PRINTED: 06/13/2013
FORM APPROVED
OMB NO. 0938-0391

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

IDR AMENDED 1225

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	595276		04/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRONTIER REHAB & EXTENDED CARE	1500 3RD AVENUE LONGVIEW, WA 98632

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This report is the result of an unannounced Quality Indicator Survey conducted at Frontier Rehabilitation & Extended Care on 03/25/13, 03/26/13, 03/27/13, 03/28/13, 03/29/13, 04/01/13, and 04/02/13. A sample of 42 residents was selected from a census of 100. The sample included 33 current residents and the records of 9 former and/or discharged residents. The Survey was conducted by: [redacted], R.N., B.S.N. [redacted], M.A. [redacted], R.N., B.S.N. [redacted], R.D., C.D. [redacted], B.S.S. AMENDED PER IDR ON 06/13/13 BY ROBIN BUCKNELL The survey team is from: Department of Social & Health Services Aging & Long-Term Support Administration Residential Care Services Division, District 3, Unit C & D P.O. Box 45819 Olympia, Washington 98501-5819 Telephone: (360) 664-8429 Fax: (360) 664-8451 Robin Bucknell, IDR Program manager 6/13/13 Residential Care Services Date	F 000	**DISCLAIMER CLAUSE** PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW.	5/8/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 6/20/13

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.

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F 000	Continued From page 1	F 000		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on interview and observation, the facility failed to provide maintenance services necessary to maintain a safe, sanitary environment in 3 of 4 units, evidenced by observation of a screen door that was not installed in a working condition, a hole in a shower room wall and a gouged, damaged door. Failure to identify and address observed problems in the resident environment placed residents at risk for injury or a diminished quality of life. Findings include: Screen door: On 03/28/13 at 1:30 p.m., inspection revealed a screen door off the track it slides on. The screen was located between the outside patio and the Riverside dining room (Ice Cream Parlor). The bottom of the screen was observed to be about 8 inches out from the track at ground level and the top of the screen was observed to be leaning against the window of the patio door. A small amount of leaves and other debris was on the ground between the screen and the door. On 03/29/13 at 12:30 p.m., Staff J, Licensed Nurse/Resident Care Manager stated sometimes	F 253	*F-253* 1. ***How corrective action accomplished for the identified residents?*** The screen door is secured on the track. The shower room wall on the long hall on the Countryside Unit has been repaired. The door separating the dining room and the Oceanside hallway has been repaired. 2. ***How you will identify other residents with the potential of being affected by the same practice?*** Maintenance/Housekeeping audits will be conducted to identify other areas with the potential of being affected by the same practice.	5/8/13 5/8/13

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F 253	Continued From page 2 the door is opened in the summer for ventilation. She stated it is usually opened "just a little" and indicated 9-12 inches with her hands. She stated the door is not used for egress. "We don't open it very much..." On 03/29/13 at 12:40 p.m. Staff F, Maintenance Director stated when the leaf blower is used in the patio area, it sometimes blows the screen out of the track. He stated the door is not supposed to be opened. Hole in Wall of Shower Room: On 03/29/13 at 10:50 a.m. a hole was observed in the wall of the shower room of the Countryside unit in the "long hall." A rectangular section of gypsum board (wall board) approximately 6 inches (height) by 12 inches (width) was missing. The hole was located in the wall behind the entry door of the shower room. The bottom of the hole was about 5 inches above floor level. Raw wood studs and the back side of the wall board in the adjacent room were visible through the hole. On 03/29/13 at 12:35 p.m. Staff F stated his staff cut the wall board from the wall because the door stop had damaged it. He stated they had not "gotten around to fixing it yet."	F 253	3. ***Address what measures will be put in place to ensure deficient practice will not recur.*** The Maintenance Manager and Housekeeping Supervisor will conduct weekly rounds to validate that the environment is clean and in good repair. . 4. ***How will the plan be monitored to ensure the solutions are sustained?*** The Executive Director will be responsible for the implementation and maintenance of this correction and will report concerns which will be reported to the monthly CQI committee.	
	Damaged Door: On 03/25/13 at 11:00 a.m. inspection of the Oceanside dining area revealed gouged/damaged areas in the door separating the dining room and the Oceanside hallway. On 04/02/13 at 9:30 a.m. the same gouges were observed again. One gouge was approximately 30 inches long and approximately 1/2 inch wide. This gouge started approximately 3 feet high on			5/8/13

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRONTIER REHAB & EXTENDED CARE	1800 3RD AVENUE LONGVIEW, WA 98632

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F 253	Continued From page 3 the door and ended about 18 inches above the bottom of the door. A second gouge was located to the left of the first gouge and was approximately 7 inches long and 1/2 inch wide. There were also several small gouges or scuff marks near the bottom of the door. These gouges had a rough surface that would be difficult to clean and sanitize effectively. The rough surface could also potentially cause a splinter or a skin tear if a resident was in contact with the damaged areas.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	*F-279* 1. ***How corrective action accomplished for the identified residents?*** Resident #65's care plan has been reviewed and revised to reflect her current status.. 2. ***How you will identify other residents with the potential of being affected by the same practice?*** A review of resident care plans will be conducted to identify other residents with the potential of being affected by the same practice.	5/8/13 5/8/13

