested as indicated.</p> <p><u>Protecting Residents in Similar Situations:</u> Staff assisting any resident with a drinkable pureed diet have been inserviced and are being monitored to ensure that the resident is receiving courses mixed individually with appropriate liquids. Nonverbal residents are being monitored for physical signs of meal dissatisfaction and alternatives are being requested as indicated.</p> <p><u>Measures/System Changes that will Occur to Insure Sustained Solutions:</u> Nursing and dietary staff will be inserviced on the updated and specific drinkable puree diet guidelines. Dietary staff will prepare and serve the drinkable puree diet rather than the NAC's mixing at the tables for improved control of palatability, texture and temperature. Weekly audits will be completed by the Registered Dietitian or designee for 90 days to ensure diet guidelines are being followed. Results of audits will be reviewed by the QAPI Committee for 90 days for compliance. <u>Date Corrective Action Completed:</u> 2 Feb 2014. <u>Person Responsible to Ensure Correction:</u> Registered Dietitian.</p>	

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F 364	<p>Continued From page 20</p> <p>Both Resident #53 and 45's tray cards directed staff to "offer food in drinkable form." Review of the resident's records revealed Speech Therapy recommended the drinkable puree format due to each resident's difficulty with eating and swallowing.</p> <p>Similar observations of distinct food items being mixed together for Resident #53 and 45 were made on 12/18/13, when staff mixed pureed spinach salad with warm bacon vinaigrette and parmesan tomato halves with water. On 12/19/13 at 12:03 p.m. Staff F mixed the puree entree, a roasted vegetable foccacia with roast red pepper hummus and the pureed vegetable, peas and carrots, with milk and then fed Resident #45. Staff F was observed to make the same mixture for Resident #53.</p> <p>Neither resident was able to respond to questions about their meals due to their cognitive loss.</p> <p>In an interview on 12/19/13 at 2:00 p.m., Staff D, Registered Dietitian, stated she thought staff mixed food that was appropriate. She explained staff know the residents and observe them for facial grimaces, clenched mouths or any other indication that they did not like the foods mixed. When asked how staff would differentiate between a resident not liking a food mixture, not liking a specific food, and not wanting to eat, Staff D stated she did not know. When asked if any other residents were served their meal mixed together, she stated no.</p> <p>In an interview on 12/19/13 at 2:15 p.m., Staff F stated Resident #45 no longer opened her mouth when staff attempted to feed her. She stated the resident would drink so staff created the puree</p>	F 364	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><u>Resident #53: Correction as it Relates to the Individual</u> Staff assisting this resident with her intake have been inserviced and are being monitored to ensure that the resident is getting her courses mixed individually with appropriate liquids. As the resident is nonverbal, staff are monitoring for physical signs of meal dissatisfaction and alternatives are being requested as indicated.</p> <p><u>Protecting Residents in Similar Situations:</u> Staff assisting any resident with a drinkable pureed diet have been inserviced and are being monitored to ensure that the resident is receiving courses mixed individually with appropriate liquids. Nonverbal residents are being monitored for physical signs of meal dissatisfaction and alternatives are being requested as indicated.</p> <p><u>Measures/System Changes that will Occur to Insure Sustained Solutions:</u> Nursing and dietary staff will be inserviced on the updated and specific drinkable puree diet guidelines. Dietary staff will prepare and serve the drinkable puree diet rather than the NAC's mixing at the tables for improved control of palatability, texture and temperature. Weekly audits will be completed for 90 days by the Registered Dietitian or designee to ensure diet guidelines are being followed. Results of audits will be reviewed by the QAPI Committee for 90 days for compliance.</p>		

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F 364	Continued From page 21 mixture. Staff F stated she mixed the red pepper sandwich and peas/carrots because it was all vegetables, however she rarely mixed meat and vegetables. She stated the decision to mix separate food items "depends on the food. We try to only mix appropriate foods." When asked if she thought the resident might like to taste the peas/carrots or sandwich separately, like other residents were served, she did not respond.  In an interview on 12/20/13 at 11:05 a.m., Staff E stated she had "never thought about it (the mixing of the food being an issue)". She explained she wanted the residents to consume as much as possible in the hour staff had to feed them, and mixing the food helped make that happen. She stated she judged the resident's reaction to food and would get something else if they didn't seem to like what she gave them. When asked how she would determine if a resident didn't like all the flavors muddled together as opposed to disliking a certain food, she stated she had not thought about that.  Failure to ensure food was served for all residents in a manner that maintained its distinct aroma, appearance and flavor placed residents at risk of diminished enjoyment of their meals.	F 364	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  <u>Date Corrective Action Completed:</u> 2 Feb 2014. <u>Person Responsible to Ensure Correction:</u> Registered Dietitian.  <u>F514—483.75(l)(1), Resident records – Complete/Accurate/Accessible</u> <u>Resident #44: Correction as it Relates to the Individual:</u> The resident's MAR and TAR have been replaced by accurately transcribed MAR/TARs. Any questions about orders have been clarified. <u>Protecting Residents in Similar Situations:</u> The current MARs and TARs were carefully checked to ensure that conflicting or confusing orders were clarified and written accurately. <u>Measures/System Changes that will Occur to Insure Sustained Solutions:</u> The nurses who inaccurately transcribed have been counseled and received additional training as to how to update any medical record as well as when order clarifications are required. All nurses are being inserviced on the correct way to make changes on MARs and TARs, and when and how to clarify any confusing or conflicting orders. The results	
F 514 SS=E	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514		

