

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

PRINTED: 04/24/2013
FORM APPROVED
OMB NO. 0938-0391

1232

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505332	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/18/2013
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF SAN JUAN ISLANDS	STREET ADDRESS, CITY, STATE, ZIP CODE 660 SPRING STREET FRIDAY HARBOR, WA 98250
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced ^{asm} Abbreviated Survey conducted at Life Care ^{4/18/13} Center of San Juan on 11/16/2012. A sample of 3 residents was selected from a census of 45. The sample included 2 current residents and records of 1 former/discharged resident.</p> <p>The following complaints were investigated as part of this survey:</p> <p>2787690 2787996</p> <p>The survey was conducted by: [REDACTED] MS, RN</p> <p>The survey team is from: Department of Social & Health Services Aging and Long-Term Support Administration Residential Care Services, Region 2, Unit B 3906 H1. Street NE, Suite 100 Arlington, WA 98223-4740</p> <p>Telephone: (360) 651-6850 Fax: (360) 651-6940</p> <p><i>Roberta Crawford</i> 4/30/13 Residential Care Services Date</p>	F 000	<p>F000</p> <p>This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This plan of correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings constitute deficiency, or that the scope or severity regarding any of the deficiencies cited is accurately applied.</p> <p>RECEIVED MAY -9 2013 ADSA/RCS Smokey Point</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Executive Director	(X6) DATE 5/8/13
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226 SS=D	<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 consistently implement all components of policy to prevent abuse. Failure to report allegations of abuse/neglect in a timely manner placed all residents of the facility at risk of possible abuse/neglect.</p> <p>Findings include:</p> <p>Washington State "Nursing Home Guidelines", dated February 2012, identifies "mandated reporters" include employees of a facility. Additionally, the Guidelines note "when an individual mandated reporter has reasonable cause to believe an incident is abandonment, abuse, neglect ...the report must be made immediately."</p> <p>1. Resident 2 was re-admitted in [REDACTED] 2013 for rehabilitation after a [REDACTED]. His Minimum Data Set (MDS) assessment, dated 03/04/13, noted he required 2 person assistance with toileting, repositioning, and dressing. Additionally, his MDS assessment identified his memory and recall had a [REDACTED] (11/15 points on the memory assessment tool).</p>	F 226F 226	<p>Correct deficiency Resident 2 has been assessed is not exhibiting symptoms of psychological harm.</p> <p>Resident 1 denied mistreatment by NA 1.</p> <p>Protect from similar situations NA 1 no longer works for the facility. NA 1 has been reported the Washington State Department of Health-licensing board.</p> <p>NA 2 has been re-educated on Washington States "Nursing Home Guidelines for mandated reporting. NA 2 received disciplinary action for failing to report the allegation in a timely manner. NA 2 was reported the Department of Health licensing board who closed case as "below threshold as an isolated incident... pose[s] minimal risk of harm to the public health, safety, or welfare, or we cannot identify a violation of the law."</p> <p>Measures taken to prevent recurrence Staff have been re-educated by the Staff Development Coordinator on their role of mandated reporter according to the "Nursing Home Guidelines", identifying abuse/neglect and mistreatment and the facility's policy and procedures related to abuse prevention.</p> <p>Random resident interviews will be conducted weekly for three months by the</p>	
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F 226	<p>Continued From page 2</p> <p>On 04/09/13 Resident 2 reported allegations of physical, verbal and psychological abuse by Nursing Assistant (NA) 1 when she provided care services to him in March 2013. Review of the facility investigation revealed the incident that precipitated these allegations was witnessed by NA 2 when it occurred in March 2013. NA 2 had training in January 2013 regarding her role as a mandated reporter and responsibility to immediately report any incident. NA 2 did not report the incident of NA 1 and Resident 2 in March 2013 when it occurred.</p> <p>On 04/18/13 at 10 a.m., Resident 2 reported there was one staff person who was "rough. She hurt me when she was helping me." He recalled he told some of the other residents of the facility and later a family member. Resident 2 stated she said "mean" things to him. He felt she was disrespectful to him. Resident 2 reported when LN 2 defined abuse for him, he replied, "I was physically, verbally, and psychologically abused" during the incident in March 2013.</p> <p>At 12:15 p.m., the Director of Nursing Services (DNS) reported she spoke with Resident 2 during the investigation. She stated he "told a consistent story over time" of physical, verbal, and psychological abuse by NA 1. The DNS stated she interviewed NA 2 on 04/10/13. At that time, NA 2 had no information of the delay in reporting the incident in March 2013.</p> <p>Review of the facility investigation revealed NA 2 wrote NA 1 "was rough with people." NA 2 was present during the incident in March 2013 that Resident 2 reported. NA 2 noted Resident 2 stated NA 1 was hurting him during peri care. NA</p>	F 226	<p>Social Service Director/designee to verify no further concerns of possible mistreatment occur. Any concerns reported will be investigated including follow up as needed.</p> <p>Monitor compliance The Executive Director will report any trends from the resident interviews to the facility Performance Improvement committee for three months.</p> <p>Date of Compliance 4/19/13</p> <p>Person responsible for compliance The Executive Director</p>		

