

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

1177

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/20/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Providence Marianwood on 03/12/13, 03/13/13, 03/14/13, 03/15/13, 03/18/13, 03/19/13 and 03/20/13. A sample of 30 residents was selected from a census of 97. The sample included 27 current residents, the records of 3 former/discharged residents, and 12 supplemental resident.</p> <p>The survey was conducted by:</p> <p>██████████, R.N., M.N. ██████████, M.S.W. ██████████, R.N., B.S.N. ██████████, RN, BSN ██████████, R.N., M.N.</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Disability Services Aging and Long-Term Support Administration Residential Care Services, District 2, Unit E 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388 Telephone: (253) 234-6000 Fax: (253) 395-5085</p> <p><i>Mike Ambrose</i> 03/26/13 Residential Care Services Date</p>	F 000	<p>RECEIVED APR 15 2013 DSHS/ADSA/RCS</p> <p>RECEIVED APR 12 2013 DSHS/ADSA/RCS</p>	
-------	--	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Chowdhury</i>	TITLE Administrator	(X6) DATE 4-12-13
---	------------------------	----------------------

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.

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 226 SS=E	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure policies and procedures that prohibit the neglect and abuse of residents were implemented for Residents # 188, 307, 13, & 141 four of four sample residents for whom incidents of potential abuse/neglect were reviewed. Failure to ensure thorough investigations of allegations of abuse/neglect detracted from the facility's ability to rule out abuse or neglect and placed all residents at risk for harm.</p> <p>Findings include:</p> <p>According to the facility May 2010 Abuse & Mistreatment Identification, Prevention, Investigation, & Reporting Guidelines policy "Upon identification of any alleged...occurrence of...abuse, neglect...or injury of unknown cause, the following steps will be taken:", "Immediately notify the Complaint Resolution Unit", "Remove the current direct caregiver (if involved in the allegation)", "complete an Unusual Occurrence Report", "Assess the resident for bodily harm, write a progress note and place resident on alert charting", "Adjust the care/service plan..." and "Injuries...are incidents that must be logged in the facility DSHS Reporting Log within five days from</p>	F 226	<p>1) How the nursing home will correct the deficiency as it relates to the resident:</p> <ul style="list-style-type: none"> • Resident #188 – <ul style="list-style-type: none"> ○ Quantros (UOR) report completed for Fx of unknown origin discovered on 2/6/13, Hotline called and placed on DSHS log ○ Quantros (UOR) report and investigation on 2/26 for fall with substantial injury amended to r/o abuse and establish origin of injury and placed on DSHS log • Resident #307 – <ul style="list-style-type: none"> ○ Staff GG is no longer employed by PMW ○ Quantros (UOR) report will be amended to include summary and conclusion ○ Resident will be assessed for psychological harm and late entry progress note will be made describing incident as reported by resident • Resident #13 – <ul style="list-style-type: none"> ○ Quantros (UOR) report and investigation completed on 1/2/13 will be amended to include summary, actions taken, and conclusion • Resident #141 <ul style="list-style-type: none"> ○ Quantros (UOR) report and investigation completed on 2/24/13 will be amended to include "injury during handling", staff witness statement, analysis of event, summary and conclusion 		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 226	<p>Continued From page 2 discovery."</p> <p>RESIDENT #188: On 03/12/13 at 2:16 p.m., interview with Staff P revealed Resident #188 had a fall about a month ago, around 02/16/13. On 03/18/13, Resident #188 was in her room watching TV, She had a fading bruised area under her right eye, She said she had fallen "a couple weeks ago...".</p> <p>On 03/14/13, review of facility's Accident/ Incident Log founds no entries identifying a fall by this resident. A separate "Fall Log" did not identify any falls during the month of February 2013. Review of nursing progress notes dated 02/5/13 revealed on the resident reported pain in her right wrist and shoulder. On 02/6/13, an X-ray identified a fracture of the right wrist. Resident #188 was unable to state how the injury occurred.</p> <p>Review of Progress notes for February 2013 found on 02/26/13 at 6:55 am, a staff member documented Resident #188 was found on the floor of her room. She could not state why she was on the floor. When assessed by a nurse she was found to have a hematoma measuring 3 by 3 centimeters on the right side of her forehead, and a black eye. This second fall was not recorded in the Accident /Incident Log or the "Fall Log".</p> <p>Injuries of unknown origin, including the fractured wrist and bruises to the face/ head sustained by Resident #188 are defined as significant injuries. Since the resident was not able to clearly state how either injury occurred, (and there were no witnesses to either injury), each would be a significant injury of unknown origin. significant</p>	F 226	<p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> • Facility Incident Log and DSHS Log will be reviewed for accuracy and completion • Sample of Quantros (UOR) reports reported since 1/1/2013 to DSHS (Reportable Events Log and/or Hotline) will be reviewed for accuracy and completion <p>3) Measures the nursing home will take or systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> • Individual staff members counseled on Abuse/Neglect policy and reporting requirements • In-service staff on reporting and investigation requirements to include incidents requiring an immediate report to CRU Hotline and suspension of staff • Utilize Quantros reports tool to meet requirements of DSHS Reportable Events Log <p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> • Establish requirement for monthly review of Mandatory Reporting and Resident rights at department/staff meetings • Director of Clinical Services to review all investigations for completion to include summary and conclusion 		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 226	<p>Continued From page 3</p> <p>injuries of unknown origin are required to be reported to the State, both via the State reporting hotline and by recording the incident in the Accident/ Incident Log.</p> <p>On 03/20/13 at 9:35 am, Staff C, a Resident Care Manager and Staff DD were asked to provide evidence of an investigation of Resident #188's wrist fracture discovered on 02/6/13 and of the incident on 02/26/13 at 6:55 when she sustained the hematoma on her R forehead and a black eye. At 10:45 am, Staff DD returned with a form identifying the fall and hematoma on 02/26/13. It was not an full investigation of the incident, and did not include interviews with staff or the resident in order to rule out potential abuse or neglect.</p> <p>On 03/20/13 at 11:40 am, Staff M, the corporate QI officer was interviewed regarding the two injuries sustained by Resident #188 in the month of February. Her report of wrist pain on 02/5/13- which was diagnosed as a fracture on 02/6/13, was not documented in the Accident/Incident Log. No investigation of the fracture was completed, even though the Resident could not identify circumstances of injury to staff. While facility staff documented the presence of the injury, staff were not interviewed and the State hotline was not notified of the fracture, which was of unknown origin.</p> <p>Resident #188's second injury on 02/26/13 (hematoma on her forehead) was also discussed. While Staff M stated he thought this was not a significant injury, he acknowledged it had not been recorded in the facility's Accident/Incident Log. and a thorough investigation was not done, as required for a significant injury of unknown</p>	F 226	<ul style="list-style-type: none"> Administrator and Director of Clinical Service will establish a monthly schedule to review a sample of investigations and reports on DSHS Log Utilize Language of Caring content "Heart, Head, Heart" to support staff <p>5) Dates when corrective action will be completed:</p> <p>May 3, 2013</p> <p>6) The title of the person responsible to ensure correction:</p> <p>Chris Bosworth, Administrator Colleen Hardy, Director of Clinical Services</p>		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 226	<p>Continued From page 4 origin.</p> <p>On 03/20/13 at 2:30 p.m., Staff B and C reported they believed the fracture on 02/5/13 was a re-fracture of a previous injury. Review of radiology reports did not identify the fracture as old or state the fracture was not of recent origin.</p> <p>RESIDENT #307</p> <p>In an interview on 03/12/2013 at 02:05 p.m., Resident #307 stated staff had been rude to her, elaborating that she was told to "Zip it" by a staff member. At this time the resident indicated she had not reported the incident and didn't want to say who did it.</p> <p>Staff B was informed of this information and on 03/15/13 provided a completed investigation. According to the "Actual Safety Event", this was alleged abuse. The incident was described as follows: "Staff member was interviewing roommate when (Resident) made some comments that she thought would be helpful. The staff member came around the curtain to face (Resident) and said "ZIP IT" while making a zipping motion across her mouth. Upon interview with (Resident) the staff member was identified as Staff GG from admissions. This behavior was reported to her supervisor for follow up. Supervisor provided counseling and training for individual on how her actions were perceived. No previous reports of this kind of interactions by this individual."</p> <p>Record review revealed no progress notes from 03/12/13-03/15/13 regarding this alleged abuse and no determination of if the resident suffered psychological harm.</p>	F 226		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029	
(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 226	<p>Continued From page 5</p> <p>There were no interviews of witnesses to the incident. There were no interviews of other residents who had recent contact with Staff GG to determine if the allegation of abuse were trendable or isolated. There was no summary or conclusion which ruled out abuse.</p> <p>RESIDENT #13 In an interview on 03/14/13 at 8:27 a.m. when asked "Has staff yelled at or been rude to you?", Resident #13 replied, "That one girl, but she's not her anymore."</p> <p>Review of the resident's record revealed a late entry note on 01/02/13 in which an LN was informed on 12/31/13 Resident #13 alleged one of the CNA's told the resident to "shut up" during care. The LN talked to the CNA who "acknowledged that she told the resident to "shut up". The LN documented the resident "allowed the CNA to take care of her for the rest of the night." According to the investigative documents the CNA cared for the resident again on 01/01/13.</p> <p>According to investigative documents the LN failed identify the act as potential verbal and/or psychological abuse as evidenced by the LN's failure to remove the CNA pending further investigation. In addition the LN failed to notify the Complaint Resolution Unit, complete an incident report, document a progress note, place the resident on alert charting for psychological harm or revise the plan of care to include psychological harm until 01/02/13.</p> <p>Further review of the investigative documents revealed the LN notified Staff C on 01/02/13 who met with Resident #13 who recalled, "When I was</p>	F 226		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 226	<p>Continued From page 6</p> <p>trying to tell her how to move me she told me to shut-up." Staff C documented that the CNA stated that she had told the resident to "Shut up". The investigation did not include a conclusion.</p> <p>In an interview on 03/18/13 at 12:36 p.m. Staff C said the CNA "did in fact tell this resident to 'shut up'." Staff C said she had told the CNA that was "considered verbal abuse." The LN was told she was supposed to have called immediately and sent the staff member home immediately.</p> <p>RESIDENT #141</p> <p>In an interview on 03/13/13 at 9:23 a.m. when asked "Have you ever been treated roughly by staff?", Resident #141 replied, "Yes." The resident pointed to his left hand and commented, "Twisted my hand", "Pretty painful." The resident was observed with steristrips to the top outer aspect of his left hand.</p> <p>According to the 02/13/13 Resident Assistant Information Sheet the resident was at low risk for Abuse/Neglect Issues because he was "able to communicate need."</p> <p>Review of the resident record revealed a 02/24/13 10:52 p.m. progress note "resident was combative during EVE shift...the CNA reported that the resident tried to hit her during care. The nurse came to the room to assess the situation, the resd was sitting on the toilet and he reported that he wanted to pulled his pajama pants up but the CNA didnt let him to. The CNA said it was unsafe for him to pull his pants up while he was sitting in the toilet so she tried to help him. The resd got upset and tried to hit the CNA. She dodged and he hit his left hand to the wall</p>	F 226		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 226	Continued From page 7 causing a 7.5 cm skin tear on his L hand. The nurse explained to him that he could not pull his pajama up while sitting on the toilet because it was unsafe and the CNA just tried to help." On 3/15/13, review of facility's Accident/ Incident Log found no entries identifying this resident. In an interview on 03/18/13 at 11:55 a.m. Staff B indicated the incident was not logged in the facility DSHS Reporting Log because the incident report listed the event as "Actual Skin Integrity" rather than as injury during care. Staff B was unable to identify which caregiver was involved in the incident, "it was not listed on there. I'd have to go look at assignment sheet or Caretraker." Investigative documents did not include an interview with the resident, interviews with other residents, witnesses if any, nor an analysis of the event including a conclusion if abuse occurred.	F 226			
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to promote a dignified environment for residents by posting personal care information for Residents #62, 31, 186, 111, and 141, five of 27 sample residents, in areas visible to the public. Additionally, the facility posted full names and dietary information for Residents #42, 220, 141,	F 241	1) How the nursing home will correct the deficiency as it relates to the resident: <ul style="list-style-type: none"> Residents #62, 31, 186, 111, and 141 white boards were updated and personal information removed Resident #111, wheel chair arm rest repaired Dietary cards in dining room removed for all residents, including residents #42, 220, 141, 186, 188, 87, 111, 98, 149, and 147 and replaced with new name cards which includes name only 		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 241	<p>Continued From page 8</p> <p>186, 188, 87, 111, 98, 149 and 147 in dining rooms where anyone could view it. Failure to recognize the potential to embarrass residents by posting personal information did not uphold their right to dignity.</p> <p>Findings include:</p> <p>RESIDENTS #62 and 31: On 03/12/13 at 9:23 am, during initial rounds of Unit D, several signs were observed posted above Resident #62's bed. Multiple care directives were written on a white board, including "Please do not leave urinal between his legs", "Apply Nystatin groin area and zinc on backside" and "Apply calmoseptine cream to L (left) buttock 3 times per day". The information about the resident's personal care was visible to anyone entering the room. On 03/18/13 at 11:15 am, efforts to interview the resident about the information posted were unsuccessful. The same three directives were present above his bed at that time.</p> <p>On 03/18/13 at 1:22 pm, an RN, (Staff K) was asked her about the facility's policy regarding posting personal resident care directives in their rooms. She stated, "Usually it's on the board or in the closet". When asked about posting something that could potentially be embarrassing to the resident, she said staff would not post it. She was asked to look at the information posted above Resident #62's bed. As she read the directives, she said she didn't know who had written the information there, but acknowledged the content was potentially embarrassing and said it would be erased. Observations of similar care information being posted in Resident #31's</p>	F 241	<p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> • Housewide inspection of all white boards for appropriate information • New dietary cards placed in dining room <p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> • Unit managers to monitor white boards in resident rooms for appropriate content and council when appropriate • In-service staff regarding HIPAA guidelines and appropriate information to be posted <p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> • Five random checks of white boards will be completed over next 30 days to ensure personal care information is not posted • On-going monthly audits to ensure compliance <p>5) Dates when corrective action will be completed:</p> <p>May 3, 2013</p> <p>6) The title of the person responsible to ensure correction</p> <p>Colleen Hardy, Director of Clinical Services</p>		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 241	<p>Continued From page 9 room were also discussed.</p> <p>On 03/18/13 at 2:05 pm , during an interview with the DNS (Staff B) she was asked about the facility's policy for posting care information in resident rooms. She said staff can write it on the white boards in the rooms. When asked how staff knew what was appropriate to post, she said they were to post "their names, any therapy information". When asked about posting personal or potentially embarrassing information, she stated this information could be posted in the resident's closet. When the directives posted in the rooms of Residents #62 and 31 were discussed, she acknowledged the information could have been posted in a more private place and did have the potential to affect resident dignity.</p> <p>RESIDENTS #186, 111 and 141: Similar findings were noted for Residents #186, 111 and 141, who each had personal care information written on the dry erase boards above the head of their beds.</p> <p>In an interview on 03/19/13 at 9:45 a.m. Staff B said of the dry erase boards over the resident's beds, "We've tried numerous times to limit how they are used." "Staff end up using it for more personal care issues that we don't necessarily want posted."</p> <p>RESIDENT #111: Observation on 03/15/13 from 10:40 a.m. to 11:45 a.m. revealed Resident #111 sitting near the nurses station, in a wheelchair with no arm rest on the left side of the wheelchair. On the resident's lap was a cylindrical object wrapped in</p>	F 241			