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F 514	<p>Continued From page 22</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to ensure clinical records were maintained on each resident that were complete and accurate. The facility failed to ensure Medication Administration Records reflected current physician's orders; Preadmission Screening and Resident Reviews and care plans were accurate; consent forms were signed; skin checks were accurate and that staff documented notifications to the physician. Failure to ensure clinical records were accurate and complete prevented staff from ensuring resident's needs were met.</p> <p>Findings include:</p> <p>Refer to: CFR 483.20(d), (k)(1), F-279, Comprehensive Care Plans CFR 483.20(m), F-285, PASRR CFR 483.25(l)(1), F-329, Unnecessary Medications</p> <p>RESIDENT #44 Review of monthly physician's orders revealed an order dated 09/01/13 for staff to weigh the resident three times a week, on Monday, Wednesday and Saturday, as well as an order</p>	F 514	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>of random MAR and TAR audits occur for 90 day and be reviewed by the QAPI Committee for 3 months to ensure compliance. <b>Date Corrective Action Completed:</b> 2 Feb 2014. <b>Person Responsible to Ensure Correction:</b> DNS or designee.</p>	

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F 514	<p>Continued From page 23 dated 10/06/13 for " Daily weights". Both of these orders were transcribed into the monthly Medication Administration Record (MAR).</p> <p>Review of the October MAR revealed staff marked out the order for daily weights and wrote "d/c see NO (new order)".</p> <p>Review of the November MAR revealed staff wrote "info" by the Daily Weights order. For the three times a week weights, staff blocked out dates for weight to be recorded but these were not consistently Monday, Wednesday and Saturday as directed in the order.</p> <p>Review of the December MAR revealed staff noted the three times a week weight was "changed 10/6/13" and daily weights were being recorded.</p> <p>In an interview on 12/19/13 at 2:30 p.m. Staff C stated she was unable to locate an original order for daily weights. She stated it appeared to have been initiated based on a nurse's judgement and should have been discontinued after a short time. Staff C stated this was a documentation issue as staff provided the care the physician wanted.</p> <p>In addition, a physician's order, dated 08/14/13, directed staff to check the resident's blood pressure and pulse every Thursday related to medication use every Friday evening. Staff failed to clarify the order with the physician to determine when the vital signs should be acquired. In an interview on 12/19/13 at 12:53 p.m., Staff C stated the order was not clear and should have been re-written.</p> <p><b>RESIDENT #76</b></p>	F 514	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>Resident #76: Correction as it Relates to the Individual:</b> The resident's MAR and TAR have been replaced by accurately transcribed MAR/TARs. Any questions about orders have been clarified. The consent for [REDACTED] has been completed with a signature from the DPOA.</p> <p><b>Protecting Residents in Similar Situations:</b> The newly issued MARs and TARs were carefully checked to ensure that conflicting or confusing orders were clarified and written accurately. Consents for all [REDACTED] meds have been audited and completion ensured.</p> <p><b>Measures/System Changes that will Occur to Insure Sustained Solutions:</b> Nurses are being inserviced on the correct way to make changes on MARs and TARs, and when and how to clarify any confusing or conflicting orders and how to complete consents. Audits by nurse managers will occur for 90 days to ensure compliance and accuracy in any changes to the MARs and TARs and that the consents are in place and complete. The results of audits will be reviewed by the QAPI Committee for 3 months to ensure compliance.</p> <p><b>Date Corrective Action Completed:</b> 2 Feb 2014.</p> <p><b>Person Responsible to Ensure Correction:</b> DNS or designee.</p>	

