

1164

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

PRINTED: 01/03/2014  
FORM APPROVED  
OMB NO. 0938-0391

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 01/02/2014
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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 12/30/13, 12/31/13 and 1/02/14. A sample of 5 residents was selected from a census of 92. The sample included 6 current residents.</p> <p>The following complaints were investigated as part of this survey: 2930640, 2929383 and 2917104</p> <p>The survey was conducted by: [REDACTED] RN, BSN [REDACTED] RN, MSN</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> <p>[REDACTED SIGNATURE] 1/3/14 Residential Care Services Date</p>	F 000	<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> <p>RECEIVED JAN 17 2014 ADSA/RCS Smokey Point</p>	
F 490	483.75 EFFECTIVE	F 490		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  [REDACTED SIGNATURE]	TITLE  [REDACTED TITLE]	(X6) DATE  1/14/14
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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 patient. (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 490 SS=F	<p>Continued From page 1</p> <p>ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews the facility's administration failed to effectively and/or efficiently use its resources to attain or maintain the highest practicable well-being of each resident. The facility administrator attempted to conduct an investigation from long distance and the administrator designee was expected to complete the investigative paperwork. The administrator designee was not familiar with conducting a thorough investigation. Failure to ensure staff designated to act in the place of the administrator implemented all components of the facility abuse prevention program placed all residents at potential risk of abuse, neglect and exploitation.</p> <p>Findings include:</p> <p>The facility's policy titled "Abuse Prohibition" with an effective date of 7/1/13 states "the Administrator, or designee, is responsible for operationalizing policies and procedures that prohibit abuse, neglect, . . ."</p> <p>The facility administrator had designated Staff E, a Resident Care Manager, in charge of the facility in his absence.</p>	F 490	<p><b>F490 - Administration</b></p> <p>1) Resident #1 investigation was updated to include the required components per facility policy and state requirements on 01/03/13 by Administrator</p> <p>Resident #1 was re-assessed on 12/24/13, 12/27/13 and 12/30/13 by Social Services and remains free of psycho-social harm. Resident #1 care plan was updated on 1/3/13 by Nurse Manager</p> <p>2) Administrator and Director of Nurses conducted review on 1/9/14 of investigations from 12/18/13 – 1/9/14. Investigations contained required components per facility policy and state requirements</p> <p>3) Education to Acting Director of Nurses, Nurse Practice Educator and Unit Managers on abuse and neglect investigations and purple book procedures was performed by, Administrator and Regional Manager of Clinical Operations on 1/2/14</p>

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F 490	<p>Continued From page 2</p> <p>On 12/24/13, Staff A, a Nursing Assistant (NA) and Staff B, NA, heard what they described as a "smack" and Resident 1 say, "Ow." Staff C, also a NA, was standing next to Resident 1 when Staff A and B looked into the resident's room. Staff A and B immediately informed Staff D, a Resident Care Manager, of what they witnessed.</p> <p>The administrator conducted interviews with Staff A, B, and C over the phone on 12/24/13. Staff E was responsible to document the interviews and write the summary of the investigation.</p> <p>The facility's conclusion to the allegation of abuse was "unable to rule out abuse and neglect at this time as event was not witnessed. However, there are also multiple noises that the accuser could have heard. One being the Velcro straps on the Mechanical lifts. Secondly, resident has been known to "bob" his upper body, slamming his arms against his bed and wheelchair repeatedly. Nursing assessment per unit manager also concluded with no bruising or redness consistent with a slap noted in resident's body."</p> <p>Staff C returned to work on 12/25/13, unsupervised.</p> <p>On 12/30/13 at 9:25 a.m., Staff F, the nursing educator, stated she was in charge of the facility while the Director of Nursing Services (DNS) was on vacation and the administrator was off.</p> <p>On 12/30/13 at 3:17 p.m., Staff E and Staff F were interviewed regarding the investigation. Staff E stated Resident 1's investigation was completed on 12/24/13.</p> <p>Review of the facility investigation revealed: - There were no written statements from the 3</p>	F 490	<p>4) Administrator to review 5 investigations prior to finalization weekly x 4 weeks then monthly x 2 months, appropriate education to be provided to involved parties with findings, trends and corrections from review discussed monthly x 3 months on going</p> <p>5) Administrator 1/9/14</p>		

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F 490	Continued From page 3 NAs. The facility administrator stated he interviewed the NAs over the phone. The statements were then typed up and signed by the NA. The statements were not dated and timed. There was no evidence the NAs were interviewed seperately. - Staff C had been working with another NA prior to the alleged incident. The NA partner was not interviewed about Staff C's behavior toward Resident 1 and other residents. - The care plan did not identify the resident behaviors of "bob his upper body, slamming his arms against his bed and wheelchair repeatedly." If this was what Staff A and B heard, the resident would have had marks on his arms.  On 12/31/13 at 11:20 a.m., Staff F stated Staff E was the person in charge while the administrator and DNS were gone. Staff F stated Staff E "was doing wound rounds" when the complaint investigator entered the facility on 12/30/13. Staff F "helped get the information" that was requested. Staff E confirmed he was in charge of the facility at this time.  On 1/2/14 at 9:40 a.m., during a phone interview, the administrator was asked who was in charge of the facility in his absence. He replied Staff E. The administrator was asked why his designee did not follow the facility's policy regarding abuse and neglect, the administrator stated he recognized he left a person in charge of the facility with limited experience.	F 490			