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 241	Continued From page 10 paper that was labeled "(Resident's last name) broken arm rest... contact (Name) PT (Physical Therapy) if unrepairable" "maintenance form has been filled up....(Name) 3/10". DINING ROOM: Observations of the Main Dining Room throughout the survey, both during and between meals, revealed tray cards standing on the tables with resident's full names and dietary information. For example, on 03/13/13 at 10:53 a.m. Resident #42's table tray card listed "regular", "Ground Texture", "Nectar Thick Liquids", "Lip Plate." Similar findings were noted for Residents # 220, 141, 186, 188, 87, 111, 98, 149 & 147. In an interview on 03/18/13 at 1:38 p.m. Staff O said the table tray cards "tell the aides where the person sits, tells the diet aide what texture and fluid consistency they are." The facility failed to ensure confidential clinical information was not visible to other residents and/or visitors. In an interview on 03/19/13 at 9:38 a.m. Staff B acknowledged the diet cards included private information was visible to all and might contribute to an undignified dining experience.	F 241			
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.	F 242	1) How the nursing home will correct the deficiency as it relates to the resident: • Resident #65, 89, 38, 149, 297, 303, and 310 care plans were updated to reflect tub bath preferences and frequency of bathing		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 242	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview and record review, the facility failed to allow Residents #65 & 89, two of three residents reviewed for choices and 5 of 21 Residents (#38, 149, 297, 303 and 310) interviewed in Stage 1, the right to make choices regarding important daily routines, including accommodating preferences for a tub bath and frequency of bathing. This failure placed residents at risk for a diminished quality of life and poor hygiene.</p> <p>Findings include:</p> <p>RESIDENT #65: Resident #65 was admitted to the facility with care needs related to a [REDACTED]. According to the 2/19/13 Minimum Data Set (MDS) assessment, the resident required staff assistance for bathing and considered it "very important" to choose to between a bath, tub bath or shower.</p> <p>In an interview on 03/12/2013 at 1:59 p.m., Resident #65 indicated he did not get a choice between taking a shower, tub or bed bath. On 3/13/13 at 8:46 a.m. the resident indicated again he would be interested in taking a bath but was never offered one.</p> <p>In an interview on 03/15/13 at 11:11 a.m., Staff V and Staff T indicated, "bathing is done twice a week, once in the day, once in the evening and sometimes more if they request it." Staff T indicated if a resident didn't want a shower, "we can do bed baths." Staff T elaborated "we don't have a tub bath on this unit, some of the private</p>	F 242	<p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> • All resident care plans were reviewed to ensure bathing preferences were incorporated into ADL care plan. • Tub was inspected and determined to be functional <p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> • NAC's will receive additional training to ensure safe tub bathing practices and all resident bathing preferences will be honored • All new admissions will be asked about bathing preferences • ADL care plans will reflect resident preferences <p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> • Random resident interviews will be conducted to monitor preferences being offered • Care conferences will be conducted and ADL preferences will be updated for resident change of condition 	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 242	<p>Continued From page 12</p> <p>rooms have a tub bath and only two of them are on this (the 100-200) unit, usually it's for practice for going home...."I don't know if they have a tub on C or D (units) anymore...We used to have one (a tub on this unit) but they took it away." Staff T who indicated she had worked at the facility for 10 years, stated, "I can't remember the last time I gave a bath." "I don't think we could (give a tub bath), if somebody on this unit wanted to wouldn't be able to, most of the people on this unit couldn't get into tub like you or I have at home..."</p> <p>Staff W, a Nursing Assistant on unit C, in an interview on 03/15/13, stated was unaware of the availability of a tub bath unless the resident room had a tub stating,"there is no tub in the shower room, we would be able to do a bed bath...we have some rooms with bathtubs I don't know (which rooms) exactly."</p> <p>RESIDENT #89: On 03/12/13 at 1:06 pm, Resident #89 was asked if she had a choice between taking a shower or a tub bath. She replied, "No, they only give showers- they don't discuss it. Its not option (taking a bath). She also commented she didn't think there was a bathtub in the facility, but would love to have a bath. Review of the most recent MDS assessment dated 1/13/13, this resident said it was "very important " to her to have a choice about bathing vs being showered. Her care plan dated 2/18/13, identified she needed assistance with a shower, but didn't address the option of providing a bath.</p> <p>When asked if she could choose how many times a week she took a bath or shower, she again replied "no, saying, "We are told we get one</p>	F 242	<p>5) Dates when corrective action will be completed:</p> <p>May 3, 2013</p> <p>6) The title of the person responsible to ensure correction</p> <p>Colleen Hardy, Director of Clinical Services</p>		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 242	<p>Continued From page 13</p> <p>shower a week- they can't accommodate residents to give more than that". Sometimes gets a second shower if she has been incontinent.</p> <p>RESIDENT #149: Similar comments were made by Resident #149 when she was interviewed on 3/13/13 at 1:08 pm, when she stated she was only given showers, but would "love to have a tub bath".</p> <p>RESIDENTS # 38, 149, 297, 303 and 310: During Stage I interviews on 3/12/13 and 3/13/13, of the 21 residents interviewed, these five stated they believed they had no choice regarding the frequency of times they could receive a shower each week. Several commented that the scheduling of baths was "up to the staff" and they had no input into this aspect of their care.</p> <p>STAFF INTERVIEWS: On 3/18/13, at 1:30 pm, an RN (Staff L) was asked if there was a bathtub available for residents who wanted to have a bath rather than a shower. She said there was a shower on Unit D- but she didn't think it was used. She showed me a locked room, with no sign posted to indicate it had a tub. The room had floor mats and other items stored there, and did not appear to be ready for use.</p> <p>On 3/19/13 at 9:20 am, during an interview with Staff C, she said there was a bathtub on unit D, but it wasn't used because there were no residents who wanted to take a bath. She confirmed the tub hadn't been in use, and attributed this to a seal around the door which leaked. She stated the tub had not been</p>	F 242			

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 242	Continued From page 14 functional for about three years, and didn't know of any plans to repair it. During the interview, the problem of eliciting resident choices/ preferences regarding/T bathing and failing to incorporate this in their care plan was also addressed, She said residents are asked about bathing as part of their initial assessment, but this information isn't on the care plan. On 3/19/13 at 11:50 am, the Administrator (Staff A) and Staff EE were interviewed regarding the availability of bathing facilities for residents. The current lack of a functioning bathtub for residents to use was discussed. Additionally, the lack of care planning of resident preferences on this issue was reviewed, along with the perception expressed by residents that baths were not an option. They stated they would would make sure a functioning bathtub was available so residents would have a choice regarding bathing.	F 242			
F 247 SS=B	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed, for two of two residents (#s 307 and 310) reviewed for roommate changes, to provide notification prior to receiving a new roommate. This failure denied residents their right to be informed of roommate changes.	F 247	1) How the nursing home will correct the deficiency as it relates to the resident: • Residents #307 & 310 were interviewed and discussion documented regarding lack of prior notification of impending roommate admission 2) How the nursing home will act to protect residents in similar situations: • All residents were rounded on to determine roommate preferences		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 247	<p>Continued From page 15</p> <p>According to the resident rights list provided to residents upon admission, "(the) resident has the right to advance notice of transfer or room change."</p> <p>RESIDENT #307: In an interview on 03/12/13 at 2:22 p.m., Resident #307 stated she "Didn't have a roommate when I first got here, but I did get a roommate. They just brought her in. I didn't know I was getting a roommate."</p> <p>In another interview on 03/18/13 at 12:05 p.m. Resident #307 stated "I know everyone is busy and there is a bed next to mine so it wasn't really a surprise that I would get a roommate at some point, but it would have been nice to know ahead of time." Record review indicated Resident #307 was "Alert and oriented x3."</p> <p>RESIDENT #310: In an interview on 03/14/13 at 9:54 a.m., Resident #310 indicated she briefly had a roommate and stated that "they didn't tell me she was coming." Record review indicated that this resident was cognitively intact. Admission neurological assessment stated resident was "Alert and oriented x3...No confusion noted. "</p> <p>Staff AA (Social Services) on 03/14/13 at 2:50 p.m. was asked about the process for a resident getting a new roommate. She stated "Well, it's kind of a team effort. Requests can come to me or nursing. Once we know about the request we try to see if they (the residents) are a good match. We will contact the family members for those that need it. Sometimes on TCU the nurses take care of the room and roommate change." Staff AA</p>	F 247	<p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> • In-service clinical staff on the requirements for notification to include: <ul style="list-style-type: none"> ○ All residents upon admission ○ Roommates and bed changes ○ Documentation of discussion • Develop system to identify and determine resident preferences for roommates upon admission • Develop team plan with Social Workers, Admissions Office, and Unit Coordinators on roommate placement <p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> • Five random resident interviews will be conducted over 30 days regarding preferences <p>5) Dates when corrective action will be completed: May 3, 2013</p> <p>6) The title of the person responsible to ensure correction Colleen Hardy, Director of Clinical Services</p>		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/20/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029
--	--

(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 247	<p>Continued From page 16</p> <p>indicated there was not a specific document pertaining to room or roommate changes that would evidence the resident was informed. Staff AA stated "They put it in the progress note. We try to put them (change in room/roommate documentation) in there. Some probably get missed."</p> <p>Staff H (Charge Nurse) was interviewed on 03/15/13 at 2:00 p.m. about room change/new roommate process. She stated, "Initially what happens is admission comes to us with a new resident. We look at are they alert, older, younger, what's available, do they need oxygen? Can they get along?" Staff H was asked if they tell a current resident a new resident is coming? She stated, "Yeah maybe an hour before we let them know." Staff H indicated there was no documentation to confirm the process of verbally telling or written notice that a resident is getting a new roommate. Staff H, when asked if she is aware of any residents who were not informed prior to getting a new roommate, stated "It happens. If they are unhappy we try to accommodate and move people when able."</p>	F 247		
F 279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p>	F 279	<p>1) How the nursing home will correct the deficiency as it relates to the resident:</p> <ul style="list-style-type: none"> Resident #309 assessed and care plan was reviewed and updated to accurately reflect care needs for dysphasia and lack of lower dentures. Resident also interviewed by Nutrition Services Resident #310 care plan was reviewed and updated to accurately reflect care needs for fractured ankle 	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 279	<p>Continued From page 17</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop and/or revise comprehensive care plans for six of 23 sample residents (#s 309, 220, 141, 310, 188 & 122) reviewed for care plans. Failure to establish care plans that accurately reflected assessed care needs and provide direction to staff on the residents' care related to dental status, nutrition, Range of Motion, dysphagia status, urinary status and smoking safety placed residents at risk to receive less than adequate care.</p> <p>Findings include:</p> <p>RESIDENT #309: Resident #309 was admitted to the facility on [REDACTED] 13 with [REDACTED] and according to the 03/09/13 Minimum Data Set (MDS), staff assessed the resident as cognitively intact.</p> <p>Observation on 03/13/13 at 11:02 a.m. revealed the resident had broken tooth stubs in her lower mouth. The resident indicated at that time she</p>	F 279	<ul style="list-style-type: none"> Resident #220 assessed and care plan was reviewed and updated to accurately reflect care needs for impaired mobility, ROM of right lower extremity, and nutrition and weight loss. Resident #141 assessed and care plan was reviewed and updated to accurately reflect care needs for nutrition, weight loss, and skin integrity right hand Resident #188 assessed and care plan was reviewed and updated to include smoking safety plan. Resident #122 assessed and care plan was reviewed and updated to accurately reflect goals and interventions for urinary elimination and functional incontinence <p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> Current resident care plans were reviewed and updated to reflect current clinical condition and care needs Nutrition Services will use the MDS interview questions (Section L) during the assessment to determine any new developments related to resident status and care 	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 279	<p>Continued From page 18</p> <p>had chewing problems stating, "I can't chew I don't have my lower denture...".</p> <p>In the nutrition note, dated 03/01/13 the Registered Dietitian documented the resident had upper dentures only but noted no problems with chewing and swallow issues. However, according to the Speech Therapy note dated 03/04/13, "consulted to conduct a swallow evaluation; pt with no dentition on the bottom and demonstrated delayed laryngeal elevation, cough, and wet voice with thin liquids and there fore judged to be at mild-moderate aspiration risk due to oropharyngeal phase dysphagia. Recommend diet change to ground/nectar with meds crushed in puree. Will cont to follow (patient) and adjust diet as indicated."</p> <p>Record review on 03/19/13 revealed no Care Plan (CP) regarding the resident's dysphagia or the lack of lower dentures.</p> <p>RESIDENT #310 Resident #310 was admitted to the facility for care needs related to a [REDACTED]. Review of CP documents revealed the resident had a [REDACTED]. In an interview on 03/18/13 at 9:29 a.m. Staff I confirmed the CP was incorrect as the resident did not have a [REDACTED].</p> <p>RESIDENT #220 On 03/12/13 at 2:09 p.m. Staff U said Resident #220 had "a very stiff (right) knee due to injury years ago" which she noted was "very hard to bend". Staff U indicated the resident was not receiving Range of Motion (ROM) or splinting.</p> <p>On 03/15/13 at 9:32 a.m. the resident was</p>	F 279	<p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> Care plans will be reviewed and evaluated upon admission, significant change, and MDS review to ensure they are reflective of resident current status and care needs Progress notes will be monitored by Nutrition Services using a schedule for meeting stated goals within the assessment In-service provided to all clinical staff on requirements of restorative program and documentation <p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> Monthly random sample chart audits to ensure clinical condition and care needs are reflected in the care plan Nutrition Services will evaluate and update the Progress Note schedule daily to ensure all residents are recorded correctly <p>5) Dates when corrective action will be completed:</p> <ul style="list-style-type: none"> May 3, 2013 <p>6) The title of the person responsible to ensure correction</p> <ul style="list-style-type: none"> Colleen Hardy, Director of Clinical Services Tim Alton, Director of Support Services 		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 279	<p>Continued From page 19</p> <p>observed sitting in a tilt in space wheelchair, tilted back. In an interview on 03/12/13 at 2:32 p.m. Resident #220 indicated that she had received Range of Motion exercises in the past and commented "I think it did help for a little while."</p> <p>According to the 01/05/13 MDS, the resident required two person extensive physical assistance for bed mobility, transfers, ambulation and used a wheelchair. The resident was assessed with functional limitation in ROM on one lower extremity with no ROM passive or assuasive over the prior seven days.</p> <p>Review of the resident's record revealed Physical Therapy (PT) service dates from 12/03/12 until 01/14/13 after a fall resulting in a hip fracture. The resident was assessed with impaired ROM to her right hip "patient did not allow any more", to her right knee "patient resists any more knee bending" and to right shoulder.</p> <p>Review of the resident's 01/30/13 CP revealed no Impaired Mobility CP. The Resident Assistant Information Sheet indicated the resident required extensive assist with one person for bed mobility, required a two person assist for a pivot transfer, used a wheelchair with one-person assist, and had Physical Therapy until 01/14/13. There was no plan addressing the resident 's impaired ROM.</p> <p>In an interview on 03/19/13 at 1:20 p.m. Staff Z said a Functional Maintenance Program was not set up after discharge from PT because the resident was fearful of pain and movement as she would not allow her right hip and knee to be flexed. She would resist and extend her legs when staff attempted to put on wheelchair foot</p>	F 279			