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NAME OF PROVIDER OR SUPPLIER  CORWIN CENTER AT EMERALD HEIGHTS	STREET ADDRESS, CITY, STATE, ZIP CODE 10901 - 176TH CIRCLE NORTHEAST REDMOND, WA 98052
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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 514	<p>Continued From page 24</p> <p>Review of the December 2013 MAR revealed the order, "██████████ 3mg (milligrams) tablet - Give 2 tablets (2mg) by mouth daily at bedtime as needed for ██████████...". Review of the original physician's order revealed the total amount administered should read "6mg" not 2 mg. Failure to ensue the MAR accurately reflected the order made the order unclear.</p> <p>An 11/12/13 Therapeutic Interchange Request / Physician's Order requested the discontinuation of the medication ██████████ 10-20 mg to be replaced with ██████████ 40 mg every night. The physician signed the order on 11/15/13. Review of the December MAR revealed the ██████████ order remained and staff handwrote "██████████", but no other part of the order. Failure to accurately update the MAR left the resident at risk for a medication error.</p> <p>In addition, review of the November 2013 MAR, located in the resident's chart, revealed a consent for the ██████████ medication ██████████. A note had been placed on the consent form that directed staff to have the resident's representative "sign when he comes in...". The consent was signed by facility staff and dated 10/31/13, however it was not signed by the resident's representative nor was there any indication verbal consent was obtained. In an interview on 12/20/13 at 10:15 a.m., Staff C stated staff had obtained verbal consent for the medication but failed to document it. She also stated the consent form should not have been removed from the active MAR until it was signed.</p> <p><b>RESIDENT #30</b> According to the 03/26/13 admission Minimum Data Set assessment (MDS), Resident #30</p>	F 514	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>Resident #30: Correction as it Relates to the Individual:</b> A Significant Change Status Assessment (SCSA) has been initiated with and ARD 11 Jan 2014. The resident's care plan has been reviewed and updated as required.</p> <p><b>Protecting Residents in Similar Situations:</b> Review the MDS Section G coding trends for all active residents admitted on or before 7 October 2013 to determine if a SCSA is indicated. The MDS coordinator will complete a SCSA if the interdisciplinary team (IDT) deems it appropriate. Care plans are updated during the MDS reviews and as changes occur.</p> <p><b>Measures/System Changes that will Occur to Insure Sustained Solutions:</b> The MDS team will communicate to the IDT when the MDS data indicates a possible significant change. The IDT, during their daily meeting, will determine if a significant change meets the guidelines and direct the team to complete a SCSA. The MDS nurse or designee will document the initial identification of a significant change in the resident's status in the progress notes. The</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505478</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/20/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CORWIN CENTER AT EMERALD HEIGHTS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>10901 - 176TH CIRCLE NORTHEAST REDMOND, WA 98052</b>		
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F 514	<p>Continued From page 25</p> <p>admitted to the facility on [REDACTED]/13 and required limited assistance for several ADLs (Activities of Daily Living) to include bed mobility, transfer, toilet use and personal hygiene. The resident was coded to be independent with eating.</p> <p>Review of the 06/21/13 quarterly MDS revealed the resident had a decline in all of the ADLs listed above. The resident required extensive assist for bed mobility, transfer, toilet use and personal hygiene. The resident was coded to need supervision with eating. Despite the change in two or more areas, there was no indication a significant change MDS was completed, nor was an explanation for the lack of assessment found in the record.</p> <p>On 12/20/13 at 10 a.m. Staff G (MDS Coordinator) acknowledged there was a decline in five areas and stated, "Quite possibly I should have done one (significant change)... I'll usually document why I didn't do one." Staff G went on to explain he did not do one in this case because the resident's ADL status did not remain the same through the 14 day period that is required for a significant change. Upon review of his notes Staff G found he did not document the reasons why he did not do the significant change MDS and stated "I did not document my thought process... my note does not explain this."</p> <p>Additionally, the 09/21/13 quarterly MDS indicated the resident still needed extensive assistance for personal hygiene. However, upon review of the care plan, staff were directed to "set up items for personal hygiene." On 12/19/13 at 2:05 p.m. Staff I stated they set her up for personal hygiene tasks like oral care and cue her.</p>	F 514	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>QAPI Committee will review SCSA's for 3 months to ensure compliance. <b>Date Corrective Action Completed:</b> 2 Feb 2014. <b>Person Responsible to Ensure Correction:</b> MDS Coordinator</p> <p>( from pg 27) <b>Resident #65: Correction as it Relates to the Individual:</b> Resident's medications have been reviewed and modified as per physician orders. The resident's MAR and TAR have been replaced by accurately transcribed MAR/TARs. Any questions about orders have been clarified . <b>Protecting Residents in Similar Situations:</b> All diabetic residents receiving medication with parameters are being monitored for compliance:</p>	

