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

1245

PRINTED: 02/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	505505		C 01/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERETT TRANSITIONAL CARE SERV	916 PACIFIC AVENUE - 6TH FLOOR EVERETT, WA 98201

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F 000	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Survey conducted at Everett Transitional Care Services on 1/14/13 and 1/22/13. A sample of 6 residents was selected from a census of 30. The following were complaints investigated as part of this survey: #2739517 The survey was conducted by: [redacted] RN, MSN The survey team is from: Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, District 2, Unit A 3906 172nd St. NE, Suite 100 Arlington, WA 98223 Telephone: (360) 651-6850 Fax: (360) 651-6940 Residential Care Services 02/05/13 Date	F 000	The Plan of Correction is submitted as required under Federal and State statutes and regulations. 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 this plan does not constitute agreement by the facility that the state surveyor's findings constitute deficiencies, or that the scope and severity determinations regarding the alleged deficiencies were correctly applied. RECEIVED FEB 15 2013 ADSA/RCS Smokey Point	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2-15-13

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 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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. 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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 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.	F 225	F225 The facility will conduct thorough investigations on all falls and hot beverage spills to rule out abuse and neglect. Patients 1,3 and 4 have been discharged. The facility incident report will be filled out completely, with each incident, by the licensed nurse. Patient incident reports form has been revised to include; mental status of patient, if fall was witnessed, and effectiveness of alarm. Licensed nurses will be in-serviced on revised patient incident report form. Random audits will be completed by DNS or designee for completion of investigation report, which will be tracked, trended and reviewed at QAA meeting. DNS to ensure complicance. Completion date is March 15, 2013	

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F 225	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct thorough investigations to rule out abuse/neglect for 3 of 6 residents (1,3,4). Failure to identify incidents, conduct a complete investigation, and develop plans to prevent reoccurrence placed residents at risk for repeated incidents. Findings include but are not limited to: Resident 3 Resident 3 had a fall on 1/9/13. The facility's investigative report form, dated 1/9/13, was not thorough. There was no documentation on the form as to his mental status at the time of the incident, whether the fall was witnessed, what injuries, if any, were sustained, what the plan was at the time, and/or whether there was a need to revise the care plan. Resident 4 Resident 4 had two falls. The investigative report for his first fall on 1/11/13 documented " pt (patient) does remove alarm on himself" and when he was discovered on the floor, his alarm had not sounded, as he removed it. On 1/21/13 the resident fell again. The facility's investigation documented the resident had removed his alarm again and fallen. When interviewed on 1/22/13 at 11:25 a.m., the DNS stated the facility had not evaluated alternatives to the clip alarm for Resident 4 who was known to remove his alarm device.	F 225	See Page 2	

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F 225	Continued From page 3 Resident 1 Resident 1 spilled hot coffee on himself on 1/7/13. Review of the facility's investigative report for Resident 1's coffee spill documented the resident spilled his coffee on his arm and stated the coffee was hot. The report documented the area where the coffee spilled was " slight pink" in color. There was no documented evidence the facility had evaluated the hazards a hot beverage spill may pose for Resident 1. There was no documented evidence that any measures were put in place to avoid any further spills. On 1/22/13 at 1:45 pm, the Director of Nursing Services stated the investigation report was primarily for record keeping purposes.	F 225	See Page 2	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to place an alarm device appropriately according to the care plan or evaluate the use of an alarm for 2 of 4 residents (4,2) and failed to identify the potential hazard a hot beverage spill may pose for one resident (1). Failure to place the alarm appropriately for Resident 2 or evaluate the use of the alarm for	F 323	F323 The facility will continue to ensure that the patients environment remains free of accident hazards as possible and that each patient receives adequate supervision and assistive devices to prevent accidents. Patient 1 and 2 have been discharged. The facility patient incident report form has been revised to include thorough assessment, investigation and appropriate interventions.	