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 279	<p>Continued From page 20</p> <p>rests. The therapists tried to perform passive ROM and the resident complained of right knee pain.</p> <p>According to the Care Tracker on 03/13/13 at 7:26 a.m. instructions to the Nursing Assistants were entered to "Provide Passive range of motion (PROM) to resident's right leg and foot. Gentle flexion and extension of leg and foot. Do not move to the point of pain. Always watch resident's face to see if she has pain. Attempt to provide 15 minutes per day." Staff documented in Care Tracker the service was provided twice on 03/13, 03/14, three times on 03/15, and twice on 03/17.</p> <p>In an interview on 03/18/13 at 11:44 a.m. Staff B said the restorative program "should be in both the CP and the aid information sheet."</p> <p>In an interview on 03/19/13 at 10:38 a.m. Staff Y said a restorative program assessment and care plan should have been completed when the restorative program was implemented.</p> <p>In an interview on 03/20/13 at 9:33 a.m. Staff U said she had implemented the ROM program because the resident's leg was "not functioning with full ROM, never will, but to prevent contractures we need PROM." Staff U said she had not consulted with PT prior to developing the program and had not completed the restorative program assessment. In addition, Staff U had not developed a restorative CP and noted, "I need to do one."</p> <p>In an interview on 03/20/13 at 10:29 a.m. Staff D indicated that the components of a restorative nursing program included a Restorative</p>	F 279			

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 279	<p>Continued From page 21 Assessment, implementation and Care Plan.</p> <p>In addition, according to the 01/05/13 MDS the resident was assessed to require one person limited physical assistance with eating, weighed 118 pounds, had experienced a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 month, was not on physician prescribed weight loss regimen, and received a therapeutic diet.</p> <p>Review of the 01/30/13 CP revealed no Nutrition CP addressing the resident's significant weight loss. The 01/30/13 Resident Assistant Information Sheet indicated the resident's diet and that the resident ate in the dining room. A Dehydration CP listed interventions including "dietary restrictions as ordered." A Risk for Impaired Skin Integrity CP listed the intervention to "provide adequate nutrition", but did not indicate how the facility planned to address the resident's significant weight loss.</p> <p>Similar findings were noted for Resident #141 whose Nutrition CP goal was not measurable.</p> <p>RESIDENT #141 On 03/13/13 at 9:32 a.m. Resident #141 was observed with a Band-Aid on his right hand between his thumb and index finger and steristrips on his left hand.</p> <p>Review of the 02/24/13 Impaired Skin Integrity CP revealed nothing regarding the skin impairment to the resident's right hand.</p> <p>The last progress note in the resident's record, dated 03/01/13, contained documented</p>	F 279			

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 279	<p>Continued From page 22</p> <p>monitoring regarding the left hand, but not the right.</p> <p>Review of the March Treatment Record revealed the weekly skin check scheduled for Thursdays was initialed as done 03/07/13 and 03/14/13, but there was no documentation of the impaired skin integrity to the resident's right hand.</p> <p>In an interview on 03/18/13 at 1:28 p.m. Staff U observed the resident's right hand which no longer had a Band-Aid. Staff U described the skin impairment as an "oid scab", "like little scratches", measuring approximately "0.5 and 0.7", "V shaped" "abrasion". Staff U was unable to determine when or how the resident developed the injury.</p> <p>In an interview on 03/19/13 at 9:32 a.m. Staff B indicated the above mentioned skin impairment should have been noted during the weekly skin check and monitored.</p> <p>RESIDENT #188: According to the 05/22/09 Resident Smoking Policy "Individual resident who choose to smoke will have their smoking appropriately... addressed in the care plan."</p> <p>During initial rounds on 03/12/13 at 8:43 a.m. two packs of cigarettes were observed in the 300 hall medication cart. Staff U said they belonged to Resident #188 who smoked with supervision. Review of the resident's record revealed progress notes indicating the resident had smoked while at the facility since November 2012 up to and including 02/26/13.</p>	F 279		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 279	<p>Continued From page 23</p> <p>Review of the resident's CP revealed no Smoking Safety plan had been developed for Resident #188. Documents were requested on 03/19/13 at 3:00 p.m. from Staff B, on 03/20/13 at 9:44 a.m. from Staff U, 03/20/13 at 8:50 a.m. from Staff E and 03/20/13 at 10:45 a.m. from Staff A, and none were provided.</p> <p>RESIDENT #122: According to the 01/03/13 MDS, Resident #122 was assessed as frequently [REDACTED]. Review of Care Tracker on 03/15/13 revealed the resident was not continent of [REDACTED] over the prior seven days, and pads/briefs were used.</p> <p>The 09/20/12 Alteration in [REDACTED] Elimination: Functional Incontinence CP listed the goal of "resident will experience fewer episodes of incontinence". Interventions included ascertain baseline incontinence status, rule out UTI, evaluate cognitive status/changes, evaluate medications for possible cause and provide pericare and skin care per protocol.</p> <p>The 09/20/12 Bowel/Bladder [REDACTED] Care CP listed the goal of "resident will establish an individual bowel/bladder routine" with a goal date of 03/01/13. Interventions listed included Toileting approximately every two hours or more often as needed, check for incontinence approximately every 2 hours, keep call light in easy reach and briefs/depends when out of bed.</p> <p>In an interview on 03/15/13 at 2:00 p.m. Resident # 122's family member said the facility staff used to put the resident on the toilet, but she had an episode, [REDACTED] and so now they can't. The</p>	F 279		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029	
(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 279	Continued From page 24 resident had increased [REDACTED] but the staff keep her clean and dry. In an interview on 03/19/13 at 11:30 a.m. when asked what interventions the staff were doing to met the goal of fewer [REDACTED] episodes Staff Y replied, "They toilet her approximately every two hours, check for incontinence", "Check as frequently as possible, change before bed, check after meals." When asked what interventions the staff were doing to assist the resident to "establish an individual bowel/bladder routine", Staff Y replied, "We can't do that anymore", "We can't train her," and "We should revise that one."	F 279		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that one of two residents (#310) reviewed for an [REDACTED] [REDACTED] was not [REDACTED] unless the clinical condition demonstrated it was necessary. Failure to assess for continued need and develop a plan of care to discontinue the indwelling [REDACTED]	F 315	1) How the nursing home will correct the deficiency as it relates to the resident: <ul style="list-style-type: none"> Resident #310 indwelling Foley catheter was discontinued on 3/20/13 and care plan updated Resident #141 care plan was evaluated for a trial in both a toileting and restorative program to prevent decline in urinary function. Call light placement was also reviewed. 2) How the nursing home will act to protect residents in similar situations: <ul style="list-style-type: none"> All residents with indwelling Foley catheters were assessed for on-going clinical need Care plans will be reviewed for appropriate restorative programs 	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 315	<p>Continued From page 25</p> <p>██████████ as soon as possible placed the resident at risk for deterioration of ██████████ function and infections. Additionally, the facility failed to ensure one (#141) of two residents reviewed, received care and services to prevent a decline in ██████████ function.</p> <p>Findings include:</p> <p>RESIDENT #310: Resident #310 was admitted to the facility on ██████████/13 with diagnoses related to a ██████████ and an ██████████. According to the 03/09/13 Minimum Data Set (MDS), the resident utilized an indwelling Foley catheter (FC) and required two person extensive assistance with bed mobility, transfers and toileting. This MDS also indicated the resident participated in both Occupational and Physical Therapy (OT and PT). Staff determined, according to this assessment, the resident was cognitively intact and able to understand and be understood in conversation.</p> <p>According to a "screening for ██████████" nursing assessment dated 03/02/13, staff assessed the resident with functional incontinence with symptoms that included physical weakness and impaired mobility and was "deconditioned."</p> <p>According to a Physician's Order dated 03/11/13, the resident "must be out of bed for all 3 meals."</p> <p>In an interview on 03/13/13 at 08:57 a.m., Staff I (Unit Coordinator) indicated the reason for the resident's ██████████ was, "she came from the hospital with it... I think it's because of mobility problems."</p>	F 315	<p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> • In-service appropriate nursing staff; <ul style="list-style-type: none"> ○ Document resident and family preferences with continued use of indwelling catheters to include risk and benefits ○ Assess residents needs for Foley on admission and when ordered ○ Requirements for on-going evaluation and clinical needs ○ Call light placement • On-going monitoring of restorative programs with MDS <p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> • Infection Control Nurse to track CA UTI's • Care Plans will be monitored to ensure they are updated to reflect clinical changes • MDS and household managers to evaluate and monitor use of indwelling catheters and effectiveness of restorative and toileting programs <p>5) Dates when corrective action will be completed: May 3, 2013</p> <p>6) The title of the person responsible to ensure correction</p> <ul style="list-style-type: none"> • Colleen Hardy, Director of Clinical Services 		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 315	Continued From page 26 Observations on 03/14/13 at approximately 10:45 a.m. revealed the resident was in a wheelchair at her bedside. The resident, who was working with a therapist, was transferred from wheelchair to bed with minimal assistance. In an interview on 03/15/13 at 8:55 a.m., Resident #310 indicated she fell while at an antique show and [REDACTED]. She further indicated she had not required the use of an [REDACTED] prior to [REDACTED] and had no issues with [REDACTED]. She was able to toilet independently prior to the fall. The Indwelling Catheter Care Area Assessment (CAA) dated 03/15/13 indicated, "CAA triggered by resident requires assistance for toileting and requires an indwelling catheter (related to status post) left ankle fracture, external fixator, wound vac. Resident is (non weight bearing left lower extremity). Mobility severely impaired...". In an interview on 03/18/13 at 8:39 a.m., the resident stated no one had talked to her about removing the [REDACTED], but that she had it in because "it's hard to get out of bed." The resident was observed in a wheelchair at her bedside eating breakfast. In an interview on 03/18/13 at 9:20 a.m., Staff G (MDS coordinator) was asked to provide medical justification for the continued use of the [REDACTED]. Staff G indicated she had spoken with Staff H and Staff J (charge nurse and unit manager) regarding the continued need of use and they indicated the resident required it.	F 315			

