

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

PRINTED: 04/16/2013
FORM APPROVED
OMB NO. 0938-0391

1241

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505372	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/12/2013	
NAME OF PROVIDER OR SUPPLIER CANYON LAKES RESTORATIVE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2702 SOUTH ELY KENNEWICK, WA 99337		
(X4) ID PREFIX TAG F 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS This report is the result of an unannounced Abbreviated Survey conducted at Canyon Lakes Restorative and Rehabilitation Center on 4/12/13. A sample of 3 residents was selected from a census of 51. The sample included 3 current residents. The following were complaints investigated as part of this survey: #2782085 The survey was conducted by: [REDACTED] R.N. The survey team was from: Department of Social & Health Services Aging & Long-Term Support Administration Division of Residential Care Services, District 1, Unit C 3611 River Road, Suite 200 Yakima, WA 98902 Telephone: (509) 225-2800 Fax: (509) 574-5597 <i>Colleen [Signature]</i> 4/16/13 Residential Care Services Date F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4) SS=D INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	ID PREFIX TAG F 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Received Yakima RCG MAY 3 2013	(X5) COMPLETION DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Christa [Signature]* TITLE Administrator (X6) DATE 5/3/13

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 225	<p>Continued From page 1</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 225	<p>It is the policy of this facility to investigate any incident or allegation of possible neglect.</p> <p>This particular incident had been verbally shared with DNS by Staff Member A and together they verbally discussed the importance of proper medication administration (including the administration of Nystatin Solution) and documentation. The DNS felt situation had been handled diplomatically without need for further follow up.</p> <p>Review of the March 2013 MARs of Resident #1 did not indicate any medications had been omitted by Staff Member A. The medication in question, Nystatin Swish/Swallow Solution, is to be swished around in the mouth and spit back out, either in a paper cup or back into the cup the solution was administered in; hence, the discovery of a medication cup half full of yellow medication in the garbage can in the room of Resident #1.</p> <p>Medications are administered in this facility according to physician's orders, manufacturer's specifications and per accepted professional standards/principles.</p>	<p>5/14/13 5/27/13</p> <p>BB</p>

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by:
 Based on record review and interview, the facility failed to ensure an incident/allegation of potential neglect involving, 1 of 3 residents reviewed (#1), was thoroughly investigated in accordance with 42 CFR 483.13(c)(3). The neglect allegation pertained to Resident #1 and alleged medication omissions by a licensed nurse (LN). Findings include but were not limited to:

Resident #1: Review of the medical record revealed the resident had multiple diagnoses including a [REDACTED], [REDACTED], and [REDACTED]. The resident [REDACTED].

Review of the March 2013 medication administration record (MAR) revealed the resident was scheduled to receive medications on the evening shift at 5:00 p.m., 6:00 p.m., and at 8:00 p.m. Her evening shift medications were ordered to treat her [REDACTED], [REDACTED], [REDACTED], and [REDACTED] (a [REDACTED] in the [REDACTED]). All the medications were in a pill form except for the [REDACTED] that was a [REDACTED] to be swished around to coat the mouth then spit out (doses at 6:00 p.m and 8:00 p.m.).

According to Staff Member A's nursing entry, dated 3/02/13 at 9:00 p.m., Resident #1's Power of Attorney (POA) was present at the facility and accused Staff Member A of not giving the resident her scheduled medications that evening.

When interviewed on 4/12/13 at approximately 3:40 p.m. about the nursing entry, the Director of Nursing (DNS) stated the family member/POA thought the resident did not receive her

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All licensed staff will be inserviced on medication errors, medication administration and documentation. Medication administration by the licensed staff will be observed by the DNS. The DNS will also keep a daily written diary/log of all conversations or situations that may need further investigation.

The DNS will be responsible for all investigations and follow up on medication administration issues/concerns.

CENTERS FOR MEDICARE & MEDICAL SERVICES

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medications that evening (at 5:00 p.m. and 6:00 p.m.); the DNS thought that medications were given prior to the POA's arrival. The DNS stated she did not complete an investigation pertaining to the POA's allegations related to the omission of the medications.

On 4/12/13 at approximately 4:25 p.m., Staff Member B, a nursing assistant, stated she had been working on the evening shift of 3/02/13. In response to a call light, Staff Member B entered Resident #1's room sometime after 8:00 p.m. and found the resident's family member looking into the garbage can. The family member picked up a medication cup approximately 1/2 full of yellow medication and asked Staff Member B what it was. Staff Member B took the medication cup to the nurse, Staff Member A, to inquire on behalf of the family member. Staff Member A reportedly "grabbed" the medication cup from Staff Member B and threw it in the garbage without an explanation. Staff Member B requested that Staff Member A talk to the family member. According to Staff Member B, another staff member, the resident's assigned caregiver that evening, had left a note for the DNS, about the family member's concerns about the medication.

Despite the family member's allegations of multiple medication omissions throughout the evening shift on 3/02/13 by Staff Member A as well as the findings of the medication cup reportedly containing medication in the garbage, the facility failed to perform a thorough investigation.

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