

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

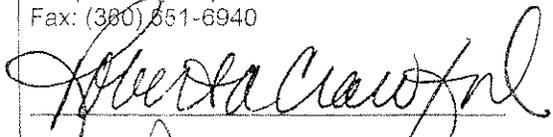
PRINTED: 08/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

1164

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505491	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/02/2013
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NAME OF PROVIDER OR SUPPLIER  EVERETT CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1919 112TH STREET SOUTHWEST EVERETT, WA 98204
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Everett Care &amp; Rehabilitation Center on 07/22/13, 07/23/13, 07/31/13, 08/01/13 &amp; 08/02/13. A sample of 9 residents was selected from a census of 90. The sample included 7 current residents and records of 2 former/discharged residents.</p> <p>The following complaints were investigated as part of this survey:</p> <p>2836898, 2842217, 2846571, 2842031 &amp; 2846410</p> <p>The survey was conducted by:  , RN, MS  , RN, MSN  , RN, BSN</p> <p>The survey team is from:                  Department of Social &amp; Health Services                  Aging and Long-Term Support Administration                  Residential Care Services, District 2, Unit B                  3906 172nd St NE Ste 100                  Arlington, WA 98223-4740</p> <p>Telephone: (360) 651-6850                  Fax: (360) 651-6940</p> 	F 000	<p>RECEIVED</p> <p>SEP 05 2013</p> <p>ADSA/RCS Smokey Point</p> <p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, <b>Everett Care &amp; Rehabilitation Center</b> does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 9/3/13
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000 Continued From: page 1  
Residential Care Services Date  
F 164 483.10(e), 483.75(l)(4) PERSONAL  
SS=E PRIVACY/CONFIDENTIALITY OF RECORDS

F 000  
**F164**  
F 164  
1) Resident information removed from public survey book on 8/2/13  
2) Public survey book was reviewed by the Administrator on 8/2/13 to ensure no protected privacy documents were incorporated  
3) Administrator reviewed F164 483.10 (e), 483.75 (l)(4) in order to self-educated on privacy regulations  
4) Administrator to review public survey book monthly x 3 months in order to maintain that no privacy documents are contained within  
5) Administrator  
8/30/13

The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview and record review, the facility failed to maintain confidentiality of resident names and records. Affected were 55

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F 164 Continued From page 2 F 164

residents. Failure to remove resident identifiers from the publicly accessible survey reports resulted in a violation of privacy rights.

Findings include:

CFR 483.10(g): Examination of Survey Results; includes the requirement that the facility must make the results of the most recent survey available for examination in a place readily accessible to residents.

The facility had a binder containing the results of the most recent annual survey inspection citations as well as all complaint investigation citations during the survey cycle. The facility survey binder was available to all current/past residents, prospective residents and any member(s) of their families as well as the general public.

On 07/23/13 at 08:30 a.m., observation of the facility survey binder found that the full annual inspection, dated 08/16/12, included the names of the 52 residents who participated in that survey. The complaint investigation survey, dated 02/01/13, also contained the names of the two sampled residents and the staff involved in that investigation. The resident/staff roster, dated 02/01/13, contained a header noting the list of names was confidential and should not be posted for public access.

The facility administrator reported he was the person who placed all annual and complaint investigation citations into the facility survey book. He was unaware any resident names were currently posted in the facility survey book.

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F 166 Continued From page 3  
F 166 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES  
SS=D

F 166  
F 166 **F166**

A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

1) Resident # 4 was discharged from facility on [REDACTED]/13

This REQUIREMENT is not met as evidenced by:  
Based on interview and record review, the facility failed to promptly address a resident grievance for 1 of 9 sample residents. Failure to communicate, update and resolve Resident 4's grievance in a timely manner placed the resident at risk of diminished quality of life.

2) Logged grievances were reviewed on for timeliness on 8/22/13 by the Social Services Director

Findings include:

3) Social Services Director was educated as to timeliness of grievance follow-up 8/26/13 by Administrator

Resident 4 was most recently readmitted in May 2013 for rehabilitation after [REDACTED]. Other diagnoses included [REDACTED] and history of a [REDACTED]. His Minimum Data Set assessment identified his memory and recall as 15/15 points on the memory assessment tool.