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 315	<p>Continued From page 27</p> <p>According to the "indwelling [REDACTED]" care plan (CP), dated 03/02/13 and unchanged on 03/18/13, the listed goal was, "no complications". Interventions listed included, "Document rationale for use of Foley catheter on admission" and "reassess use of catheter (every) 14 days".</p> <p>When asked for the medical justification for the FC in an interview on 03/18/13 at 10:57 a.m., Staff H stated, "she's 90 years old with pins, she came to us with a FC, she is compromised with transfers, she cannot weight bear on the left leg." Staff H was able to confirm the resident was transferred out of bed for all meals and participated with therapy. Staff H was unable to explain why, if the resident used a bedpan for bowel movements, staff did not consider the same method for voiding.</p> <p>In an interview on 03/18/13 Staff D reviewed medical diagnoses which justified the use of indwelling [REDACTED] which included, "a [REDACTED] or [REDACTED] prevention of pain with repositioning in a terminally ill resident, and terminal illness." Staff D further stated, "If they don't have these diagnoses we shouldn't have that (catheter)" and "mobility isn't a medical diagnosis which would require the use of an indwelling FC."</p> <p>In an interview on 03/18/13 at 11:42 a.m. Staff H stated, "I spoke with the ARNP (Advanced Registered Nurse Practitioner) and the ARNP said it (the [REDACTED]) was family preference." Record review revealed no evidence of a medical justification for the indwelling [REDACTED], no plan for it's discontinuation and no evidence staff had</p>	F 315		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 315	<p>Continued From page 28</p> <p>discussed the [REDACTED] with the resident or family to include risks and benefits of continued use in absence of medical necessity.</p> <p>RESIDENT #141</p> <p>The 10/25/12 Nursing Admission Assessment indicated Resident #141 had risk factors indicative of functional [REDACTED] including [REDACTED], [REDACTED], impaired [REDACTED] and [REDACTED], contributing [REDACTED] of [REDACTED] including [REDACTED].</p> <p>Disease and risk factors indicative of functional incontinence including [REDACTED] and impaired mobility. This assessment concluded the type of incontinence the resident experienced was "unknown" with instructions to staff to "place on 72 hour screening to [REDACTED] frequency and pattern of incontinence."</p> <p>On 03/19/13 at 12:52 p.m. Staff E provided a Bladder Detail Report for 10/25/12 though 10/31/12. in which the nursing assistants documented on an every shift basis. Review of the records revealed the resident was continent when on a scheduled toileting program except for two evening shifts, 10/28/12 and 10/29/12, but no further frequency or pattern of incontinence could be determined. The resident was noted to be incontinent on 10/28/12 day shift, when the resident was not on a scheduled toileting plan and did not use the toilet. Staff E was unable to provide any further documentation that a 72 hour screening had been performed.</p> <p>According to the 11/01/12 Admission MDS Resident #141 was occasionally incontinent with less than seven episodes. The [REDACTED] CAA, dated 11/07/12, indicated the resident had need for extensive assistance with</p>	F 315		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 315	<p>Continued From page 29</p> <p>toileting and had occasional [REDACTED]. Resident "would benefit from a toileting program and restorative program to increase res(ident) continence and remain as independent with toileting as possible... Will proceed to CP."</p> <p>According to the 01/21/13 Quarterly MDS, the resident had declined in bladder continence to frequently incontinent with seven or more episodes of incontinence. In addition this MDS indicated that no trial toileting program had been attempted since [REDACTED] was noted in the facility.</p> <p>The 02/13/13 Occasional [REDACTED] CP listed interventions including "offer toileting assistance frequently", "keep call light within reach", and "keep resident clean, dry and comfortable at all times." The Risk for Fall CP instructed staff to "assess for toileting needs," "keep call bell in reach", and "frequent offering of bathroom assist." The Restorative Maintenance program CP listed a goal that "Resident will achieve maximum functional ambulation mobility" and listed only ambulation interventions. The 02/13/13 Resident Assistant Information Sheet indicated the resident needed one person extensive assistance with toileting, and was occasionally [REDACTED] with [REDACTED].</p> <p>The care plan did not include a trial toileting program or a restorative program designed to increase continence and/or toileting independence.</p> <p>On 03/13/13 at 9:35 a.m. Resident #141 was observed seated in a wheelchair next to his bed. The call light was observed by his pillow on the opposite side of the bed, not within his reach.</p>	F 315		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 315	<p>Continued From page 30</p> <p>When asked what he would do if he needed staff assistance, Resident #141 replied, "Call out to my person." The facility failed to ensure the resident's call light was within reach according to the plan of care.</p> <p>In an interview on 03/20/13 at 9:26 a.m. when asked what Resident #141's toileting plan consisted of, Staff U replied, "before and after meals and every two hours." According to the facility Standards of Care staff were expected of "Offer assistance to bathroom (if necessary) upon awakening, after meals and at HS (bedtime)." The facility did not provide an individualized toileting program designed to increase the resident's continence.</p> <p>According to the undated facility policy "Promoting Residents' Health Status", "if an incontinent resident is eligible for a prompted voiding trial, the prompted voiding protocol is implemented." In addition to the comprehensive assessment, criteria that may exclude a resident from a prompted voiding trial were listed, none of which were applicable to Resident #141.</p> <p>Review of the resident's record revealed no evidence the resident was placed on 72 hour screening to determine frequency and pattern of incontinence, a prompted voiding trial, a toileting program or a restorative program designed to increase the resident's continence and or prevent further decline in continence.</p> <p>On 03/20/13 at 10:29 a.m. Staff D was notified and further information was requested however none was provided.</p>	F 315			

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to analyze resident accidents to determine the circumstances of the events in an attempt to implement measures to prevent reoccurrence for two (#s 220 & 298) of three residents reviewed for accidents. In addition, the facility failed to ensure one (#188) of two resident smokers were assessed and a plan implemented to ensure a safe smoking environment. These failures placed the residents at risk of accidents and injury.</p> <p>Findings include:</p> <p>RESIDENT #220: Review of the 12/27/12 Minimum Data Set (MDS) Quarterly Summary revealed the resident required extensive physical assistance of one for bed mobility, a maxi lift and extensive assist with two persons for transfers, incontinent of bladder, and had not fallen in the prior quarter.</p> <p>The 12/13/12 Falls Care Plan (CP) listed the goal of "Resident will remain free from fall and injury." The interventions listed included "position and support with pillow", "Use assistive devices as</p>	F 323	<p>1) How the nursing home will correct the deficiency as it relates to the resident:</p> <ul style="list-style-type: none"> Resident #220, Quantros (UOR) report for 1/23/13 will be reviewed and amended to summarize findings based on time of day, interventions in place, resident activity, and environment to better establish origin of accident Resident #298, Medications and fall risk will be assessed. Quantros (UOR) report (aka AFSEER) for fall on 3/12/13 reviewed and corrected to accurately reflect witnessed accident while being assisted by staff. MDS dated 3/12/13 will be reviewed for accuracy and use of wheel chair Resident #188, Quantros (UOR) report will be completed for safety event on 12/10/12. Smoking safety assessment completed and care plan updated <p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> Care plan for all residents who smoke will be reviewed and updated if needed Review MAR's for residents identified as high risk for falls to ensure appropriate medication risk factors are identified 		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029	
(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 323	<p>Continued From page 32</p> <p>ordered", and "Bed in low position for safety with floor mat in place." The [REDACTED] CP listed the intervention to "follow toileting schedule."</p> <p>Review of the resident record revealed on 01/23/13 the resident was found on the floor next to her bed by a CNA at 2:30 p.m. The resident sustained a 4 cm by 4 cm laceration to her left forehead and a minor laceration to her lips. The resident was transported to the emergency room where she received sutures to her right forehead.</p> <p>Review of the facility fall investigation revealed the resident did not know what happened and it was determined the resident fell from bed. The investigation did not include the events preceding the accident including but not limited to how long the resident had been in bed or when the resident had last been observed.</p> <p>In an interview on 03/19/13 at 9:55 a.m. Staff C was asked if the care plan interventions were in place prior to the fall as planned. Staff C referred to the fall assessment. Staff had answered "No, the resident was not continent", Staff C said that was in general, not specific to the fall. On the assessment, staff answered, "No, the resident was not trying to get to the bathroom without assistance". When asked how the staff determined this, Staff C replied, "I don't know, she's not able to communicate." The assessment did not indicate the last time the resident was checked/changed and/or toileted or if she was wet or dry at the time of the fall.</p> <p>In addition, staff noted the assistive devices were still appropriate, and referred comments to a foot</p>	F 323	<p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> • In-service staff on policies and processes to include; <ul style="list-style-type: none"> ○ Accident investigation and reporting ○ Comprehensive post fall assessment ○ Monitoring, vitals and charting requirements ○ Smoking Safety Assessment ○ Resident environmental safety and hazards • Review current falls policy and post fall assessment process for effectiveness on identifying medication risk factors that may contribute to falls/accidents. <p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> • Director of Clinical Services to review Quantros (UOR) reports for completeness, accuracy, and reporting guidelines • Accident hazards to be discussed as a standing agenda item on monthly safety committee • (See F 226) Administrator and Director of Clinical Service will establish a monthly schedule to review a sample of investigations and reports on DSHS Log

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 323	<p>Continued From page 33</p> <p>rest. If the resident fell from bed, the foot rest was not a relevant factor in the fall. The assessment did not address if the additional CP interventions had been implemented as planned including if the resident had been positioned with pillows for support when laid down, and if the bed was in low position when the resident was found, if the floor mat was in place. The facility failed to determine if the plan of care was implemented or determine the circumstances of the accident.</p> <p>RESIDENT #298: According to the 03/12/13 MDS, Resident #298 was admitted to the facility on [REDACTED]/13 with diagnoses including [REDACTED], [REDACTED] and [REDACTED].</p> <p>When asked in an interview on 03/12/13 at 1:33 p.m., if the resident had a fall and/or sustained a fracture within the last 30 days Staff H stated, "the resident had a fall today."</p> <p>According to the "Actual Fall and Slip event report (AFSER)" dated 03/15/13, "NAC (Nursing Assistant) was with patient and he lost his balance...". This report indicated the resident fell at 10:00 a.m. on 03/12/13 and the resident's most recent blood pressure recorded prior to the fall was 126/70, however there was no indication facility staff obtained vital signs at the time of the fall.</p> <p>The AFSER indicated the resident was trying to get to the bathroom without assistance. This was in conflict with the general statement the resident had assistance at the time of the fall. There was no indication facility staff considered the last time the resident was toileted or if the resident</p>	F 323	<p>5) Dates when corrective action will be completed:</p> <p>May 3, 2013</p> <p>6) The title of the person responsible to ensure correction</p> <p>Chris Bosworth, Administrator Colleen Hardy, Director of Clinical Services</p>	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 323	<p>Continued From page 34</p> <p>required more frequent toileting or an individualized toileting plan to assess for toileting needs.</p> <p>The AFSER indicated, in regard to assistive devices, "one foot rest was missing. RN had notified maintenance day prior to incident to help find missing foot rest." However, according to the 03/12/13 MDS, the resident did not require the use of a wheelchair and observations on all days of the survey did not reveal the resident utilizing a wheelchair.</p> <p>The AFSER directed staff to assess effects of multiple medications, including "diuretics and antihypertensives" to which staff documented, "NA" (not applicable).</p> <p>Review of Medication Administration Records (MARs) for 03/13 revealed the resident received [REDACTED] (an [REDACTED] medication) twice a day, which has listed side effects of [REDACTED] and [REDACTED]. According to the Nursing 2009 Drug Handbook, Nursing considerations include, "Monitor elderly patients carefully, drug levels are about 50% higher in elderly patients than in younger patients" and "Inform patient that he may experience low blood pressure when standing."</p> <p>Additionally, the resident received [REDACTED] (a [REDACTED] with side effects of [REDACTED] and [REDACTED]). According to the Nursing 2009 Drug Handbook, "a [REDACTED] may increase risk of [REDACTED]. Use together cautiously." The resident also received the [REDACTED] daily, which has side effects of [REDACTED] and [REDACTED].</p>	F 323			