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F 279	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to develop a comprehensive care plan in accordance with the comprehensive assessment for 1 of 26 (#65) of 27 sampled stage 2 residents. Findings include: Resident #65 was admitted to facility on [redacted]/2011 with diagnoses of [redacted] Weight Loss, [redacted] and [redacted] The resident's Minimum Data Set (MDS), an assessment tool, dated 02/25/13 indicated Resident #65 had a poor appetite more than half the days of the resident assessment period and required extensive assistance for eating. The Care Area Assessment (CAA) indicated nutritional problems placing the resident at risk of weight loss and documented an inability to perform Activities of Daily Living (ADLs) without significant assistance due to weakness and a recent decline.	F 279	3. ***Address what measures will be put in place to ensure deficient practice will not recur*** Nurse Managers will be re-educated on the RAI process which includes developing a comprehensive care plan in accordance with the comprehensive assessment. The DNS will randomly audit comprehensive and care plans to validate compliance. . 4. ***How will the plan be monitored to ensure the solutions are sustained?*** The DNS will be responsible for the implementation and maintenance of this correction and will report concerns to the monthly CQI committee.	
	On 03/28/2013 at 8:50 a.m, Resident #65 was observed sitting at a dining table during the breakfast meal. The resident was observed holding a fork in the air for approximately two minutes before placing the food in her mouth. The resident then stared at the wall and watched other residents. During a 35 minute observation, the resident repeatedly held a fork in the air for up to two minutes before eating the food on the fork.			5/8/13

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F 279	Continued From page 5 On 03/28/13 at 9:52 a.m., Staff H, a Nursing Assistant Certifed, was asked how staff determine the level of eating assistance to provide to individual residents. Staff H stated, "It is on their care plan." On 03/28/13 at 1:58 p.m., when asked what type of eating assistance was provided for Resident #65, Staff G, a Resident Care Manager stated, "We set up her tray and encourage her to eat." When asked what level of eating assistance Resident #65 was assessed to need, Staff G looked in the resident's chart and said, "We have her as extensive assistance." When asked if the resident's care plan reflected the comprehensive assessment, Staff G turned to the care plan and stated, "We just have her as assist." On 03/29/2013 at 9:02 a.m., Resident #65 was observed during the breakfast meal. The resident again held a fork in the air for up to two minutes at a time and appeared to be staring at the wall and across the room throughout the 30 minute dining observation. On 3/29/13 at 11:20 a.m., when asked to explain the difference between assisting a resident with meals and providing extensive assistance, Staff I, a Licensed Nurse, stated, "Assistance means to set up and encourage the resident to eat. Extensive assistance means the resident can't lift the fork to their mouth and staff has to feed them." Refer to F325 CRF483.25 (i) for the outcome.	F 279		5/8/13

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STREET ADDRESS, CITY, STATE, ZIP CODE
1600 3RD AVENUE
LONGVIEW, WA 98632

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F 279	Continued From page 6	F 279		
F 431 SS=C	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. 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. 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.	F 431	*F-431* 1. ***How corrective action accomplished for the identified residents?*** Medications are stored in accordance with acceptable standards and labeled appropriately when opened.t. 2. ***How you will identify other residents with the potential of being affected by the same practice?*** Any residents has the potential of being affected by the same practice.	5/8/13 5/8/13

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NAME OF PROVIDER OR SUPPLIER: FRONTIER REHAB & EXTENDED CARE		STREET ADDRESS, CITY, STATE, ZIP CODE: 1500 3RD AVENUE LONGVIEW, WA 98632	

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F 431	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure expired medications were promptly removed and disposed from 2 of 5 medication carts and in the central supply. This failure allowed Resident # 55 to receive expired medication. Findings include: Observation on 03/28/13 of Mountainside medication cart revealed a bottle of slow magnesium opened 03/18/13 had an expiration date of 09/12. Per record review, resident # 55 had an order for the medication to be taken four times per day. Per review of medication administration record (MAR) the resident had been receiving the ordered dose. Per interview on 03/28/13 at 2:15 pm with Staff D, Resident Care Manager stated she couldn't believe they missed the expiration date and confirmed the resident had been receiving the expired medication. Observation 03/28/13 of Oceanside medication cart revealed one bottle of slow magnesium with an open date of 02/28/13 and an expiration date of 06/12. Observation 03/28/13 of the central supply room revealed the following expired medications: · 2 bottles of Slow Release Iron, expiration date 09/12 · 2 bottles of Vitamin E 400 IU, expiration date	F 431	3. ***Address what measures will be put in place to ensure deficient practice will not recur.*** Licensed Nurses will be re-educated on the requirement to check expiration dates and remove expired medications immediately, as well as to label medications with the date they are opened. The Staff Development Coordinator or designee will audit nursing carts and medication storage areas routinely to validate that accepted standards for medication storage are being followed. 4. ***How will the plan be monitored to ensure the solutions are sustained?*** The DNS will be responsible for the implementation and maintenance of this correction and will report concerns to the monthly CQI committee.	5/8/13

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F 431	Continued From page 8 02/13 · 2 bottles of Multi Vitamins, expiration date 02/13 These findings were brought to the attention of Staff E, who was present in central supply. This is a repeat citation from 02/27/12	F 431		5/8/13

08/08/2013 14:24 3606363003 FRONTIER COUNTRYSIDE PAGE 14/16