4) Social Services Director to audit the grievance log monthly times 3 months to ensure timeliness of follow up is maintained

On 07/22/13 at 8:40 a.m., Resident 4 reported he owned a gel liner for the [REDACTED], but it was [REDACTED]. He reported the [REDACTED] to therapy in May 2013. In the 2 months since he reported the issue, no one from the staff had updated him on what the facility was doing to address the grievance. He felt "frustrated." Resident 4 explained he told the staff and "they have not done anything." He stated he reminded Staff [REDACTED] during the previous week, but

Social Services to review, validate, track and trend audits and present in PI (Performance Improvement Committee) monthly x 3 months with interventions as determined by team to ensure process maintained

5) Social Services Director  
8/26/13

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F 166	<p>Continued From page 4</p> <p>nothing changed. Resident 4 phoned the medical supply company and they explained to him he had to have a physician order to obtain the gel liner.</p> <p>On 07/23/13 at 3:15 p.m., Staff A reported he did not recall when he first learned of the missing gel liner for the [REDACTED]. He had no information of the status of the missing item.</p> <p>At 2:45 p.m., Staff E reported she told nursing in May 2013 of the missing item. She phoned several clinics and supply companies in the past 2 months. About 2 days ago, she learned a written physician justification was required. She had no information whether anyone was apprising the resident of the status of the gel liner.</p> <p>Review of the clinic record of Resident 4 revealed no evidence of documentation of notification to Resident 4 of the status of the grievance for the missing item. There was no listing of the concern on the grievance log.</p>	F 166		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure services provided met professional standards of quality for 2 of 3 residents (4 &amp; 8) when they failed to monitor or recognize changes in the Resident's condition (8) and failed to implement physician orders in a</p>	F 281		

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F 281 Continued From page 5

timely manner (4). This failure resulted in the potential for harm for Resident 8 with the delay in obtaining an x-ray, and a potential for harm for Resident 4 with the delay in obtaining and testing a urine sample

Findings include:

According to the American Nurses Association, Scope and Standards of Practice, 2011, "A licensed nurse shall, in a complete, accurate and timely manner, report and document nursing assessments or observations, the care provided by the nurse for the client, and the client's response to that care. Nurses assume a liability risk if they fail to monitor a patient or to recognize changes in a patient's condition. Failure to recognize the significance of changes or to communicate them clearly and promptly to the attending practitioner could endanger the patient."

According to WAC 246-840-700 Standards of nursing conduct or practice.

(3) The following standards apply to registered nurses and licensed practical nurses:

(b) The registered nurse and licensed practical nurse shall document, on essential client records, the nursing care given and the client's response to that care;

1. Resident 8 was admitted to the facility on [redacted]/13 with diagnoses that include [redacted]. His MDS assessment dated 06/20/13 indicated that the resident was cognitively intact. The MDS assessment also indicated the resident needed extensive assistance of one to two persons for all of his activities of daily living except eating.

F 281

**F281**

1) Resident # 4 was discharged from facility on [redacted]/13

Resident # 8 received x-ray on 7/19/13, diagnosis of [redacted]

2) Labs and x-ray orders were reviewed to ensure timeliness

3) Licensed Nurses were educated on proper documentation of order, recognizing changes in resident's condition and implementing Physician orders in a timely manner on 8/22/13 by Director of Nursing

4) Resident Care Managers to audit labs and x-ray orders to ensure they are carried out weekly times 1 month and monthly times 2 months

Resident Care Managers to review, validate, track and trend audits and present in PI (Performance Improvement Committee) monthly x 3 months with interventions as determined by team to ensure process maintained

5) Resident Care Managers

8/30/13

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The resident's medical record was reviewed on 08/10/13. On 7/18/13 during routine care, it was discovered that the resident had swelling to his [REDACTED] lower leg. The facility did not arrange to have the resident's leg x-rayed until approximately 13 hours after the swelling was identified. The care plan was not updated that there was no plan put in place to stabilize the leg or prevent it from further injury until the x-ray was performed.

The resident's x-rays on 07/19/13 showed the resident's leg was [REDACTED] and the care plan was still not updated. The resident was sent out to the emergency room on the evening of 07/19/13 and came back with a diagnoses of "[REDACTED]" to the [REDACTED] leg.

2. Resident 4 was readmitted in May 2013 after a [REDACTED] of the [REDACTED] leg. He had a history of a [REDACTED]. On 07/01/13, the renal physician ordered a urine sample collection and analysis (UA) to be done "as soon as possible in his nursing home" when Resident 4 returned to the facility after his clinic appointment that same day.

On 07/23/13 at 3:40 p.m., Staff A reported he did not know when the UA was done.

Review of the clinical record of Resident 4 revealed no evidence of performance of the order.

On 07/24/13 the Director of Nursing Services wrote the order had not yet been implemented.