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 323	<p>Continued From page 35</p> <p>hypotension. According to the Nursing 2009 Drug Handbook this medication, "may cause excessive hypotension with diuretics." The resident also received the [REDACTED] e daily, which has side effects of [REDACTED]s and [REDACTED] (altered [REDACTED]).</p> <p>The AFSER directed staff to "monitor for adverse effects" and "check orthostatic BP, apical pulse when indicated." There was no evidence staff implemented either of the approaches.</p> <p>Review of the resident's MARs revealed the 5:00 p.m. [REDACTED] on 03/12/13 was held related to a [REDACTED] (BP) of 90/50. There was no indication in the AFSER that staff considered this significantly low BP or that the resident's BP medications could possibly have impacted the resident's fall.</p> <p>In an interview on 03/18/13 at 1:13 p.m., Staff D stated, "we do postural vital signs for some antipsychotic medications... I am not sure if we do post fall posturals." Staff D was unable to explain why facility staff failed to consider, in light of the low BP requiring the holding of [REDACTED] medications noted on the same day of the fall, the resident's drug regime as a possible contributing factor to the fall. Failure to consider medications possible impact detracted from staff's ability to prevent further falls.</p> <p>SMOKING SAFETY The Resident Smoking Policy dated 05/22/09 indicated "individual residents who choose to smoke will have their smoking appropriately assessed and addressed in the care plan." "The Smoking Assessment will be completed by</p>	F 323		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 323	<p>Continued From page 36</p> <p>Nursing and Social Services for residents who wish to smoke while residing in the facility." "The assessment will be completed upon Admission, Quarterly and as needed when cognitive and/or physical changes are noted."</p> <p>In an interview on 03/19/13 at 9:27 a.m. Staff B indicated the facility had only one resident smoker, Resident #72. Staff B stated the facility had a smoking policy which included a safety assessment to determine if the resident can go out independently on their own. The facility did not have supervised smoking times as the facility individualized the plan according to the resident's needs and attempted to accommodate the resident preferences.</p> <p>RESIDENT #188: During initial rounds on 03/12/13 at 8:43 a.m. two packs of cigarettes were observed in the 300 hall medication cart. Staff U said they belonged to Resident #188, who smoked with supervision.</p> <p>In an interview on 03/19/13 at 8:41 a.m. Resident #188 was observed in her room wearing an oxygen cannula. Resident #188 said she smoked "every once in a while." Resident #188 described the location of the designated smoking area and noted "If I want to, I have to go and tell them I want a cigarette, but I can't go by myself." The resident said she thought it was "stupid" that she had to go out with a staff member. Resident #188 commented that she had smoked with her oxygen on in the past and didn't understand why she had to take it off beforehand.</p> <p>Review of the resident's record revealed the resident had been a smoker in the facility for over</p>	F 323		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 323	<p>Continued From page 37</p> <p>four months. A 11/10/12 9:45 a.m. progress note revealed a conversation with the resident who "understood that she is an oxygen user and smoking is dangerous and done with caution make sure no oxygen tank near by. She understood, verbally agreed not to go out to smoke."</p> <p>A progress note on 11/12/12 at 11:44 p.m. indicated the resident "requested cigarettes several times during eve. Became upset when told she was not allowed to go out to smoke unless staff member with her. Wanted to go out with another resident only. Explained pt would need to wait unit staff member available to accompany".</p> <p>A note dated 11/14/12 at 11:11 p.m. revealed the residents's "Son-in-law took pt outside to smoke, did not return cigarettes to cart when done. Pt arguing about having to place in cart."..."confrontational about not being able to keep cigarettes with her and go out whenever she wants, and needing staff or family with her. At one point after 2100 pt came out into hallway yelling loudly, "where are my cigarettes." staff is not always available at times she demands....".</p> <p>Staff documented on 12/10/12 at 10:30 p.m. a "NAC found patient smoking 1/4 cigarette in her room with her oxygen on. Assisted resident outside to smoke. safety checks every 30 minutes-1 hour performed. Resident slept well during the night. Cigarettes are currently in the nurse's station."</p> <p>A 12/10/12 3:12 p.m. social work note revealed, "It was reported that this patient was smoking in</p>	F 323		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 323	<p>Continued From page 38</p> <p>her room and this writer has tried to speak to her several times today without success. She has either been gone from the room or sound asleep. At this point, the cigarettes have been removed from the room and per her roommate, she has never seen (resident) smoke in the room. She says that if she did, she would certainly put on the call light ASAP. She was reassured that the staff does not expect her to police her roommate - only to call for help if needed. This writer also called daughter, who was appalled that her mom smoked indoors. She will be in tonight and will reinforce that this is unsafe. Pt is forgetful however and so staff will have to monitor closely and a problem has been added to the care plan. (Daughter) says that her mom was at home yesterday while they were closing out her apartment and she suspects that her mom picked up the cigarettes there. (Daughter) says that the family never has nor never would provide cigarettes so hopefully, the issue is resolved now that the nurses have taken the cigarettes away. Will alert the LTC social worker of this event."</p> <p>In an interview on 03/20/13 at 11:36 a.m. Staff A said he could not find an incident report or investigation regarding the resident smoking in her room.</p> <p>The resident's record had documentation the resident was still smoking while at the facility on 02/26/13. In an interview on 03/19/13 at 8:50 a.m. Staff Q said, "I think she's had 1-2 in the past two months" but "I usually work the other set." "I think she's more likely to smoke when they're (residents family) here." Staff Q added, "Usually the CNAs take her out and sit with her and make sure her oxygen is off."</p>	F 323		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 323	Continued From page 39 Review of the resident's record revealed no Resident Smoking Assessment had been completed including but not limited to at admission, quarterly or after the incident. In addition, the resident record did not contain a Safety Risk related to smoking CP. In an interview on 03/20/13 at 9:44 a.m. Staff U said when Resident #188 was in the TCU she was in a room with a resident who actively smoked, so she started smoking again. When she was transferred to long term care she asked to smoke a couple of times in the beginning. Staff U recalled one episode when the family took the resident out to smoke and left her cigarettes in her room. Staff U said since then the family had asked staff to keep the cigarettes on the medication cart. Staff U said she was unaware "that we have to have a smoking assessment" and noted "I think we probably have to care plan that."	F 323			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325	1) How the nursing home will correct the deficiency as it relates to the resident: <ul style="list-style-type: none"> Resident #141 nutrition care plan was updated to reflect RD recommendations. MAR updated to "offer Ensure between meals" Resident #220 referral to RD for evaluation and assessment. Resident was weighed and Care Tracker and Care plan updated. Diet information for dining room tray updated Delineate the responsibility for completion of the nutrition section of the care plan to Registered Dietitian or Diet Technician 		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	<p>Continued From page 40</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure two of three residents (#s 141 and 220) reviewed for nutrition received planned interventions the residents were assessed to require. This failure placed the resident at risk for unidentified significant weight change and impaired nutritional status.</p> <p>Findings include:</p> <p>RESIDENT #141: According to the 11/01/12 Minimum Data Set (MDS), the resident was assessed as 70 inches tall, weighing 126 pounds, requiring one person physical assist to eat, with no significant weight change. The 11/06/12 Nutritional Status Care Area Assessment (CAA) indicated "Low weight and body mass index noted. Family reported resident has always been thin and his current weight is his usual body weight. No interventions for weight gain. Resident is monitored for weight and PO intake."</p> <p>The 02/13/13 Nutrition Care Plan (CP) listed the goal of "Resident will consume 75% to 100% of meals and Maintain ideal body weight." Interventions included, "Diet as ordered regular type chopped texture and finger food," "RD (Registered Dietician) interventions PRN (as needed)" and "Ensure vanilla between meals and at lunch and dinner" but did not indicate the discipline(s) responsible.</p> <p>The 02/05/13 RD Quarterly Assessment indicated the resident's adaptive equipment was "finger</p>	F 325	<p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> • Review of all resident weight logs to ensure they are being completed • Refer identified residents with change in nutritional status to RD for evaluation and assessment • Nutrition care plans will be updated by nutrition services on a quarterly basis or as needed <p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> • Monthly weights will be entered into Care Tracker for monitoring and tracking • RD recommendations will be evaluated per resident and added to care plan as appropriate • Dietary supplements will be added to MAR and signed off as given • Nutritional care plan updated to reflect "who" is responsible • Nutritional services to implement check list for each resident when quarterly reviews are done to ensure steps in the process are not inadvertently missed 	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 41</p> <p>foods". Interventions listed included, "continue current diet", " Record weekly weight(wt) on shower day", "Monitor PO intake and weight".</p> <p>The March 2013 Physician Order's (PO) listed the diet order for "Chopped, prefer finger foods, thin, give vanilla ensure between meals".</p> <p>At breakfast on 03/14/13 at 8:17 a.m. Resident #141 was served a breakfast which included scrambled eggs and oatmeal. For lunch on 03/15/13 at 12:25 p.m. Resident #141 was served a fish filet, rice, and peas. None of these foods constituted "finger foods."</p> <p>The February and March 2013 Medication Administration Records (MAR) instructed staff to give Resident #141 a "vanilla ensure between meals". The MAR did not indicate the time it was to be given, the amount to be given, and did not include documentation as offered or refused.</p> <p>In an interview on 03/12/13 at 2:15 p.m.. Staff U said the resident was not receiving a nutritional supplement between or with meals. Resident #141 was observed during lunch on 03/12/13, 03/15/13 and 03/19/13 and no vanilla Ensure was noted to have been served.</p> <p>In an interview on 03/19/13 at 1:17 p.m. Staff Q said "I usually give him one (can of vanilla Ensure) before breakfast, with his medication at 6:00 a.m.", "He always drinks all of it because he likes it." Staff Q indicated she only worked with Resident #141 once a month, and did not document when offered or the amount taken because the MAR instructions are "info only."</p>	F 325	<p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> Weight loss results will be monitored and reviewed by Director of Clinical Services and nutritional services RD reports will be provided and discussed/reviewed at quarterly QI meeting <p>5) Dates when corrective action will be completed:</p> <p>May 3, 2013</p> <p>6) The title of the person responsible to ensure correction</p> <p>Colleen Hardy, Director of Clinical Services</p>		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 42</p> <p>In an interview on 03/20/13 at 9:23 a.m. Staff U said the family would like vanilla Ensure between meals, the facility assigned it to the kitchen and the kitchen sends it out. In addition, "I give him pills in the morning with Ensure, he's a night get up so I'm giving it, and he drinks it".</p> <p>In an interview on 03/18/13 at 1:58 p.m. Staff O said the kitchen did not serve the resident Ensure at lunch or dinner. The facility failed to serve a nutritional supplement (Ensure) to the resident according to the CP and POs.</p> <p>In an interview on 03/18/13 at 1:58 p.m. Staff O said the CP goal "would be measured by the meal monitor on Care Tracker." Review of the Meal Intake for Resident #141 revealed although meal monitoring was initiated on 10/28/12, it had not been completed since 11/29/12. Staff O commented that usually once a long term care resident's weight was stable the meal monitor was discontinued, and as such the goal was no longer measurable. The facility failed to monitor intake as directed in the RD interventions.</p> <p>Review of Resident #141's weights revealed weights were obtained once a month except for January 2013, when two weights were documented as obtained. According to the facilities Standards of Care "Residents are weighted monthly or when... requested by dietitian." The facility failed to monitor the resident's weight as indicated in the dietician's quarterly assessment's planned interventions.</p> <p>RESIDENT #220 According to the 10/13/13 MDS, the resident was 64 inches tall and weighed 137 pounds with no</p>	F 325			

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 43</p> <p>significant weight change, on a therapeutic diet and required one person physical assist with supervision and cueing to eat. According to the 10/19/12 CAA, Nutritional Status was addressed in the CP and referred readers to the RD Assessment.</p> <p>According to the 01/05/13 MDS, the resident was assessed to require one person limited physical assistance with eating, weighed 118 pounds, had experienced a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 month, was not on physician prescribed weight loss regimen and received a therapeutic diet.</p> <p>Review of the 01/30/13 CP revealed no Nutrition CP addressing the resident's significant weight loss. The 01/30/13 Resident Assistant Information Sheet indicated the resident's diet was Low Concentrated Sweets (LCS), thin liquids, extra gravy, and that the resident ate in the dining room. A Dehydration CP listed interventions including "dietary restrictions as ordered." A Risk for Impaired Skin Integrity CP listed the intervention to "provide adequate nutrition."</p> <p>In an interview on 03/18/13 at 1:38 p.m. Staff O said the CP is done by whoever completes the MDS. The Dietician/Dietary Aid handwrites the dietary interventions on the Plan of Care Sheets and the CP is done by nursing. In an interview on 03/20/13 at 9:26 a.m. Staff U said the dietician has to do to the Nutrition CP because they do the MDS. Neither nursing nor dietary staff could explain why the resident did not have a Nutrition CP.</p> <p>A 02/02/13 Nutrition Note indicated the resident's</p>	F 325			

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	<p>Continued From page 44</p> <p>diet was changed to ground texture with chopped meat after a fall in January 2013. Snacks/supplements were ordered three times a day. The resident's weight was noted to have declined 3.3% from 01/25/13 to 113.9. The RD planned to monitor in 7-10 days and if weight loss continued to discuss options with physician.</p> <p>A 02/11/13 Nutrition Note revealed no significant weight change and that "weight gain is desired." The plan included "Continue with snacks and supplements, Weekly weight on shower day placed into Care Tracker", "Rd to monitor in 10-14 days."</p> <p>According to the shower schedule, Resident #220's shower day was scheduled for Thursdays indicating a weight would have been obtained on 02/14/13, 02/21/13, 02/28/13 and 03/07/13. Review of the weights entered into Care Tracker revealed only weights for 02/14/13 and 03/07/13. The facility failed to monitor weights as planned.</p> <p>Review of the PO's revealed no physician ordered diet or supplements. In an interview on 03/12/13 at 2:10 p.m.. Staff U said the resident was not receiving a nutritional supplement between or with meals. In an interview on 03/18/13 at 2:08 p.m. Staff O confirmed there were no supplements ordered for the resident, or listed on the dietary tray card to be sent from the kitchen as planned.</p> <p>On 03/15/13 at 12:23 p.m. Resident #220 was observed independently eating a lunch meal consisting of green beans, a fish fillet, and mashed potatoes. The table tray card indicated the resident's diet was "finger food" texture. In an</p>	F 325			

