

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

1245
PRINTED: 11/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505505	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2013
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------------------

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

(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 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Everett Transitional Care Services on 10/23/13, 11/1/13 and 11/20/13. A sample of 6 residents was selected from a census of 27. The sample included 3 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>#2887863</p> <p>The survey was conducted by:</p> <p> RN, MSN</p> <p>The survey team is from:</p> <p>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</p> <p>Telephone: (360) 651-6850 Fax: (360) 651-6940</p> <p> <u>11/22/13</u> Residential Care Services Date</p>	F 000	<p>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.</p> <p style="text-align: right;">DEC 06 2013 ADSA/RCS Region 3</p>	
-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 12-6-13
--------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------	-----------------------------

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.

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

PRINTED: 11/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505505	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2013
NAME OF PROVIDER OR SUPPLIER EVERETT TRANSITIONAL CARE SERV			STREET ADDRESS, CITY, STATE, ZIP CODE 916 PACIFIC AVENUE - 6TH FLOOR EVERETT, WA 98201		
(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 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</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>	F 225	<p>F225- Investigate/Report Allegations/Individuals</p> <p>The facility will continue to conduct thorough investigations to rule out abuse/neglect.</p> <p>Resident #3 was discharged from the facility.</p> <p>All bruises will be documented, assessed and investigated to rule out abuse, neglect or mistreatment.</p> <p>All staff will be in-serviced in regards to Mandatory Reporter status.</p> <p>Licensed Nurse staff will be in-serviced in regards to documenting, investigating, and reporting bruises and other injuries of unknown origin.</p> <p>Periodic audits will be done to assure compliance with abuse/neglect reporting.</p> <p>Results of audits will be reviewed in monthly CQI Meeting.</p> <p>DNS to assure compliance.</p> <p>Completion Date 12/27/13</p>		

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

PRINTED: 11/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505505	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2013
NAME OF PROVIDER OR SUPPLIER EVERETT TRANSITIONAL CARE SERV		STREET ADDRESS, CITY, STATE, ZIP CODE 916 PACIFIC AVENUE - 6TH FLOOR EVERETT, WA 98201		
(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 225	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to conduct thorough investigations to rule out abuse/neglect as the cause for facial bruising for 1 of 4 residents (3) . This failure placed the resident at risk for the possible reoccurrence.</p> <p>Findings include:</p> <p>The " Nursing Home Guidelines" for investigation define a substantial injury as an area not generally vulnerable to trauma such as the face. The nursing home must investigate bruising and if they relate that an incident is reasonable connected to circumstances, they need to document how the incident was determined to be "reasonably related" and not an incident of possible abuse.</p> <p>The facility's policy, dated 5/1/09, directed all staff to report allegations of abuse, neglect immediately to appropriate state agencies and that any employee, who is a mandated reporter, does not make a report to the state, or report it to management, including a charge nurse, may be disciplined.</p> <p>RESIDENT 3: Resident 3 was admitted on [redacted]/13. The admit nursing assessment documented he had no skin issues including bruises and had [redacted] on [redacted]/13, [redacted]/13, [redacted]/13 & [redacted]/13.</p> <p>Review of the nursing notes, dated [redacted]/13, documented "new bruise noted L [redacted] by [redacted]</p> <p>On 10/23/13, the Director of Nursing (DNS)</p>	F 225	See Page 2	

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

PRINTED: 11/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505505	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2013
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	-----------------------------------------------------------------