See also F-309 for additional information

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F 309	Continued From page 7 F 309 483 25 PROVIDE CARE/SERVICES FOR SS=G 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 observation, interview, and record review, the facility failed to evaluate, document and communicate to the resident, his physician and Power of Attorney (POA) acute changes in the condition of wounds for 1 of 2 residents (1). This failure resulted in harm for Resident 1 as evidenced by the worsening of his wounds, hospitalization and subsequent surgery.  Findings include:  Resident 1 was admitted to the facility on [REDACTED] 13 with diagnosis that included [REDACTED], [REDACTED] and [REDACTED]. The resident's most recent Minimum Data Set (MDS) assessment, dated 06/03/13, indicated that the resident was severely impaired in his cognition.  Resident 1 had a significant history of [REDACTED] as evidenced by prior [REDACTED] in 2003, 2007 & 2008. In addition the diagnosis of [REDACTED] increased the risk of [REDACTED] and the delay in [REDACTED]	F 309 F 309	<b>F309</b>  1) Resident # 1 was discharged from facility on [REDACTED] 13  2) Nurse Managers and Director of Nurses assessed residents at risk for skin breakdown 8/7/13 and 8/9/13. Care plan and treatment records were reviewed and updated as applicable, physician, resident and interested party were informed  3) On 8/22/13 licensed nurses were educated to evaluate, document and communicate to the resident, physician and interested party, acute changes in condition  4) Resident Care Managers to audit ten skin integrity reports for worsening of wounds weekly times 1 month and then monthly times 2 months  Resident Care Managers to review, validate, track and trend audits and present in PI (Performance Improvement Committee) monthly x 3 months with interventions as determined by team to ensure process maintained	

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F 309 Continued From page 8  
The resident was discharged on 07/09/13, after the podiatrist requested he be sent to the hospital for treatment of an [REDACTED] (death of soft tissue) toes and subsequently underwent an above the [REDACTED]

F 309 5) Resident Care Managers  
8/30/13

The facility's policy on "Skin Integrity Management", with a revision date of 10/01/10, was reviewed. The policy instructed staff to perform weekly skin evaluations, to monitor for any signs of decline in wound status and document daily and adjust the plan of care, as indicated. Staff were to document any conditions or factors that may have potential to delay or impede healing including [REDACTED] and [REDACTED]. The policy further directed staff to notify family and/or health care decision maker of status and to provide appropriate education regarding risk factors, wound status, wound goals, patient goals.

The "Skin Integrity Management" policy included care plan instructions to consider the resident's specific, individual risk factors; refer to the risk assessment and to include approaches to stabilize or improve co-morbidities and interventions limiting the effects of risk factors.

On 07/23/13 at 11:30 a.m., the corporate regional nurse (Staff B stated that the facility also used the Lippincott Manual of Nursing Practice for guidelines for diabetic foot care.

The Lippincott Manual of Nursing Practice included the following:  
Inspect the feet carefully and daily  
Bathe the feet daily in warm water, massage the feet with an absorbable agent, and avoid injuries

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to the feet  
If an injury occurs - wash the area with soap and water, cover with a dry sterile dressing without adhesive and wear white cotton socks (dye in colored socks and wool may serve as irritants when skin is already irritated.)

On 06/27/13 Resident 1 complained to facility staff of right foot pain. He reported that his pain level was a 7 out of 10 indicating that he had "Severe/Horrible" pain (per the facility pain sheet) that day. Staff C documented in the progress notes that skin tears were discovered on the 1st and 2nd toes on the resident's right foot. The second toe had [REDACTED] (fluid that was yellowish with small amounts of blood) and had about 50% granulation tissue (usually occurs at day 3 to 4 of normal healing stages) and was about 50% purple / bruise.

On the same day, Staff C sent a fax to the physician describing the injuries and informing the physician that the areas had been cleansed with normal saline and were covered with a band aid. Staff C also requested the physician order treatment to "cleanse with normal saline and cover with band aid/border gauze daily until healed."

The facility fax did not inform the physician that the resident was a [REDACTED] or that he had a history of [REDACTED] in the [REDACTED] with [REDACTED].

From 6/27 to 7/3/13 the resident received dressing changes at least 2 times daily. There was no evidence facility staff were performing ongoing assessment and monitoring of the resident's wounds, evaluating the resident's

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response to treatment and providing ongoing notification of the status of the resident's wounds to his physician and POA.

On 07/01/13 Staff C documented on the skin integrity report that the surrounding tissue around the 2nd toe was inflamed and the wound edges were macerated (The softening and breaking down of skin resulting from [REDACTED] to moisture which can increase the risk of [REDACTED] and prolong healing).

