

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

PRINTED: 05/07/2013
FORM APPROVED
OMB NO. 0938-0391

1240

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505251	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/26/2013
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NAME OF PROVIDER OR SUPPLIER WHITMAN HEALTH & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1150 WEST FAIRVIEW ROAD COLFAX, WA 99111
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Whitman Health and Rehab on 4/11/13. A sample of 4 residents was selected from a census of 36. The sample included 1 current resident and the records of 3 former and/or discharged residents.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#2782607</p> <p>The survey was conducted by: [REDACTED] R.N., B.S.N.</p> <p>The survey team is from: Department of Social & Health Services Aging and Long-Term Support Administration (AL TSA) Division of Residential Care Services, Dist. 1, Unit B 316 West Boone Avenue, Suite 170 Spokane, Washington 99201-2351 Telephone: (509) 323-7300 Fax: (509) 329-3993</p> <p><i>[Signature]</i> Residential Care Services</p>	F 000	<p>Continued from page 2. requirements for a safe and orderly discharge.</p> <p>The title of the person(s) responsible to ensure correction Executive Director</p> <p>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 SOLEY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND SATE LAW.</p> <p>RECEIVED MAY 15 2013 DSHS ADJAHCS SPOKANE WA</p>	<p>5/13/13</p> <p>5/13/13</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ken S. Alexander</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>5/10/13</i>
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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 204 SS=D	<p>483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG</p> <p>A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide a safe and orderly discharge for 1 of 4 residents (#1) who were reviewed for discharge planning. Findings include:</p> <p>Resident #1 had diagnoses that included [REDACTED] and [REDACTED]. Per record review, the resident had [REDACTED] and was moderately [REDACTED] for decision making. The resident required extensive assist with most activities of daily living.</p> <p>Per record review, the resident was transferred to the facility on [REDACTED]/13 after being hospitalized for [REDACTED] on [REDACTED] medications. Per the hospital history and physical, it was noted that the resident was unable to comprehend his medication regimen.</p> <p>Per record review, the facility's initial discharge plan dated [REDACTED]/13 documented the resident had been living at home with his wife. The initial discharge care plan identified barriers to discharge which included medication management, safety concerns, and activities of daily living management.</p> <p>Per record review, a Social Services note dated 2/25/13 documented the resident's son from Utah was going to take the resident to his home and care for him. The resident was in</p>	F 204	<p>How the nursing home will correct the deficiency as it relates to the resident Resident #1 discharged from the facility and is residing with family.</p> <p>How the nursing home will act to protect residents in similar situations The Social Services Director was reeducated on the requirements for a safe and orderly discharge plan. The facility reviewed the discharges over the last 30 days to validate that each had a safe and orderly discharge.</p> <p>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur The Interdisciplinary Team (IDT) met 4/11/13 to review the discharge of resident #1. The IDT members were reeducated on the safe and orderly discharge requirements, and the Post Discharge Care Plan form that is developed by the IDT members with the resident and/or responsible party when anticipated discharge date has been set.</p> <p>How the nursing home plans to monitor its performance to make sure that solutions are sustained The Executive Director will verify with the IDT members that the Post Discharge Care Plan has been reviewed with the resident and/or responsible party and it meets the</p>	

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F 204	<p>Continued From page 2</p> <p>agreement with the plan. On 2/26/13, it was noted the resident's wife was informed of the discharge plan for the resident to live with his son and she agreed because she felt she was no longer able to care for the resident. The resident's son was to call back and confirm the discharge date with the Social Worker.</p> <p>Per record review, the next Social Services note that pertained to discharge was on [REDACTED]/13 "resident discharged to home yesterday at 11:00 a.m. Resident returned to his wife...Resident's daughter-in-law was informed by phone."</p> <p>During an interview on 4/26/13 at 11:30 a.m., a collateral contact reported the resident's daughter-in-law stated she was not contacted by the facility when the resident was discharged. The daughter-in-law reported she did not have contact with him or the staff while he was in the facility. The Home and Community Services (HCS) case manager was also interviewed and reported the resident was on their case load but they had not been notified by the facility when the resident was discharged.</p> <p>During an interview on 4/11/13 at 2:15 p.m., Staff #A stated the resident was first going to be cared for by his son and daughter-in-law in his hometown and then he was supposed to be cared for by another son in Utah but they "both fell thru." Staff #A confirmed she didn't contact HCS because she wasn't aware the resident had Department of Social and Health (DSHS) services. She stated the resident was taken home by the facility van, dropped off at his house with his wife.</p> <p>On 4/11/13 at 2:50 p.m., Staff #C stated the resident was sent home with a list of his medications including new medications for [REDACTED] and [REDACTED] and that list of medications</p>	F 204	<p>Continued from page 2.</p> <p>requirements for a safe and orderly discharge.</p> <p>The title of the person(s) responsible to ensure correction Executive Director</p>	5/13/13

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F 204	<p>Continued From page 3</p> <p>was faxed to a local pharmacy. She stated the facility reviewed the medications with the resident and gave him a copy of that list. When asked if they provided any education or assessment as to whether the resident had understanding of the medication she stated, "no."</p> <p>During an interview on 4/26/13 at 12:45 p.m., the resident's wife stated the facility had contacted her to ask if it was alright for the resident to be discharged to her home and she agreed. She stated the facility did not review the resident's medication list and no discharge planning had been done between her and the facility. The resident's medications did not arrive because the facility did not coordinate which pharmacy to use and the information went to the wrong pharmacy.</p> <p>The facility failed to provide a safe and orderly discharge for the resident. The resident's care giver was not a participant in the discharge planning and the resident was not capable of fully understanding his discharge instructions. This placed him at risk for an unsafe discharge.</p>	F 204			