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 325	Continued From page 45 interview on 03/18/13 at 1:38 p.m. Staff O said the table tray cards informs the diet aid what texture and fluid consistency the residents are to receive. Staff O said what the resident was served was not finger foods, but noted that the resident's diet had been changed 01/24/13 and commented "I should have changed her tray card at the time." There was no further nutrition note which indicated the resident had been monitored by the RD after the 02/11/13 visit as planned. In interview 03/18/13 at 1:38 p.m. Staff O said "it didn't happen."	F 325			
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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. 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	F 329	1) How the nursing home will correct the deficiency as it relates to the resident: <ul style="list-style-type: none"> Resident #129, MAR reviewed. CIPRO stopped on 3/18. Quantros (UOR) report completed for Transcription error on 3/13 Resident #306 MAR reviewed to ensure correct use indicated Resident #154 MAR pain and anxiety meds reviewed, GDR requested to include documentation of reasons why not appropriate and least effective dose Resident #111 MAR reviewed. GDR will be requested for Seroquel 12.5mgs and Citalopram 10mg to include documentation. Labs to be order for TSH (Thyroid) and Cholesterol levels Resident #42 Target Behavior sheet updated to reflect simplified behaviors. Quetiapine discontinued. Quantros (UOR) medication error report completed for failure to d/c order on 3/7. 		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 329	<p>Continued From page 46 drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents received adequate monitoring of medications, medications only as ordered, non-drug interventions, gradual dose reductions or that medications had adequate indications for use for Residents #129, 154, 306, 89, 111 & 42, six of ten sample residents reviewed for unnecessary medications. These failures placed residents at risk for adverse side effects or to receive unnecessary medications.</p> <p>Findings include:</p> <p>LACK OF ADEQUATE INDICATION FOR USE</p> <p>RESIDENT #129: Resident #129 was admitted to the facility on [REDACTED]/13 with multiple [REDACTED]</p> <p>According to facility documents, the resident had a [REDACTED] dipstick test done on 03/10/13 which was positive for blood, nitrates and "large" [REDACTED], indicative of a [REDACTED]</p> <p>According to Physician Orders (POs) dated 03/10/13, the resident was started on Cipro (an antibiotic) twice a day.</p> <p>Laboratory results dated 03/13/13 revealed the</p>	F 329	<ul style="list-style-type: none"> Resident #89, MAR reviewed to include interactions between anti-diabetic and anti-psychotic meds. Physician order requested to monitor blood sugars <p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> Consultant pharmacist to audit and review residents required for GDR <p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> Meeting to be scheduled with pharmacist to review deficiencies and develop plan to improve GDR process and documentation to include appropriateness and least effective dose Review psychoactive medication policy and update accordingly <p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> Continue to discuss and review results at Quality Committee meeting and PAMQR Monitor pharmacy recommendations binder to include supporting documentation and follow-up when needed <p>5) Dates when corrective action will be completed: May 3, 2013</p> <p>6) The title of the person responsible to ensure correction</p>	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 329	<p>Continued From page 47</p> <p>██████ was resistant to ██████. A Physician note dated 03/13/13 indicated, "her ██████ came back positive for pseudomonas sensitive only to IV drugs... will not treat urine now." Review of Medication Administration Records (MARs) revealed the resident continued to receive the Cipro until 03/18/13.</p> <p>In an interview on 03/19/13 at 9:13 a.m., Staff H (charge nurse) stated she was unsure why the resident continued to receive the medication from 03/13/12 to 03/18/12. Staff H further stated, "if we know it (the UTI) is resistant (to the antibiotic) we have to stop it..."</p> <p>In an interview on 03/19/13 at 9:49 a.m. Staff P (Advanced Registered Nurse Practitioner-ARNP) confirmed this was "a medication error" and the medication should have been discontinued. Administration of a medication in the absence of a clinical indication constitutes the use of an unnecessary medication.</p> <p>RESIDENT #306: Resident #306 was admitted to the facility on ██████/13 with multiple ██████</p> <p>Review of admission documents revealed a PO for "██████ 25 mg caps... four times a day as needed (prn)." Review of 03/13 MARs revealed Resident #306 received as needed ██████ 25 mg at 9:30 p.m. on 03/10/13 for "sleep" and it was not effective at 12:15 a.m. Staff administered the medication again on 03/11/13 at 10:00 p.m. for "██████" with no documentation regarding effectiveness. Additionally, there was no evidence of non-drug</p>	F 329		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 329	<p>Continued From page 48</p> <p>interventions prior to the administration of this medication.</p> <p>According to the 2012 AGS Beers criteria for potentially inappropriate medication use in older adults, oral diphenhydramine is "highly anticholinergic, clearance reduced with advanced age...increased risk of confusion, dry mouth, constipation and other anticholinergic effects/toxicity", and should be "avoided."</p> <p>In an interview on 03/19/13 at 1:48 p.m., Staff H indicated the [REDACTED] was for allergies. She stated, "everything I see is for allergies" (in the record) "I will look to see if there is anything in the nurses notes of [REDACTED]." In an interview on the morning of 03/20/13 Staff I confirmed staff administered the [REDACTED], which was intended to treat allergies, as a sedating medication. Failure to administer medications for their intended use constituted the use of an unnecessary medication.</p> <p>RESIDENT #154: Record review revealed Resident #154 had [REDACTED]</p> <p>According to the target behavior (TB) sheets in the MAR, staff identified the resident had TBs of "depression and 2) inappropriate comments 3) anger 4) aggressiveness". The TB form had the additional notation of "****were any target behaviors observed? record numbers*** Staff additionally documented, "Resident rarely exhibiting any above mentioned behaviors."</p> <p>Non pharmacological interventions included, "1)</p>	F 329			

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 329	<p>Continued From page 49</p> <p>offer rest 2) re-approach 3)active listening 4) ask if need to toilet 5) inquire re: pain" An additional notation indicated, "**** document intervention(s) utilized on psychotropic med sheet during shift with appropriate number (s)****"</p> <p>Review of 03/13 MARS revealed the resident received [REDACTED] mg on 03/05/13, for "left leg pain" at 1:06 p.m. and received [REDACTED] on 03/05/13 at 6:30 p.m. for "increased yelling out."</p> <p>In an interview on 03/14/13 at 1:10 p.m. Staff Q (Licensed Nurse) stated, "we document (the existence of) behaviors and non drug interventions on the orange sheets prior to administration (of as needed [REDACTED] medications)."</p> <p>Staff did not document the resident exhibited any target behaviors which required the use of [REDACTED] medication nor did they document non drug interventions prior to the administration of prn Ativan on 03/05/13. Staff failed to rule out the resident was experiencing discomfort despite receiving prn pain medication five hours before.</p> <p>According to February 2013 MARs the resident received prn [REDACTED] on 02/14/13, 02/21/13 and 02/25/13. Review of the TB sheets revealed the resident demonstrated no TBs and no non drug interventions in the month of February.</p> <p>Review of 01/13 MARs revealed the resident received prn [REDACTED] on 01/10/13 and 01/17/13 but the TB sheets revealed the resident demonstrated no TBs which required the use of antianxiety medication and there was no evidence of non drug interventions. Additionally, staff</p>	F 329		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 329	<p>Continued From page 50</p> <p>handwrote on the TB monitor, "please note resident is occasionally receiving prn [REDACTED] and [REDACTED] please document given."</p> <p>According to December 2012 MARs the resident received prn [REDACTED] at the same time prn Morphine was administered on 12/17/12, for "increased yelling , agitation" and "generalized pain"; on 02/19/12 for "increased yelling/agitation" and [REDACTED] for "increased yelling/ c/o pain" Similar findings were identified on 12/21/12. While the resident received prn [REDACTED] on 12 occasions in 12/2012, there were no documented non-drug interventions.</p> <p>In an interview on 03/18/13 at 2:15 p.m., Staff C stated, "we would expect TBs to be documented and non drug interventions attempted (prior to the administration of prn psychotropics)". Staff C further stated it was, "not typical" to administer prn pain and anxiety medications at the same time as, "it is the expectation we rule out pain prior to the administration of prn antianxiety medication."</p> <p>LACK OF GRADUAL DOSE REDUCTION Record review revealed Resident #154 received the same dose of the [REDACTED] for over a year.</p> <p>According to the Psychoactive Medication Quarterly Review (PAMQR) dated 02/22/12 staff documented the last dose reduction was done on 12/11/11 with the outcome of "stable but somnolent (a side effect of the [REDACTED]), "trying to determine if somnolence related to (antidepressant) or low oxygenation." Staff documented at that time the least effective dose</p>	F 329		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 329	<p>Continued From page 51</p> <p>was not established but did not consider a dose reduction. Subsequent PAMQRs dated 05/16/12 and 08/01/12 indicated the resident had a "stable" outcome from the previous dose reduction but did not consider a subsequent dose reduction.</p> <p>PAMQR documents dated 10/31/12 indicated a dose reduction was not appropriate at this time, the least effective dose was not established and documented, "Continue current meds will be reviewed by hospice...". Staff documented, "Harborview saw on 04/19/12 and closed case 9/06/12 as stable". There was no indication of why a GDR would be contraindicated.</p> <p>On 11/28/12 staff documented again the Citalopram was last reduced on "12/21/11-stable." The PAMQR dated 02/06/13 indicated the resident no longer required mental health as, "case closed 9/06/12 as stable". Further notes indicated, "On hospice, declining, does not get out of bed...continue on current medications...".</p> <p>Progress notes dated 03/04/13 indicated "resident appears to be in a more rapid decline. He has become less responsive, more difficult to arouse and his appetite has worsened."</p> <p>In an interview on 03/19/13 at 8:22 am, Staff C stated, "We talk about gradual dose reductions (GDR) of each medication quarterly...". When asked if staff considered a GDR specifically for the Citalopram, Staff C stated, "There is no indication of that in the quarterly review." In an interview on 03/19/13 at 10:55 a.m., Staff C confirmed there was no evidence staff attempted or documented the contraindication of attempting a GDR for the Citalopram.</p>	F 329		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 329	Continued From page 52 RESIDENT #111: Record review revealed Resident #111 had diagnoses of [REDACTED] and [REDACTED]. According to POs, the resident received the [REDACTED] 12.5 mg and the [REDACTED] 10 mg every day. Review of Target behavior records for March, April and May 2012 revealed the resident demonstrated no problem behaviors. June 2012 TB records indicated the resident experienced drowsiness and hit staff on 12 of 30 days. Target behavior documents for July through December 2012 revealed the resident demonstrated no behaviors. A similar absence of behaviors was identified for January, February and March 2013. Care plans for "Alteration in [REDACTED] well being" indicated on 09/20/11 "doing well, no s/s of depression" and on 02/15/12 "continues to do well no s/s of [REDACTED]." Care plans for "daily use of [REDACTED]" indicated an approach of "ARNP declines to decrease [REDACTED] d/t lowest maintenance dose possible family wishes and increased [REDACTED]." There was no documentation to support the 12.5 mg was the lowest effective dose. A Pharmacy communication dated 12/29/11 recommended a dose reduction for the resident's [REDACTED]. The ARNP documented, "No, stable and family doesn't want any changes." Staff C was requested on 03/20/13 to provide documentation to evidence discussions with the	F 329			

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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)	
F 329	<p>Continued From page 53</p> <p>family regarding possible dose reductions. No information was provided.</p> <p>Record review revealed a PAMQR dated 07/17/12 which indicated the resident had a dose reduction of the ██████████ on 10/13/11 with a "stable" outcome. Staff documented the ██████████ was last reduced 01/19/11 with a "stable" outcome. Staff documented the resident was noted "drowsy almost daily in May and June..." and "consider ██████████ dose reduction next pharmacy review."</p> <p>Record review revealed no pharmacy recommendations regarding dose reductions of ██████████ medications or addressing monitoring effectiveness of thyroid and cholesterol medications. In an interview on the morning of 03/20/13 Staff C was unable to provide evidence of pharmacy recommendations stating "I don't see any pharmacy consults in the record."</p> <p>In a telephone interview on 03/20/13 at 11:20 a.m., the facility pharmacist indicated recommendations regarding medication reviews did exist and provided a recommendation from May 2012 which indicated, "This resident takes ██████████ 12.5 mgs (each evening). CMS guidelines required periodic consideration of gradual dosage reductions... Pt has been on this low dose since 09/15/11." There was no indication the facility acted on this recommendation or provided evidence why the reduction would be contraindicated.</p> <p>An additional pharmacy recommendation was provided which indicated, "The resident takes</p>	F 329		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 329	<p>Continued From page 54</p> <p>██████████ 10 mg for ██████████. If used to manage behavior, stabilize mood or treat a ██████████ disorder, consideration for an attempted gradual dose reduction is required by the CMS guidelines. Although ██████████ 10 mg might be considered a typical effective dose and family doesn't want to make any changes, is it possible to try for a dose reduction at this time?" There was no indication facility staff responded to this recommendation. Staff C was requested to provide information supporting the family's declination of dose reduction and any risks/benefits discussed. No information was provided.</p> <p>RESIDENT #42 Review of the resident's record revealed a 01/02/13 Mental Health (MH) note with the plan of "We will observe over three months before we d/c ██████████. Treatment/intervention: Simplify behavior monitoring 1) resistance to care 2) angry or anxious mood. 2. we will discontinue quetiapine in 2 month if she remains cooperative with care."</p> <p>Review of the TB sheets in January, February and March 2013 identified the same monitoring ordered since 09/24/09 which included 1) facial expression (frowning) and heavy breathing which may appear to be worry, 2) increased word salad when frustrated, 3) wandering and 4) resist care. The facility failed to simplify the behavior monitoring as planned.</p> <p>Review of a 02/13/13 PAMQR indicated a ██████████ dose reduction was considered appropriate at that time with a note that the date of last dose reduction on 11/03/12 had a stable</p>	F 329			

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 329	<p>Continued From page 55</p> <p>outcome. The IDT recommendations included, "Consider MH rec(commendation) of discontinuing ██████ in March if no care resistance or angry/anxious mood. Used to resist when walking but now in a w/c no issues with resistance when walking."</p> <p>On 03/07/13 a Psychiatry outpatient provider noted, "MAR for Feb and March and Vista Keane detail no mood or behavior problems." The documented assessment was "It appears that she has had stable behaviors since last decrease in ██████ with no reports of care resistance, and no notes documenting distress r/t anxiety. Will trial off of ██████, but continue ██████." Instructions to staff included, "Please discontinue 12.5 mg ██████ and monitor mood and behaviors in the MAR please."</p> <p>On 03/18/13 review of the POs revealed the order for Quetiapine 12.5 po at bedtime had not yet been discontinued. Review of the March 2013 MAR revealed the medication had been administered every evening.</p> <p>In an interview on 03/19/13 at 11:41 a.m. Staff Y noted an undated ARNP signature and "OK" on the 03/07/13 Psychiatry recommendation. Staff Y noted there was no correlating PO and the medication had not been discontinued as intended.</p> <p>LACK OF MONITORING: Review of Physician Orders revealed Resident #111 received daily doses of ██████ (to ██████) and ██████ (to treat ██████). The last cholesterol level in the record was dated 02/29/12 with no regularly</p>	F 329		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 329	<p>Continued From page 56 scheduled labs.</p> <p>On 03/20/13 Staff C was asked to provide evidence the facility monitored the effectiveness of either the [REDACTED] or Simvastatin. A pharmacy recommendation dated 9/12 indicated, "Pt continues receiving [REDACTED]... daily for [REDACTED]. Last TSH (blood test for [REDACTED])... was drawn on 07/25/11. It has been a little over a year, please consider having another TSH." There was no evidence to support facility staff responded to this recommendation. While staff was able to provide evidence the resident's thyroid level was checked during a hospitalization in 10/12, no current evaluation of the [REDACTED] was available. In an interview with the facility pharmacist on 03/20/13, these labs should be checked at least annually.</p> <p>RESIDENT #89: Resident #89 was admitted [REDACTED]/10 with care needs related to [REDACTED], [REDACTED], [REDACTED] and [REDACTED]. Record review found an MDS Assessment dated 01/13/13 identifying the resident's diagnosis of [REDACTED] and use of an [REDACTED] medication on a daily basis. Review of the 03/05/13 care plan related to the management of her [REDACTED] included a goal stating the resident would have "No complications related to the diagnosis of [REDACTED]." The March 2013 Physician's orders, included prescribing an oral [REDACTED] medication twice a day. Further review of laboratory tests and Medication Administration records for February and March 2013 found no monitoring of the resident's blood sugar levels to determine if her current medications and diet were effective in helping manage potential symptoms of [REDACTED]. One</p>	F 329			