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505478	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  12/20/2013
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F 514	<p>Continued From page 26</p> <p>Review of the "7-Day ADL Assessment" for the 09/21/13 MDS revealed the resident was noted to need limited assistance, not extensive assistance. In the same interview on 12/20/13 Staff G stated that was a coding error. Staff failed to accurately document the care a resident required.</p> <p><b>RESIDENT #65</b> Resident #65 admitted to the facility on [REDACTED]/13 with multiple diagnoses to include [REDACTED]. Review of physician's orders revealed the resident was to have her blood sugar checked twice a day. If the blood sugar results were noted to be over 300, staff were directed to "notify the ARNP" (Nurse Practitioner).</p> <p>Review of the MAR revealed that on both 11/20/13 and 11/28/13 the blood sugar was recorded as a value over 300. No indication that the ARNP was informed was found in the record.</p> <p>On 12/20/13 at 12:15 p.m. Staff C was not able to find record that the nurse practitioner was informed of the blood sugar results. Staff C later stated that the ARNP was present the following days after the blood sugars were elevated and was verbally informed. Staff C acknowledged staff should have documented the notification but failed to do so.</p> <p><b>RESIDENT #48</b> Resident #48 admitted to the facility on [REDACTED]/13. Review of this resident's MAR indicated staff conducted weekly skin checks. Staff were directed to write a minus (-) sign if no new skin issues were present. Staff were to write a plus (+) sign if a new skin issue was present. On the skin check for 07/28/13, staff wrote a plus sign</p>	F 514	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>Measures/System Changes that will Occur to Insure Sustained Solutions:</b> Nurses are being inserviced regarding the need to follow parameters associated with medication, when to notify the physicians and proper documentation. MAR's and charts will be audited for 90 days with the results of the audits to be reviewed by the QAPI Committee for 3 months to ensure compliance. <b>Date Corrective Action Completed:</b> 2 Feb 2014. <b>Person Responsible to Ensure Correction:</b> DNS or designee.</p> <p><b>Resident #48: Correction as it Relates to the Individual:</b> Resident's skin monitors are correct and according to facility guidelines. <b>Protecting Residents in Similar Situations:</b> Nurse has been counselled and received training in facility protocol. <b>Measures/System Changes that will Occur to Insure Sustained Solutions:</b> Nurse has been counselled and received training in facility protocol and treatment nurse will review documentation when she makes her rounds.</p>	
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F 514	<p>Continued From page 27</p> <p>indicating a new skin issue was present, however, below the plus sign "no new skin issues" was written.</p> <p>On 12/18/13 at 10:10 a.m. Staff C reviewed the medical record to see if a new skin issue was documented anywhere in the nursing notes. Staff C was unable to find any indication of a skin issue and concluded the plus sign was a mistake in documentation.</p> <p><b>RESIDENT #7</b> Review of the December 2013 MAR revealed Resident #7 received a dose of an "as needed" [redacted] medication on 12/10/13 at 2010 (8:10 p.m.).</p> <p>The clinical record identified the resident had a fall at 2145 (9:45 p.m.), after the medication was administered. In an interview on 12/19/13 at 3:30 p.m., Staff J, Licensed Nurse, stated the time written on the MAR was not correct. She explained she recalled administering the medication after the resident fell, based on her call to the Hospice Nurse who directed her to administer the [redacted] medication. She stated she documented the time on the MAR inaccurately.</p> <p>Failure to ensure the MAR accurately reflected the actual time medication was administered placed the resident at risk for medication errors and prevented the facility from investigating a fall with all the necessary information.</p>	F 514	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p><b>Date Corrective Action Completed:</b> 2 Feb 2014. <b>Person Responsible to Ensure Correction:</b> Treatment Nurse or designee.</p> <p><b>Resident #7: Correction as it Relates to the Individual:</b> No change is possible in the resident record; however a note has been added detailing the inaccuracy of the time initially recorded. <b>Protecting Residents in Similar Situations:</b> Nurses have been inserviced about the use of the 24 hr. clock. The nurse making the error has received counselling and training as to how to determine time per the 24 hr. standard. <b>Measures/System Changes that will Occur to Insure Sustained Solutions:</b> Clocks that indicate time using the 24 hr standard have been ordered and will be placed at each nursing station. <b>Date Corrective Action Completed:</b> 2 Feb 2014. <b>Person Responsible to Ensure Correction:</b> DNS or designee.</p>	

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