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

(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 225	<p>Continued From page 3</p> <p>verified no investigation was initiated for the [REDACTED] on Resident 3's eye.</p> <p>On 11/1/13 at 12:55 p.m., the DNS stated she "knew how the [REDACTED] happened". There was still no documented evidence an investigation was initiated to rule out abuse or neglect.</p> <p>On 11/20/13 at 6:43 a.m., a staff member (LN T) was interviewed regarding what the facility's policy was regarding allegations of possible abuse or what the procedure would be if she discovered a new [REDACTED] on a resident's face. LN T stated she would document the bruise, and initiate an incident report. She stated the facility has directed her to notify the DNS who will call the State even though she is a mandated reporter.</p> <p>On 11/20/13 at 6:22 a.m., LN K was interviewed regarding allegations of abuse and substantial injuries (i.e. [REDACTED] on [REDACTED]) of unknown origin. She stated that substantial injuries are investigated by the DNS and the DNS determines if an investigation needs to be initiated to rule out abuse or neglect.</p>	F 225	See Page 2	
F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive</p>	F 279	<p>F279 – Develop Comprehensive Care Plans</p> <p>Facility will continue to develop comprehensive care plans on all residents per RAI manual.</p> <p>Resident #4 was discharged from the facility.</p> <p>Each resident will be assessed to ensure that their Care Directives accurately reflect their care needs.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505505	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2013
--------------------------------------------------	-------------------------------------------------------------------------	----------------------------------------------------------------------	---------------------------------------------------------------------

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

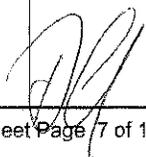
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	----------------------

F 279	<p>Continued From page 4 assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop care plans for 1 of 4 Residents (4). This failure placed the resident at risk for falls and unmet care needs.</p> <p>Findings include:</p> <p>RESIDENT 4: Resident 4 was admitted on [REDACTED]/13 with [REDACTED] diagnoses. The nursing admit assessment form revealed he was at risk for [REDACTED]</p> <p>The Care Area Assessment (CAA) for [REDACTED] dated [REDACTED]/13, documented Resident 4 had a history of [REDACTED] issues, and was on medications that placed him at risk for additional [REDACTED]</p> <p>Review of the clinical record revealed he was [REDACTED], had periods of [REDACTED], had a personal alarm (PA) in place and was known to remove the PA.</p> <p>Review of the facility's investigative report, dated 9/23/13, documented he was "on the floor" and</p>	F 279	<p>Continued from Page 4 F279 – Develop Comprehensive Care Plans</p> <p>Facility fall policy and procedure has been revised.</p> <ul style="list-style-type: none"> • All patients admitted to the facility are assumed to be at risk for falls. • Fall precautions are initiated on admission for all patients. • Care directives for all residents will reflect fall precautions. • Assessment for necessity will take place before any assistive device will be considered for use. <p>All staff will be in-serviced on facility policy in regards to falls.</p> <p>Periodic audits will be done to assure compliance with facility policy.</p> <p>Results of audits will be reviewed in monthly CQI meetings.</p> <p>DNS to assure compliance.</p> <p>Completion Date 12/27/13</p>	
-------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--