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F 323	Continued From page 4 Resident 4 placed these residents at risk for additional falls. Failure to evaluate whether the temperature of hot beverages was safe for Resident 1 placed him at risk for a possible reoccurrence and posed a possible hazard to other residents. Findings include: Resident 1: Resident 1 was admitted on [redacted]/12 with diagnoses of an[redacted]and a [redacted]. The Minimum Data Set (MDS) assessment, dated 1/3/13 and 1/9/13, indicated the resident required supervision with meals and had periods of inattentiveness. The Critical Assessment Analysis (CAA) dated 1/3/13, documented that he had cognitive deficits and received multiple mood altering medications due to his dementia and agitation. On 1/14/13 at 5:35 p.m., Resident 1 was observed seated in the dining room in his wheelchair. A hot beverage in a cup was observed on his tray. He stated that he had "spilled his coffee on his lap" a few days ago. Review of the facility's investigative report, dated 1/7/13, documented the resident spilled his coffee on his arm and stated the coffee was hot. The report documented the area where the coffee spilled was " slight pink" in color. On 1/22/13 at 11:53 a.m., the coffee carafe (pump) was observed under the hot water dispenser brewing coffee for the noon meal. The Nursing Assistant (NAC J) stated staff made the coffee for the residents and when they served	F 323	Continued from page 4 Random audits will be completed by DNS or designee for completion of investigation report, which will be tracked, trended and reviewed at QAA meeting. DNS to ensure compliance Completion date is March 15, 2013	

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F 323	Continued From page 5 coffee, the coffee was served without lids on the cups. The NAC stated she did not know what the coffee or hot water temperatures were when served to the residents. On 1/22/13 at 12:25 p.m., temperatures of the coffee and hot water were taken with the dietary manager (DM) and Director of Nursing (DNS). The water from the orange hot water dispenser was 178 degrees. The coffee from the carafe that was prepared earlier was at 172 degrees. The DM stated the temperatures of hot beverages were not taken before the beverages were delivered to the residents. On 1/22/13 at 1:45 p.m., the DNS stated she had observed Resident 1's arm after he had spilled his coffee. She was unable to state what interventions were put in place to prevent further incidents of possible hot beverage spills for Resident 1. Resident 2: Resident 2 was admitted to the facility on [redacted]/12 with a history of falls. On 1/14/13 at 3:35 p.m., Resident 2 was observed in his wheelchair self-propelling around the facility. The CAA for falls, dated 12/13/12, identified him to be at risk for falls due to his impaired balance and mobility and his decreased safety awareness. The plan of care for fall prevention was to attach an alarm to Resident 2 when he was in his wheelchair. Review of the facility's investigative reports documented that Resident 2 had 2 falls on 12/15/12 out of his wheelchair. The plan was to have an alarm with a short string attached to the resident when the resident was in his wheelchair	F 323	See Pages 5 and 6	

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F 323	Continued From page 6 to alert the staff should he attempt to self-transfer without assistance or lean forward in his chair. The facility's investigative report, dated 12/15/12 at 6:15 p.m., documented Resident 2 had a fall from his wheelchair. The facility documented that the resident's alarm had not sounded and the cord of the alarm was wrapped around his wheelchair handle. On 1/22/13 at 11:25 a.m., the DNS verified Resident 2's alarm had not been placed correctly according to his plan of care. She verified no additional measures were evaluated to prevent similar occurrences. Resident 4: Resident 4 was admitted to the facility on [redacted]/12 with diagnoses of [redacted] The nursing notes documented he was confused, forgetful and had impaired judgment. The plan of care to prevent falls included the application of a tab alarm, which would alert staff if he attempted to get up without assistance. Resident 4 had two falls. The investigative report for his first fall on 1/11/13 documented " pt (patient) does remove alarm on himself" and when he was discovered on the floor, his alarm had not sounded, as he removed it. The resident's second fall occurred on 1/21/13. The facility's investigative report documented his alarm was not sounding because he had removed it. There was no documented evidence	F 323	See Pages 5 and 6	

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F 323	Continued From page 7 the facility had evaluated the effectiveness of continued use of the alarm when they had knowledge Resident 4 removed his alarm device. When interviewed on 1/22/13 at 11:25 a.m., the DNS stated the facility had not evaluated alternatives to the clip alarm for Resident 4 who was known to remove his alarm device. Please refer to citation written under 483.13(c), F 225-Investigate/Report Allegation/Individuals	F 323	See Pages 5 and 6	