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 329	Continued From page 57 potential adverse effect of the [REDACTED] medication prescribed for Resident #89 included elevated blood sugar levels. On 03/20/13 at 11:05 a.m., an RN, (Staff L) was asked how the facility monitored Resident #89's blood sugar levels. Review of the record did not yield lab results or other evidence of monitoring of this resident's blood sugar levels, despite daily use of the medication to manage her [REDACTED]. No physician orders were found to indicate a plan for future monitoring. Staff L said there had been a previous order to monitor Resident #89's blood sugar levels three times per week, but she refused them. Staff L acknowledged there were no recent/ current plans to monitor this resident's blood sugar levels.	F 329		
F 364 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure residents received food served at appropriate temperatures and consistency to maintain food quality, palatability and attractiveness. Residents #141, 46, 89, 310, 309, 303, and 307, seven of the 21 residents interviewed during Stage 1, voiced concerns about the palatability of meals. Facility staff failed	F 364	1) How the nursing home will correct the deficiency as it relates to the resident: For all residents, the following actions will be taken by dietary staff: <ul style="list-style-type: none"> • Increase temperature of pellet warmer • Remove fewer pellets from holding warmer at any one time. Remove pellets from warmer as close to service time as possible • Reduce amount of elapsed time between food leaving kitchen and being served to residents • Ensure temperature of vegetables is at correct temperature when served • Improve presentation of pureed vegetables to be more palatable 	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029	
(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 364	<p>Continued From page 58</p> <p>to ensure hot foods were sufficiently hot when served to residents.</p> <p>Additionally, the facility failed to ensure food was served to Residents #188, 220, 42 and 98 at the most liberal texture to retain its appearance and palatability. These failures by the facility detracted from the palatability of meals and placed residents at risk for less than adequate nutritional intake.</p> <p>Findings include:</p> <p>RESIDENT INTERVIEWS: On 03/12/13 and 03/13/13, during interviews with Stage 1 sample residents, seven residents identified concerns with palatability of meals. When asked about food temperatures, four of these seven residents said hot food was "not always hot", "not warm", "Not warm at all-not very good" or that the food was not at the proper temperature. A fifth resident said he/she rarely received hot coffee. Two other residents described dissatisfaction with the taste, visual appearance (or both) of different meals.</p> <p>RESIDENT #309 & #141 In an interview on 03/13/13 10:54 a.m. Resident #309 stated, "I don't know where the food goes from the kitchen to here, but this morning is the first hot coffee I've had, very rarely is the food hot."</p> <p>In an interview on 03/19/13 at 1:07 p.m., the resident stated, "I am getting tired of the food being in the condition, I am pretty sure it was hot when it left the kitchen but I have had very few meals that I would say were hot, they were either luke warm or, in fact, last night I asked if they would put it in the microwave it was... tasty but</p>	F 364	<p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> Retraining of dietary staff on the procedures for removing pellets from holding warmer and food presentation <p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> Review the necessity for replacing pellet warmer and or plate warmer Review necessity for replacing/updating food delivery system Meet with Executive Chef about the timing of vegetable preparation. Loss of flavor, aroma and reduced palatability that may occur when the peas are pureed and retained at cooking temperatures for an extended period of time. Dining Services will assess the viability of presenting our puree vegetables by garnishing and/or using different techniques to plate the vegetables <p>4) How the nursing home plans to monitor its performance to made sure that solutions are sustained:</p> <ul style="list-style-type: none"> Food cooking and serving temperatures will be continually monitored and recorded by dietary staff 	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 364	<p>Continued From page 59</p> <p>cold, so they microwaved it for me... but the taste of the food is good... I know it waits out in the hall for at least a while, I am not blaming anyone I just want to be honest...".</p> <p>Observation on 03/20/13 at 7:57 a.m. revealed a cart with food at the end of the 200 unit. The cloth sided covers were down and no staff was in sight. At 8:03 a.m. staff were passing trays, the cloth sides of the cart were draped on the top of the cart leaving two sides exposed until all trays were delivered at 8:23 a.m.</p> <p>Similar observations were made on 03/12/13 at 12:30 p.m. as staff passed the hall trays to the 400 unit while the cloth sides of the cart were left open, thrown over the top of the cart.</p> <p>On 03/20/13 at 8:18 a.m. Resident #141 was observed in the dining room eating breakfast. When asked about the temperature, Resident #141 replied, "It could be a little warmer."</p> <p>TEMPERATURE: On 03/18/13, during observations of the noon meal service, Staff X was observed at 11:40 a.m. as initial food temperatures were checked prior to meal service. The minimum required temperature for hot food items is 140 degrees Fahrenheit (dF). Initial temperatures documented for entree items prior to the lunch meal service were as follows: Beef Stroganoff =167 dF; Steamed broccoli = 155 dF; Pureed stroganoff = 163 dF.</p> <p>At 12:05 p.m. on 03/18/13, a lunch test tray was requested and was placed on a cart with meal trays for residents from the 100 unit. The cart with meal trays arrived on the 100 unit at 12:10 p.m.</p>	F 364	<ul style="list-style-type: none"> • Food tray testing and assessment to include temperature and visual appeal • Implement guidelines for pureed vegetable presentation • By assessing the feasibility of establishing a Food Committee comprised of residents, dining staff, nursing, and administration <p>5) Dates when corrective actions will be completed: May 3, 2013</p> <p>6) The title of the person responsible to ensure correction: Tim Alton, Director of Support Services</p>	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 364	<p>Continued From page 60</p> <p>The last meal tray was served at 12:24 p.m. The temperatures of hot food items on the test tray were measured at 12:25 p.m.. The temperature of the beef stroganoff was 120 dF and barely warm when tasted. The temperature obtained for a serving of pureed beef stroganoff was 112 dF. The steamed broccoli was 98 dF and was cold, minimally seasoned when tasted.</p> <p>On 03/19/13 between 8:05 and 8:11 a.m., part of the breakfast meal service was observed. At 8:09 a.m., a breakfast test tray was requested and was placed on a cart with meal trays for residents of the 300 unit. The last breakfast tray was served from the cart at 8:24 a.m. When the temperatures of hot food items on the test tray were measured at 8:25 a.m., the temperature of a serving of scrambled eggs was 106 dF; the eggs were cold when tasted. The temperature obtained for a slice of stuffed French toast was 108 dF and barely warm. A bowl of oatmeal was 122 dF, and barely warm to taste.</p> <p>On 03/19/13 at 1:40 p.m., interview with the facility's Registered Dietitian (Staff O) revealed she checked food temperatures using test trays two to three times a week. When asked what temperature she used to determine acceptable temperatures for hot food, she stated hot foods should be at least 130 dF or above when served. When asked about the results she obtained for test trays, she said, "Probably one of three trays has temperatures that are low". She also stated she was aware of resident concerns about low food temperatures and wasn't surprised by the test trays results on 03/18/13 and 03/19/13.</p> <p>LACK OF VISUAL APPEAL:</p>	F 364		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 364	Continued From page 61 On 03/14/13 at 8:49 a.m. Resident #188 was observed in her room with a breakfast tray. She had been served what appeared to be pureed pancakes, but according to the diet the resident was to have received a "Ground" diet. In an interview on 03/20/12 at 8:21 a.m. Staff O said the resident should have received a pancake soaked in juice and put on the plate. On 03/12/13 at 12:15 p.m. in the main dining room Resident #220 was served what appeared to be a mound of pureed green substance. In an interview on 03/20/13 at 8:21 a.m. Staff O indicated the resident was on a ground diet, and the menu called for pureed peas. Staff O said a ground texture indicated fork mashable vegetables, so the resident could have been served diced carrots. Similar findings were noted for Residents #42 and 98 who had ground diets ordered and received pureed vegetables. In an interview on 03/20/13 at 8:21 a.m., Staff O agreed the residents were served a more restricted texture than ordered, which altered the appearance and decreased the attractiveness of the foods.	F 364			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services	F 425	1) How the nursing home will correct the deficiency as it relates to the resident: <ul style="list-style-type: none"> Resident #297 site rotation log was completed to include Levonox Resident #10 LN was instructed in aspiration method for IM injection Resident #303 LN was instructed on proper procedure for administering eye drops Resident #312 LN were instructed in proper PICC flush and MAR was updated to include flush volume 		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 425	<p>Continued From page 62 (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This LEVEL B is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to: follow Physician Orders/Manufacturer recommendations for three of eight residents (#297, 10 and 303) reviewed during medication pass. These failures placed residents at risk for pain related to repeated injections in the same location and decreased medication effectiveness.</p> <p>Additionally, the facility failed to provide appropriate treatment and care for specialized intravenous access devices such as PICC lines (______). The facility did not ensure Physician Orders were clarified and/or facility pharmacy policies were followed concerning the flushing of PICC lines based on the type of PICC. This failure placed one of one residents (#312) in the facility who had PICC lines at risk for failure of the lines due to clotting and irritation of the vein wall (______). Additionally, other serious and potentially life threatening complications could result from the failed facility practice including _____ (infection in</p>	F 425	<p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> All residents receiving IM injections were assessed for site rotation monitoring All residents with central / PICC lines had orders clarified for proper flushes <p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> In-service clinical staff on proper PICC line flushes and documentation In-service clinical staff on site rotation documentation In-service clinical staff on proper IM injections using standard nursing practice (Ref. Lippincot Manual) In-service clinical staff on proper technique for administering eye drops <p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> Random chart audits for rotation site monitoring 2 months of direct observation of IM injection and administration of eye drops on sample of residents Monitor PICC line / Central line flush practices quarterly x3 quarters <p>5) Dates when corrective action will be completed: May 3, 2013</p> <p>6) The title of the person responsible to ensure correction Colleen Hardy, Director of Clinical Services</p>	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/20/2013	
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 425	<p>Continued From page 63</p> <p>the bloodstream), and/or air embolism (air enters the blood stream and blocks flow to the heart) related to repeated unnecessary Intravenous access.</p> <p>Findings include:</p> <p>RESIDENT #297: On 03/19/13 at 7:34 a.m. a medication pass for Resident #297 was observed. One medication administered during this time was the injectable [REDACTED] (an [REDACTED] used to prevent [REDACTED]). Prior to administration, Staff R a Registered Nurse (RN) stated to the resident "We'll give it on this side" (indicating an area on the left lower abdomen). At 8:45 a.m. on 03/19/13 Staff R was asked about site rotation documentation. Staff R indicated staff did not document site rotation for [REDACTED] stating "we do for [REDACTED]." Staff R was then asked how she determines where to give [REDACTED] and she stated "I avoid the bruising."</p> <p>Review of [REDACTED] Nursing 2012 Drug Handbook (located at facility's TCU A nurse's station) stated for [REDACTED] "Give deep subcutaneous injection, alternating doses between left and right anterolateral and posterolateral abdominal walls. Rotate sites and keep record."</p> <p>In an interview on 03/19/13 at 9:15 a.m. Staff B was asked if there should be site rotation documented for [REDACTED] on residents. She stated "You'll have to ask her" (indicating staff development).</p> <p>On 03/19/13 at 9:57 a.m. Staff D (staff</p>	F 425		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 425	<p>Continued From page 64</p> <p>development) was asked if they document site rotation for injectables other than [REDACTED]. She stated "Yes we do. There is a form we use. They should be rotating the sites. We also look for bruising as well."</p> <p>Staff K, an RN, at 10:30 a.m. on 03/19/13 indicated the facility did have a form to document injection site rotation. She stated the form "is similar to the one for [REDACTED]."</p> <p>On 03/19/13 at 10:32 a.m. Staff F (RN) was asked about site rotation documentation and she stated "I just use my judgement and each day I alternate. The resident will help too sometimes. They will say 'I got it here yesterday'." Staff F had been the nurse for Resident #297 on 03/18/13 the day before and indicated there was no documentation for resident's [REDACTED] site rotation. Staff F was unable to explain how she would ensure site rotation if she didn't work the previous day and/or the resident was not interviewable.</p> <p>RESIDENT #10 During observation of a medication pass on 03/15/13 at 9:17 a.m. Resident #10 received an [REDACTED] (IM) of [REDACTED] (a supplement). During administration of the IM medication Staff Q did not aspirate (Process of giving IM injection to ensure blood does not appear, which would indicate being in a blood vessel, not a muscle) prior to injection.</p> <p>Review of a nursing guide at facility's nurse's station stated for IM injections to "Aspirate the syringe to see if the needle is in a blood vessel. If it isn't, give the injection."</p>	F 425		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 425	<p>Continued From page 65</p> <p>In an interview on 03/15/13 at 11:27 a.m. Staff B stated they "Don't have a policy on how to give IM injections. They (nurses) use their skills."</p> <p>RESIDENT #303 Observation on the morning of 03/18/13 at 9:21 a.m. revealed Staff F prepare and administer [REDACTED] eye drops to Resident #303. Staff F was observed to place her index finger on the resident's left lacrimal sac for approximately 15 seconds. According to the Nursing 2012 Drug Handbook used by staff as a reference, staff were to "apply light finger pressure to lacrimal sac for one minute after drops are instilled."</p> <p>PICC MAINTENANCE RESIDENT #312 Observation on 03/15/13 revealed Resident #312 had a PICC inserted into her right arm. Record review revealed the resident received an [REDACTED] treatment, via the PICC, which ended on 03/08/13. Review of the March MARs indicated staff were directed to "SASH ([REDACTED]) protocol after each ABO ([REDACTED]) treatment" for which staff didn't document on 03/02, 03 or 07/2013. There was no indication of how much of the saline or heparin were administered. Additionally, while staff documented they monitored the PICC line each shift for infection, there was no evidence staff continued to make periodic infusions into the PICC to keep it patent.</p> <p>In an interview on 03/15/13 at 1:02 p.m., Staff CC stated for Resident #312, "we flush each shift with NS (Normal Saline) we use 10 cc (cubic centimeters), because it (PICC) doesn't have a</p>	F 425		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 425	<p>Continued From page 66</p> <p>clamp, , if it did have a clamp then it would be 10 cc saline then 5 cc [REDACTED]...". Staff CC explained the administration as, "first saline then medication then saline and [REDACTED], then we only do saline for flush maintenance (after the antibiotic order is discontinued). It depends on if it has a clamp...".</p> <p>Upon review of the MAR Staff CC stated, "It (the maintenance flush) should be on the MAR to document we are doing it, sometimes if we are very busy... I don't know if it is always documented so well, "I've been here 13 years, should be on the treatment sheets...we should really write it down." Staff CC explained that the PICC was being flushed with 10 cc NS each shift despite it not being documented.</p> <p>In an interview on 03/18/13, Resident #312 stated, "I don't know if they do it every shift... they do come in every day and put something in it (PICC).</p> <p>Review of the facility Central Venous Access Devise chart revealed valved PICC lines require no heparin for flushing, and that for [REDACTED] not in use staff should administer 20 cc NS weekly.</p> <p>In an interview on 03/18/13 at 8:31 a.m., Staff BB was asked how much of the [REDACTED] and saline should be administered for a PICC line. She replied, "we have a protocol here (in the MAR)." When no protocol could be located in the MAR Staff BB stated, "depending on the (type of) lines you can get different amounts, you have your midline, [REDACTED] lines and PICC lines; if there is a clamp it is different than if there isn't a clamp." Staff BB checked the previous months MAR book and no protocol was located.</p>	F 425		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 425	Continued From page 67 In an interview on the morning of 03/20/13 Staff DD, the facility pharmacist, stated, "I would want the specific volume (for the PICC flush) indicated in the order... that should be on the MAR I would think. The facility does the MARs we don't do that anymore." Staff DD indicated specific directions for different types of lines were located in the IV policies. Staff DD further stated, "it is not unusual for a resident to continue to have a PICC line after the antibiotic is over, but of course we would have to have directions to to maintain the line...". Failure to ensure clear directions to staff regarding the flushing of PICC lines, resulted in the resident receiving heparin (which was not called for by the clinical policy/procedure) and receiving three time a day flushes as maintenance when the policy called for only a weekly flush.	F 425		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	1) How the nursing home will correct the deficiency as it relates to the resident: <ul style="list-style-type: none"> • All expired medications were discarded • Resident #12 expired Systane eye drops ordered and replace • Resident #186 expired Vancomycin solution ordered and replaced • Resident #72 expired Gentamycin ordered and replaced 2) How the nursing home will act to protect residents in similar situations: <ul style="list-style-type: none"> • All medication carts and medication rooms audited for expired medications and open dates 	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029	
(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 431	<p>Continued From page 68</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure medications were labeled, dated and discarded according to facility policy and pharmacy standards. Failure to label, date and discard medications as indicated placed residents at risk to receive medications that were expired.</p> <p>Findings include:</p> <p>UNIT C MEDICATION CARTS: During initial rounds 03/12/13 at 8:43 a.m., the Medication Cart (MC) on Unit C contained Humalog insulin dated 02/04/13. This medication was discarded by Staff K. In an interview on 03/15/13 Staff B indicated that insulin can be used up to 30 days after opening. Staff B confirmed the insulin was expired.</p>	F 431	<p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> All medication carts and med rooms will be cleaned out monthly and any expired medications will be removed Reinforce with clinical staff that Insulin is only used for 30 days after opening Rotation of stock / e-kit medication prior to expiration <p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> Implement random spot checks of all medication carts Communicate with household managers if any expired medications are found with follow-up requested <p>5) Dates when corrective action will be completed: May 3, 2013</p> <p>6) The title of the person responsible to ensure correction Colleen Hardy, Director of Clinical Services</p>	

