



AGING AND DISABILITY SERVICES ADMINISTRATION
Nursing Home Survey Report
STATE AND CORRESPONDING FEDERAL REQUIREMENTS

1. Page 1 of 1 Pages
 2. DATES OF DATA COLLECTION
5/10/16
 5. TIME OF SURVEY Day Night
 Weekend Holiday
 7. LICENSE NUMBER
1240

3. NAME OF FACILITY
Whitman Health & Rehab Center
 4. TYPE OF SURVEY
 Full Post Complaint Other: specify _____

6. STREET ADDRESS
1150 West Fairview Road
 CITY STATE ZIP CODE
Colfax Washington 99111

NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.

8. <input type="checkbox"/> The requirements of the following WAC's and corresponding CFR's were not met. The text of the statements of deficiencies and the licensee's plan of correction may be read on CMS form 2567, dated: <u>4/8/16</u> . <input checked="" type="checkbox"/> The following deficiencies were determined to be corrected. 14. **Licensee must complete column	9. WASHINGTON ADMINISTRATIVE CODES 388-97	10. CODE OF FEDERAL REGULATION 42 CFR 483.	11. FEDERAL DATA TAG NUMBER	12. REPEAT DEFICIENCY FROM SURVEY DATED	13. NEW CITATION ON POST SURVEY	14. LICENSEE'S PLANNED DATE OF CORRECTION
		-0640(2)(b)	.13(c)(1)(iii)&(2)&(4)	F226	8/25/15	<input type="checkbox"/>
	-1680(2)(b)(i)	.75(e)(8)	F497		<input type="checkbox"/>	
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15. SURVEYOR'S SIGNATURE(S)

SIGNATURE <i>Patricia Zimmerman, MEd</i>	DATE <u>5/10/16</u>	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

16. LICENSEE OR AGENT

SIGNATURE OF LICENSEE (OR AGENT)	TITLE	DATE
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/20/2016
FORM APPROVED
OMB NO. 0938-0391

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 04/08/2016
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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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(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
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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 Rehabilitation Center on April 1, 2016 and April 8, 2016. A sample of 8 residents was selected from a census of 43 residents. The sample included 8 current residents.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#3197169 #3198396 #3190109</p> <p>The survey was conducted by: Patti Zimmer, R.N.</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services, Region 1 - South 3611 River Road, Suite 200 Yakima, Washington 98902</p> <p>Telephone (509) 225-2800 Fax: (509) 574-5597</p> <p><i>Cindy Colwell</i> 4/28/16 Residential Care Services Date</p>	F 000	<p>Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of interest against the facility or the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and 19 programs. The submission of the Plan of Correction within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. This Plan of Correction is submitted as the facility's credible allegation of compliance.</p>	
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DSHS ADSA RCS
SPOKANE WA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE ADMINISTRATOR	(X6) DATE 4/28/16
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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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NAME OF PROVIDER OR SUPPLIER WHITMAN HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1150 WEST FAIRVIEW ROAD COLFAX, WA 99111		
(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 record review and interviews, the facility failed to implement their policy/procedures for timely reporting allegations of verbal abuse, to the state survey and certification agency, and facility administration, for 4 of 8 sampled residents reviewed for incidents (1,2,3,4). This failure placed residents at risk for continued abuse, and delays in investigations. Findings include:</p> <p>Review of the facility policy and procedure entitled Event Reporting and Investigation, updated on February 2007, directed staff to immediately report any allegations of abuse to both the Administrator, and the state survey and certification agency (via the reporting hotline). The facility policy also documented staff were to follow state regulations related to mandatory reporting, which says if there is reasonable cause to believe abuse of a resident has occurred, staff will immediately report to the state survey and certification agency.</p> <p>Review of a facility investigation report revealed on 03/10/16, a written statement by Staff F, Physical Therapist (PT), was brought to the attention of administrative staff. On that morning, Staff F was assisting Resident #1 in a transfer.</p>	F 226	<p>F226 §483.13(c) DEVELOP/IMPLEMENT ABUSE/NEGLECT, ECT POLICIES</p> <p>Facility will ensure implementation of facility policy and procedures for timely reporting allegations of verbal abuse by continuing re-education on facility policy and procedure for reporting suspected abuse. Corrective action for involved staff members include; termination of staff A, and staff members B,C,D and G were disciplined for not reporting timely and re-educated on facility policy and procedure for reporting allegations of abuse. Residents 1,2,3 and 4 were placed on alert charting and MD notified.</p> <p>Audit and interviews completed for residents and staff to identify potential abuse, no additional allegations found.</p> <p>Re-education has been done and will be addressed again in the upcoming all-staff meeting.</p> <p>Facility will include this citation and Plan of Correction as part of the Quality Assurance Performance Improvement (QAPI) agenda to review monthly at a minimum of 3.</p>	X 5/6/16	