On the same day, Staff C sent a fax to the physician that stated the resident had a current order for triple antibiotic ointment for his right second toe. The big toe was not healing so Staff C asked the physician for an order to clean the toe with normal saline, apply triple antibiotic ointment and cover with a gauze or band aid and the treatment was set up to be once a day. Staff C did not inform the physician that the toe had maceration or that the toe was inflamed. Again staff did not remind the physician of the resident's diagnosis of [REDACTED] or history of [REDACTED].

There was no documentation the facility spoke with the resident or notified the POA about the status of the wounds or the change in the treatment.

On 07/03/13 the resident's physician saw the resident. Neither the resident's progress note nor the physician's note indicated the resident's wounds were observed by the physician and that the physician had been notified by staff of the status of the resident's wound. The physician wrote the resident was lying on his bed and the toe was covered with a band aid on his left toe

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NAME OF PROVIDER OR SUPPLIER  EVERETT CARE & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1919 112TH STREET SOUTHWEST EVERETT, WA 98204		
(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 309	<p>Continued From page 11</p> <p>(wrong foot). The physician's "assessment" was that the resident had "COPD" and the "plan" was to "monitor."</p> <p>From 07/03/13 to 07/05/13, again there was no evidence facility staff were performing ongoing assessment and monitoring of the resident's wounds, evaluating the resident's response to treatment and providing ongoing notification of the status of the resident's wounds to his physician and POA.</p> <p>On 07/06/13 Staff C wrote on a fax to the physician that the resident was a [REDACTED] and had [REDACTED] on the [REDACTED] foot. Another "new area" had developed that was [REDACTED] on the [REDACTED] of the [REDACTED] foot. The "new area" on the [REDACTED] was mostly slough (The dropping off of dead tissue from living flesh), with serous (thin watery [REDACTED] substance) [REDACTED]. The area was deep purple in color measuring 1.5 x 1.5 cm. The second toe was also dark purple measuring 1.4 x 1 cm and the capillary refill was greater than 3 seconds (normal would be less than 3 seconds). There was no documentation about the inflammation but Staff C requested a wound consultation and the physician agreed. There was no documentation that the resident or the POA was notified of the new area of breakdown. Staff C did not inform the physician about the status of the inflammation that had been on the toe prior.</p> <p>An appointment for a wound consultation was made for 07/16/2013; for 10 days later. There was no documentation that Staff C contacted the physician to discuss other alternatives for treatment since the wound specialist could not see the resident for 10 days. There was no documentation that the facility discussed the</p>	F 309		

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

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F 309	<p>Continued From page 12</p> <p>appointment with the resident or the POA was aware. The resident and POA were denied the opportunity to research other alternatives.</p> <p>On 07/08/13 the podiatrist was in the facility. There was no evidence that the facility requested the podiatrist make the resident a priority so he could be seen that day.</p> <p>On 07/9/13 the resident was seen by the podiatrist and the description of the resident's [REDACTED] was documented. The documentation showed the resident had mild [REDACTED] and the big toe toward the center had a black area measuring 0.9 X 0.5 centimeters (cm). The underneath of the toe had an [REDACTED] that measured 2 x 1.5 cm in diameter. The base was dark in color of [REDACTED]. The second toenail was loose and there was [REDACTED] at the area of the nail bed that measured 1.5 x 1.5 cm. The base was filled with [REDACTED] slough and there was 5 cm of [REDACTED] (reddening of the skin) surrounding the open area. There was also a red linear streaking area going along the top of the right foot 5 cm in length as well. The Podiatrist's assessment was that the resident had [REDACTED] "s with cellulitis" of the right foot and "early gangrenous changes."</p> <p>The podiatrist recommended that the resident be sent to the emergency room to be started on [REDACTED] antibiotics. The podiatrist felt the wound clinic appointment was too far out and that the resident needed be seen by the hospital vascular staff.</p> <p>Resident 1 was transported to the hospital on [REDACTED] 2013.</p>	F 309		

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F 309	<p>Continued From page 13</p> <p>On that same day the hospital history and physical confirmed that the resident had full thickness black [REDACTED] and [REDACTED] forefoot cellulitis that was positive for MRSA ([REDACTED]).</p> <p>On 07/19/13 at 2:30 p.m., the resident's POA was interviewed. She stated the facility "never" told her about the injury to the toes on the resident's [REDACTED] foot. She did not learn about the injury until [REDACTED] 13 when the resident was being sent to the hospital. The POA stated if the family had known about the injury, they would have taken the resident to his own physician who had managed the resident [REDACTED] prior to his admission to the nursing home.</p> <p>On 07/22/13, Resident 1's care plan was reviewed and revealed no intervention for prevention of injury to the resident's [REDACTED] no instruction to staff regarding ongoing assessment and monitoring of the resident's [REDACTED] and what staff should be looking for.</p>	F 309		