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 431	<p>Continued From page 69</p> <p>In the same MC, Isotop eye drops were found dated 09/12/12. Staff K also discarded this medication.</p> <p>Additionally during initial rounds on 03/12/13, in the second MC on Unit C, there was a discrepancy with expiration dates for Systane eye drops ordered for Resident #12. The label stated to discard 12/01/13, but the bottle expiration date listed was 02/2013. The bottle was also not dated when opened. Staff U stated that medications need "to be dated when opened." In an interview on 03/15/13 at 9:49 a.m. Staff B said for eye drops staff should follow the manufacturer's expiration date. The medication was expired according to the manufacturer's expiration date.</p> <p>Metamucil was dated as opened 09/11/12 with a manufacturer's expiration date of March 2012. According to Staff U it was house supply and expired, and should have been discarded. In an interview on 03/15/13 Staff B confirmed it was expired.</p> <p>UNIT C & D MEDICATION ROOM: Influenza vaccines were found in the refrigerator with an open date of 02/09/12. Staff B stated "That should be thrown out." She indicated that influenza vaccinations should only be used for the season they were issued and are not to be used for the following year.</p> <p>Two bags of Vancomycin solution for Resident #186 were found with expiration dates of 02/22/13 and 03/09/13. Gentamycin for Resident #72 was found with an expiration date of 03/04/13. Staff B indicated these medications</p>	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 431	Continued From page 70 should be discarded. TCU MEDICATION ROOM: Observation of the TCU medication room during initial rounds revealed promethazine which had an expiration date of 02/14/13. According to staff, "it is house stock... that should be removed."	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	1) How the nursing home will correct the deficiency as it relates to the resident: <i>Only two specific residents noted in SOD</i> <ul style="list-style-type: none">• Resident #213, water carafe replaced and covered• Resident #303, assessed for any eye infection 2) How the nursing home will act to protect residents in similar situations: <ul style="list-style-type: none">• All water carafe's will be covered• All residents who receive eye drops were reviewed to ensure proper administration was occurring• All residents identified in March Infection control report with facility acquired UTI's showing microorganisms associated with fecal matter will be assessed for possible source of contamination	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029	
(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 441	<p>Continued From page 71 hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure an effective infection control program. The facility failed to analyze microorganisms, identify trends and implement corrective actions regarding facility acquired infections. These failures detracted from staffs ability to identify trends and implement interventions, placing residents at risk for nosocomial infections. Additionally, one staff failed to use personal protective equipment (PPE) when coming in contact with bodily fluids of one resident.</p> <p>Findings include:</p> <p>INFECTION CONTROL PROGRAM Determining the origin of infections assists the facility to identify the number of residents who developed infections. The comparison of current infection control data to past data enables detection of unusual or unexpected outcomes, trends, effective practices, and performance issues. The evaluation of facility practices then can help determine if the facility should change processes or practices to minimize the potential of infection transmission.</p>	F 441	<p>3) Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> • The March Infection Control Report for UTI's showing microorganisms associated with fecal matter will be analyzed to include: <ul style="list-style-type: none"> ○ Evaluation of common causal factors; microorganisms and/or staff peri-care practices ○ Summative analysis to include RCA of trends ○ Action plan to address trends ○ Re-evaluation of action plan • In-service for clinical staff on eye drop policy and techniques recommended by CDC for administration of eye drops • In-service clinical staff on infection control in relation to providing personal care <p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> • Infection Control Log will be reviewed by Director of Clinical Services (or designee) at least monthly for tracking, analysis, and evaluation of trends • Quarterly monitoring to ensure new guideline are being followed <p>5) Dates when corrective action will be completed: May 3, 2013</p> <p>6) The title of the person responsible to ensure correction Colleen Hardy, Director of Clinical Services</p>

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 441	Continued From page 72 Record review of the facility's QA (Quality Assurance) Infection Control Tracking (ICT) data showed a trend of in-house acquired Urinary Tract Infection (UTI) rates. The numbers for in-house acquired UTIs are as followed beginning in August of 2012: August: 8 September: 17 October: 11 November: 15 December: 9 January: 4 February : 9 The rise in UTI rates from August to September was identified in the third quarter Tracking Summary Report (TSR) for 2012 that stated "We also saw a return to previous higher levels of UTI especially related to foley catheter use." There was no indication of what this meant or why Foley catheter use would catalyze more than a 100% increase in the rate of infection from August to September. There was no analysis of microorganisms or interventions to potentially lower rates of infections. In an interview 03/20/13 at 11:30 a.m. Staff D (Infection Control Nurse) indicated that she and another staff member collect data monthly and the Director of Nursing Services (DNS) writes the summaries quarterly. The fourth quarter TSR for 2012 again identified in-house acquired UTIs . Review of the facility's ICT for January 2013 identified four residents with in-house acquired UTIs. Urine culture results showed that two of four residents, fifty percent, were positive for	F 441			

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 441	<p>Continued From page 73</p> <p>escherichia coli (E-coli a microorganism associated with fecal matter) in their urinalysis.</p> <p>In an interview 03/20/13 at 12:00 p.m., Staff D was asked how many of the UTIs identified had fecal association. She replied "That's a good question...". Looking at the data, Staff D confirmed that fifty percent of the people who acquired in-house UTIs in January had E-coli. When asked how this information was significant, Staff D stated "We need to do better peri-care."</p> <p>When asked about any interventions to address the problems identified, Staff D referred to notes that were found on individual care plans for residents. Staff D was able to talk about global interventions to implement to decrease the number of in-house acquired UTIs, but was not able to produce documentation of facility-wide interventions implemented or review of outcomes to ensure interventions were effective.</p> <p>In looking at the ICT for February 2013 it was noted that the number of in-house acquired UTIs increased over one-hundred percent (100%), from four to nine residents. Staff D was asked about the rise in numbers from January to February and she stated that the rise was because "We did a lot better tracking." Staff D was then asked if that meant the other months were incorrect. She stated "Oh no, that's not what I mean. We might have acquired more in-house infections." Staff D indicated at this time the February increase would not be identified until the quarterly review was due in April stating, "maybe we should do it (the summary) monthly."</p> <p>Review of urine cultures done in February, six of</p>	F 441		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 441	<p>Continued From page 74</p> <p>nine in-house acquired UTIs, sixty-six percent, again showed microorganisms associated with fecal matter.</p> <p>There was no evidence to suggest facility-acquired infectious diseases were evaluated for common causal agents, microorganisms, or for the possibility staff improperly provided personal care or any other failed facility practice that would be implicated in acquired infections. There was no summative analysis with information that identified the root cause of infections and/or trends, proposed corrective action, rationale, or evaluation of effectiveness of corrective action. This documentation was not present in the Infection Control Log or the Quality Assurance Committee minutes which were provided.</p> <p>A comprehensive infection control program encompasses and documents the components of surveillance, investigation, analysis, planning, implementation, and evaluation of outcome to prevent and/or control the spread of infection. The components of investigation, analysis, planning, implementation and evaluation of outcome were not documented with any clarity or cohesiveness in the facility infection control program.</p> <p>SPREAD OF INFECTION</p> <p>On 03/13/13 at 2:50 p.m. water carafs being distributed by staff in TCU A hall were not covered on the cart. These carafes were being placed in each resident room.</p> <p>On 03/19/13 at 7:17 a.m. during an observation of a medication pass for Resident #213 it was</p>	F 441		

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 441	<p>Continued From page 75</p> <p>observed that the water carafe on his bedside table did not have a covering on it. The nurse doing the medication pass (Staff R) acknowledged that the carafe should be covered.</p> <p>In an interview 03/19/13 at 11:38 a.m. with Staff S (NAC) on Unit D indicated that the carafes being referred to were only used on the TCU, but states that she "would think they should be covered."</p> <p>In an interview on 03/19/13 at 12:00 p.m. Staff T (NAC) on TCU indicated that the carafes should be covered during delivery to rooms while in the hall and when at the bedside in the resident rooms.</p> <p>Observation during medication pass on 03/18/13 at 9:40 a.m. revealed Staff F prepare and administer [REDACTED] to Resident #303. Staff F was observed to remove the brown plastic canister containing the eye drops from the medication cart and place them in her pocket. Upon entering the room, Staff F washed her hands then removed the canister from her pocket, removed the bottle of eye drops from container, and placed the container on overbed table next to hair brush and yogurt. After administering the eye drops Staff F said to the resident, "can you... you need to... press your eye...". Staff F then placed her ungloved index finger on the resident's left lacrimal sac for approximately 15 seconds.</p> <p>Staff F then picked up the container with her now contaminated hand, placed the eye drop bottle into the container and put it back in her pocket and proceeded to wash her hands.</p> <p>In an interview on 3/18/13 at 2:10 p.m., Staff F</p>	F 441			

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

PRINTED: 03/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505418	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/20/2013
NAME OF PROVIDER OR SUPPLIER PROVIDENCE MARIANWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 3725 PROVIDENCE POINT DRIVE SOUTHEAST ISSAQUAH, WA 98029		
(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 441	Continued From page 76 indicated she doesn't wear gloves for eye drops. She stated, "I wash my hands before and after" but there were "no gloves in the hall". In an interview on 03/18/13 at 2:23 p.m., Staff D (Staff Development) indicated she wasn't sure if staff should use gloves for the administration of eye drops. She indicated there was a laminated protocol for eye drop administration in the front of the Medication Administration book. While the protocol didn't specify the use of gloves, it displayed a picture of someone demonstrating the administration of eye drops who was wearing gloves. When asked if staff should touch resident's eyes without gloves, Staff D replied, "certainly not."	F 441			