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

PRINTED: 11/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505505	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2013
NAME OF PROVIDER OR SUPPLIER EVERETT TRANSITIONAL CARE SERV			STREET ADDRESS, CITY, STATE, ZIP CODE 916 PACIFIC AVENUE - 6TH FLOOR EVERETT, WA 98201		
(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 279	Continued From page 5 the PA would be placed back on the resident. The investigative report indicated the resident complained of [REDACTED] pain after the fall. On [REDACTED]/13 the physician's order read: "[REDACTED]" Review of the Resident 4's Care Directive (POC) revealed there was no documented plan of care to inform staff what interventions were in place to prevent possible [REDACTED]	F 279	See page 4		
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 observations, interview, record review, the facility failed to assess and evaluate the need for assistive devices (siderails or personal alarms) for 3 of 4 residents (1, 2, 3). This failure placed the residents' safety at risk. Finding include: The facility's goal for "Personal Alarms (PAs) "	F 323	F323 Free of Accidents/Supervision/Devices. Facility will continue to ensure that resident environment remains as free of accidental hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Residents #1, 2 & 3 were discharged from the facility. Each resident with side rails and/or a personal alarm in use will be assessed and Care Directives updated.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505505	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2013
NAME OF PROVIDER OR SUPPLIER EVERETT TRANSITIONAL CARE SERV		STREET ADDRESS, CITY, STATE, ZIP CODE 916 PACIFIC AVENUE - 6TH FLOOR EVERETT, WA 98201		
(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 323	<p>Continued From page 6</p> <p>was to "utilize PA for emergent medically necessary situations only, for the shortest possible period of time". The procedure before a PA was to be considered, was to assess the resident for unmet needs (i.e. pain), and the decision to place PA must be made by IDT (interdisciplinary team). The reason for implementation must be clearly documented and noted on the Care Plan. The Policy stated the "poor safety awareness alone is not a justification to use a PA and if patient declines to use an alarm or continually removes it indicating they do not want it, the alarm "CANNOT" be used.</p> <p>RESIDENT 1 Resident 1 was admitted to the facility on [REDACTED]/13 with diagnoses of [REDACTED] with [REDACTED]. The CAA (Care Area Assessment), dated 10/1/13, documented she was unable to communicate her needs or understand others, had [REDACTED] decreased [REDACTED] awareness, decreased [REDACTED] and required a 2 person assist with [REDACTED] due to [REDACTED].</p> <p>The facility's consent form for use of both siderails and a safety alarm, dated 9/25/13, indicated the resident used half side rails to assist with bed positioning and for bed control use and the personal alarm was to remind her to call for assistance and allow staff to know when she needed help.</p> <p>There was no documented evidence the facility assessed the Resident's need for use of side rails or a personal alarm prior to the facility obtaining the resident/family member's signature on the consent form for the use of these devices.</p> <p>On 10/23/13, at 10:05 a.m., Resident 1 was</p>	F 323	<p>Continued from page 6</p> <p>F323 – Free of Accidents/Supervision/Devices</p> <p>Facility has new policy on Personal Alarms. An assessment has been added that must be completed prior to implementing a personal alarm. Assistive device assessment will continue to be done on PT/OT & initial evaluation. Nursing admission assessment has been revised to include cognitive, communication and medication component of assistive device assessment.</p> <p>All Licensed Nurses and Therapy staff have been in-serviced on new policy and assessment requirements for personal alarms.</p> <p>Periodic audits will be done to assure compliance with PA policy and procedure.</p> <p>Audit results will be reviewed during monthly CQI meetings.</p> <p>DNS to assure compliance.</p> <p>Completion Date 12/27/2013</p> 	

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

PRINTED: 11/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505505	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2013
NAME OF PROVIDER OR SUPPLIER EVERETT TRANSITIONAL CARE SERV			STREET ADDRESS, CITY, STATE, ZIP CODE 916 PACIFIC AVENUE - 6TH FLOOR EVERETT, WA 98201		
(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 323	<p>Continued From page 7</p> <p>observed seated in her wheelchair in the nursing station. The resident did not speak [REDACTED] and staff members were observed to cue her to eat her meal. Multiple attempts to observe the resident while in bed were unsuccessful.</p> <p>On 10/23/13, Resident 1's bed had siderails in the elevated position on both sides. The right side of her bed had a siderail with vertical bars and the left side of her bed had a J shaped siderail. The bed control was a separate box device which was on her bed and was not attached to the bedrail.</p> <p>Review of clinical records revealed there was no documented evidence regarding assessment for siderail use or for personal alarm attachment.</p> <p>Review of the Occupational therapy notes from [REDACTED] to [REDACTED]/13, revealed the resident required 2 person maximum assistance for toileting, was unable to sustain trunk control, and required maximum assistance of hand guidance to help her get out of bed due to decreased attention and decreased truck control. An entry for 10/8/13 documented Resident 1 remained unsafe with sitting/standing/ and balance.</p> <p>On 10/23/13 at 12:25 p.m., during an interview with the skilled therapist (OT M), she stated Resident 1 required "guiding her hand to know where the siderails were, her sensory awareness was off and she was not orientated to her surroundings. The OT stated the resident required cueing to use her siderails and did not independently use the rails for mobility. The OT stated Resident 1 was noted to put her "legs over the rails".</p> <p>On 10/23/13 at 11:40 a.m., when the Director of</p>	F 323	See Page 6		