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F 226	<p>Continued From page 2</p> <p>There was some hesitation in the resident performing a routine transfer, which they had been working on for several days previously. Staff D, Nursing Assistant (NA), who was assisting with the transfer, told the resident the transfer would not to be like "yesterday." Per the investigation, Staff D then informed Staff F that the day before (03/09/16), Staff A (NA) had yelled at the resident.</p> <p>When Staff D was interviewed by administrative staff on 03/10/16, she said she had observed Staff A yell and scream at the resident the day before (03/09/16), during a transfer. She told him "you don't sit until I tell you to sit...she was yelling loud, it was harsh and demeaning." After the resident was positioned in bed he apologized to Staff A, who then stated to him, "No you're not (sorry)...You don't care, you did this on purpose. You tried to hurt my back." Staff D also said many staff were scared of Staff A. "She won't help you, or do her part if she is mad at you. You will be on your own to take care of everyone." Staff D also referenced other incidents involving Staff A, using "scare tactics" with residents.</p> <p>Further review of the facility investigation revealed a written statement, dated 03/11/16, by Staff B (NA), which indicated she observed Staff A taking Resident #2 off the toilet. She became frustrated with the resident, and said to her, "you need to stand up, you're hurting my back." When the resident voiced she could not stand, Staff A kept insisting she could, over and over. She "came off as harsh and demeaning." Staff B stated Staff A also yelled at Resident #3 during cares and transfers.</p> <p>Review of a written statement by Staff G (NA),</p>	F 226	<p>The first review will be during the next scheduled QAPI meeting.</p> <p>Corrective action will be completed by May 6, 2016.</p> <p>The Administrator or designee will ensure correction.</p>	5/6/16

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F 226	Continued From page 3 dated 03/10/16, revealed on a few occasions, she had witnessed Staff A raise her voice, and change her tone during care. On one occasion they were in the room of Resident #4, and he was being combative. Staff A raised her voice, told the resident to stop and "knock it off." The resident was not able to understand or communicate. Staff G also expressed a concern that if Staff A knew a statement had been written about her, she would "treat me different in the work field." The investigation report noted Staff C (NA), had seen Staff Member A yell at Resident #2, when trying to stand her up. Her tone of voice was demanding and she was yelling (the resident was able to hear without difficulty). She stated it had also happened to Resident #3. Interviews conducted on 04/08/16 with Staff D at 12:50 p.m., Staff B at 1:15 p.m., and Staff C at 1:30 p.m., revealed Staff A had displayed demeaning, loud behavior towards residents for several years. They stated the incidents were not reported, due to fear of retaliation by Staff A. Despite facility policy directing staff to report alleged incidents of verbal abuse immediately to administration and the state survey and certification agency, there was no evidence they reported until they were interviewed, as part of an investigation conducted by administrative staff on 3/10/16, relative to Resident #1.	F 226		5/6/16
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12	F 497	F497 §483.75(e)(8) NURSE AIDE PERFORM REVIEW- 12 HR/YR INSERVICE	5/6/16

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F 497	<p>Continued From page 4</p> <p>months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure completion of the required performance reviews for 4 of 4 Nursing Assistants (Staff A,B,C,D). Failure to complete annual performance evaluations disallowed an opportunity to address areas of weakness, and/or to provide education to address deficiencies. Findings include:</p> <p>Staff A. Review of Staff A's personnel file noted she was hired as a Nursing Assistant (NA) on 12/01/08. There was no evidence a performance evaluation had been done since her date of hire (over seven years ago).</p> <p>Staff B. Review of Staff B's personnel file noted she was hired as a NA on 03/17/12. There was no evidence a performance evaluation had been done since her date of hire (over four years ago).</p> <p>Staff C: Review of Staff C's personnel file noted she was hired as a NA on 03/17/09. There was no evidence a performance evaluation had been</p>	F 497	<p>Facility will ensure annual performance reviews to be completed for nurse aides employed 12 months or longer.</p> <p>Audit completed to identify nurse aides employed 12 months or longer.</p> <p>The facility will complete annual performance evaluations for nurse aides identified by May 6, 2016 and then annually from the date of hire.</p> <p>Facility will include this citation and Plan of Correction as part of the Quality Assurance Performance Improvement (QAPI) agenda to review monthly at a minimum of 3.</p> <p>The first review will be during the next scheduled QAPI meeting.</p> <p>Corrective will be completed by May 6, 2016.</p> <p>The Director of Nursing or designee will ensure correction.</p>	5/6/16
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F 497	Continued From page 5 done since her date of hire (over 7 years ago). Staff D. Review of Staff D's personnel file noted she was hired as a NA on 07/20/04. There was no evidence a performance evaluation had been done since 08/2007 (over eight years ago). An interview on 04/08/16 at 3:30 p.m. with Staff E, Administrator, revealed he had no knowledge performance evaluations had not been conducted on NAs as required. The Administrator started employment with the facility on 02/11/16.	F 497		5/6/16	



AGING AND DISABILITY SERVICES ADMINISTRATION
Nursing Home Survey Report
 STATE AND CORRESPONDING FEDERAL REQUIREMENTS

1. Page <u>1</u> of <u>1</u> Pages
2. DATES OF DATA COLLECTION 4/1/16, 4/8/16
5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Holiday
7. LICENSE NUMBER 1240

3. NAME OF FACILITY Whitman Health & Rehab Center	4. TYPE OF SURVEY <input type="checkbox"/> Full <input type="checkbox"/> Post <input checked="" type="checkbox"/> Complaint <input type="checkbox"/> Other: specify _____
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6. STREET ADDRESS 1150 West Fairview Road	CITY Colfax	STATE Washington	ZIP CODE 99111
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NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.

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 MAY 02 2016
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 SPOKANE WA

15. SURVEYOR'S SIGNATURE(S)			
SIGNATURE <i>Patricia Ginner</i>	DATE 4/15/16	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

16. LICENSEE OR AGENT		
SIGNATURE OF LICENSEE (OR AGENT) <i>[Signature]</i>	TITLE ADMINISTRATOR	DATE 4/28/16