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F 226	<p>Continued From page 3</p> <p>1 replied to Resident 2 it was "for his own good." NA 2 thought NA1's behavior during the incident was "scary and worrisome." There was no information to explain why NA 2 failed to report the allegations in March 2013 when the incident occurred.</p> <p>2. Resident 1 was admitted in [REDACTED] 2011 with diagnoses including [REDACTED]. Her most recent MDS assessment, dated 03/04/2013, identified her memory and recall as intact (14/15 points on the memory assessment tool).</p> <p>On the morning of 04/08/13, Nursing Assistant (NA) 3 found a reddish-purple bruise, 14 centimeters (cm) x 12 cm, on the right forearm of Resident 1. Resident 1 told NA 3 she thought the bruise was from when a NA "grabbed" her arm during a transfer. Review of the facility investigation revealed NA 2 provided care services to Resident 1 on the evening of 04/07/13. During that time, NA 2 assisted Resident 1 with transfer. Resident 1 "yelled" when Na 2 held her arm. NA 2 did not report the incident.</p> <p>On 04/18/13 at 9:45 a.m., observation of Resident 1's right forearm found two dark purple-yellow colored areas present on the top and side of her arm.</p> <p>Resident 1 reported about 2 weeks ago one of the staff "grabbed my arm." Resident 2 stated she "yelled and screamed", then the NA let go of her arm. Resident 1 reported she still had the bruise. Resident 1 reported her skin was fragile and bruised easily.</p>	F 226		
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F 226	Continued From page 4 At 12:15 p.m., the DNS reported she interviewed NA 2 about the incident on 04/08/13. During that interview on 04/08/13, the DNS reviewed definitions of mandated reporters and the importance of reporting any possible allegations of abuse/neglect immediately. The DNS recalled NA 2 verbalized she understood her role as a mandated reported and the requirement to immediately report any allegations of possible abuse/neglect. NA 2 did not tell the DNS of any other incidents of abuse/neglect for any other residents during that interview on 04/08/13. The DNS noted all NAs, including NA 1 and NA 2, were most recently in-serviced on resident rights and immediately reporting allegations of abuse/neglect in January 2013. Review of the facility investigation revealed NA 2 was identified as the staff person involved in the incident with Resident 1. The DNS interviewed NA 2 on 04/08/13. NA 2 told the DNS she did not think Resident 1 was injured. She did not report the incident to the nurse on duty on 04/07/13. Licensed Nurse 1 wrote no staff person told her of any incident on 04/07/13 involving possible injury to any resident. Resident 1 told staff she did not think the injury was intentional.	F 226			

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