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

PRINTED: 11/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505505	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2013
NAME OF PROVIDER OR SUPPLIER EVERETT TRANSITIONAL CARE SERV			STREET ADDRESS, CITY, STATE, ZIP CODE 916 PACIFIC AVENUE - 6TH FLOOR EVERETT, WA 98201		
(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 323	<p>Continued From page 8</p> <p>Nursing (DNS) was asked about the facility's process for personal alarm or siderail assessment, she stated " I dont think we do" have a process to follow.</p> <p>Review of the nursing progress notes from 9/28/13 to 10/23 documented Resident 1 required 1 person assist with bed mobility, was agitated, confused, attempted to get out of bed and was able to remove her personal alarm.</p> <p>The OT and DNS verified the resident was unable to use the bed control to put head of bed up or down or use her siderails to pull herself over and up in bed.</p> <p>Review of the facility's investigative report, dated 10/15/13, documented Resident 1 had a fall when she "slid off bed, trying to use BSC (bedside commode)". The report documented the type of restraint/safety device at the time of the fall included "siderails and PA (personal alarm). The report did not document whether the siderails were up or down when she "slid" off her bed.</p> <p>There was no documented evidence the facility had considered whether the bedrails posed a safety hazard for Resident 1 who was known to require cueing for bedmobility and attempted self-transfers and removed her personal alarm.</p> <p>On 10/23/13 at 4:30 p.m., the DNS and Assistant Director of Nursing verified the facility had no formal assessment for assistive devices such as siderails or alarms. They stated the facility had only initiated a form, "Assistive Devices Assessment", 2 days ago. Prior to that they had only been discussing devices in morning meetings and had not documented either the</p>	F 323	See Page 6		

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

PRINTED: 11/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505505	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2013
NAME OF PROVIDER OR SUPPLIER EVERETT TRANSITIONAL CARE SERV			STREET ADDRESS, CITY, STATE, ZIP CODE 916 PACIFIC AVENUE - 6TH FLOOR EVERETT, WA 98201		
(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 323	<p>Continued From page 9 assessment or the risks and/or benefits of SR use for each resident.</p> <p>There was no documented evidence the justification for the use of a PA for Resident 1 had been evaluated by the IDT.</p> <p>During an interview on 11/20/13 at 6:03 a.m., the Nursing Assistant (NA M) stated the resident was extensive assist of two with her care and staff needed to pull her up in bed. NA M stated during the night, Resident 1's siderails remained in the up position.</p> <p>During an interview on 11/20/13 at 6:07 a.m., with NA H, she stated Resident 1 would "crawl out of bed, that was the reason her bed remained in a low position. She verified the resident's half siderails on her bed remained in the up position all the time during the night. NA H stated Resident 1 was forgetful and had periods of agitation.</p> <p>On 11/20/13 at 6:15 a.m., the Licensed Nurse (LN J) was interviewed regarding Resident 1's mobility and how she used her siderails when she was in bed. LN J stated Resident 1 was restless and tried to roll out of bed. Her bedrails remained in the up position when she was in bed and she was unable to independently reposition herself in bed. She stated she had observed the resident move her legs a lot when in bed and would hang her left leg out of the bed.</p> <p>On 11/20/13 at 6:43 a.m., LN T verified Resident 1's siderails were in the up position when in bed and she was unable to use them to reposition herself.</p> <p>RESIDENT 3</p>	F 323	See Page 6		

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

PRINTED: 11/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505505	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/20/2013
NAME OF PROVIDER OR SUPPLIER EVERETT TRANSITIONAL CARE SERV		STREET ADDRESS, CITY, STATE, ZIP CODE 916 PACIFIC AVENUE - 6TH FLOOR EVERETT, WA 98201		
(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)	
F 323	<p>Continued From page 10.</p> <p>Resident 3 was admitted on [redacted]/13 with diagnosis of [redacted]. His medications included [redacted] medications, a [redacted] and [redacted] medications. The admit form for consent for Use of Siderails and safety alarm, dated 8/8/13, had documented he had two different siderails on his bed, 1/2 rails and fulls rails for safety and a personal alarm to remind him to call for assistance and allow staff to know when he required assistance.</p> <p>Review of the nursing assessment revealed Resident 3 was not a fall risk even though he was receiving medications ([redacted]) which placed him at risk for falls. On 11/1/13 at 11:23 a.m. the DNS verified that the fall assessment was incomplete and the personal alarm was placed on admit due to his diagnosis of [redacted]. It would alert staff if he tried to use the bathroom in the middle of the night.</p> <p>The CAA, dated 8/13/13, documented Resident 3 had impaired balance, impaired trunk balance and he was "alert and aware, has not been noted to be attempting any self transfers".</p> <p>The nursing notes documented he was able to make his needs known and required two person extensive assist for bed mobility and transfers during August 2013.</p> <p>On 10/23/13 at 4:30 p.m., during an interview with the DNS, she stated Resident 3 was not aware of his limitations, lacked insight due to [redacted] and was not safe, so the personal alarm was "put on".</p> <p>Interview on 11/1/13 at 11:45 a.m. with skilled therapy (PT R) stated Resident 3 was alert but due to his multiple [redacted] he had limited ability</p>	F 323	See Page 6	

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

PRINTED: 11/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505505	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2013
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	---------------------------------------------------

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

(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 323	<p>Continued From page 11</p> <p>on his r [REDACTED] and could be impulsive.</p> <p>The facility was unable to provide documented evidence that an assessment was completed for the use of siderails or the personal alarm.</p> <p>Review of an investigative reports, dated 8/21/13, revealed the resident had a fall when attempting to transfer to bed. The report revealed his alarm sounded. The reason his alarm was in place was "he's not safe to stand/transfer at this time".</p> <p>There was no documented evidence the facility evaluated the need for the alarm which had not prevented his fall on 8/21/13 or how the device affected his well-being.</p> <p>RESIDENT 2: Resident 2 was admitted on [REDACTED]/13 with diagnoses of [REDACTED] and [REDACTED]. The Nursing assessment, dated 10/4/13, documented she was alert, had appropriate behavior and her speech was clear. According to the initial fall risk assessment, she was able to communicate clearly and followed directions.</p> <p>The nursing progress notes from 10/4/13 to 10/5/13 documented the resident got [REDACTED] and [REDACTED], and had been forgetful and impulsive.</p> <p>The facility's consent form for use of siderails and safety alarms, dated 10/4/13, indicated Resident 2 had half siderails to assist her with bed mobility. Personal alarm use was not checked off as being used on admission to the facility.</p> <p>Review of the facility's investigative report, dated</p>	F 323	See Page 6	
-------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	------------	--

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

PRINTED: 11/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505505	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/20/2013
--------------------------------------------------	------------------------------------------------------------------	----------------------------------------------------------------------	---------------------------------------------------

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

(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 323	<p>Continued From page 12</p> <p>10/5/13, revealed the resident had eloped from the facility and was discovered outside of the facility in her wheelchair. The report indicated the staff would perform 15 minute checks and that a personal alarm (PA) was placed to prevent further elopements.</p> <p>Review of the clinical record revealed Resident 2 continued to be confused, agitated and repeatedly set off her PA. There was no documented evidence an initial assessment was done by the IDT (interdisciplinary Team) or an evaluation regarding the justification to continue using the alarm when they identified the resident knew how to remove it.</p> <p>Resident 2 was transferred to another skilled nursing home on [REDACTED] 13. The transfer form documented she was forgetful, wandered, was confused and had a safety alarm on, but the "pt (patient) knows how to remove it".</p> <p>On 10/23/13 at 4:30 p.m., the DNS stated Resident 2's elopement was " a meaningful trip" and verified there was no documented assessment for the use of her PA and no evaluation regarding the effectiveness or what other interventions had been considered when the facility had knowledge she removed the PA.</p> <p>The DNS verified that there was no justification for the use of the alarm as per facility goals and/or informed consent regarding the benefits and risks of the device.</p>	F 323	See Page 6	
-------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	------------	--