

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

PRINTED: 05/23/2014
FORM APPROV
OMB NO. 0938-00

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505347	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ JUN 03 2014 B. WING _____	(X3) DATE SURVEY COMPLETED 05/15/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB CENTER- LAKEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 11411 BRIDGEPORT WAY TACOMA, WA 98499
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Standard Survey conducted onsite at Kindred Health Care Center Lakewood on 5/15/2014. The sample included 8 residents out of a census of 68. The sample included 7 current residents and the records of 1 former resident.</p> <p>The following are complaints investigated as part of this survey:</p> <p>#3006195 #3011843</p> <p>The survey was conducted by: Donna J. DeVore, RN, MSN</p> <p>The surveyor is from: Department of Social and Health Services Aging and Long-Term Support Administration Division of Residential Care Services District 3, Unit B PO Box 45819, MS: N27-24 Olympia, WA 98504-5819</p> <p>Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p><i>Wendy D. Sheehan</i> 5/26/14 Residential Care Services Date</p>	F 000	<p>This plan of correction is the center's credible allegation of compliance.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law.</p> <p style="text-align: center;">RECEIVED JUN 13 2014 DSHS - ADSA RCS - REGION 5</p>	6-19-
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Wendy D. Sheehan</i>	TITLE Administrator	(X6) DATE 6-13-
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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 224 SS=G	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN</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 interview, the facility failed to ensure 1 of 4 residents (Former Resident #1) reviewed for coordination of appointments in the community was free from neglect.</p> <p>Staff E had knowledge that Resident #1's appointment was cancelled and neglected to report the information to oncoming staff.</p> <p>This failure resulted in psychological harm for Resident #1 who suffered emotional distress when she was left in the lobby of the community building for an undetermined amount of time. The failure also potentially placed the resident at risk for an undetected change of medical condition while alone in the lobby.</p> <p>Findings include: Record review revealed Resident #1 admitted to the facility during [REDACTED] 14 with medical diagnoses including [REDACTED] disease. Review of the resident's most recent comprehensive assessment dated 4/4/14</p>	F 224	<ol style="list-style-type: none"> Resident #1 no longer resides in the facility. Staff E is no longer employed by the facility. All residents may need coordination of community appointments and could be affected by omissions in communication. Nursing Staff were educated on coordination of care with respect to community appointments and a new scheduling system. Instruction included an assessment of the resident prior to leaving for an appointment and communication of care needs in a timely manner to meet the needs of the resident. Appointments are now logged into a computerized scheduling system that can be accessed by nursing and social service staff. 	6-19-14
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F 224	<p>Continued From page 2</p> <p>revealed the resident required 1 person assistance for mobility in the wheel chair. Review of a physician order dated 3/29/14 revealed an order for oxygen at 2 liters per minute to maintain oxygen saturation levels above 90%.</p> <p>Telephone interview with hospice staff (G) on 5/14/14 at 11:50 a.m. revealed she called the facility early in the morning on 4/29/14 and spoke with Staff E (RN). She stated she was concerned about the resident making the trip to her appointment because of a recent decline in the resident's terminal illness. Staff E reported the resident had a "bad night" and stated she would not be able to make the appointment. Hospice staff G informed Staff E she would cancel the resident's appointment which she did. Staff E did not inform Staff D (day shift RN) that the appointment was cancelled.</p> <p>During interview on 5/15/14 at 10:15 a.m., Staff D (day shift RN) revealed she received report and Resident #1's appointment packet from Staff E on 4/29/14. Staff E did not report concerns about the resident and did not inform her that hospice was going to cancel the appointment. Staff D stated she assessed the resident and did not note acute change of condition or distress. She informed the resident about the appointment and the resident agreed to go. Staff D administered pain medication prior to transferring the resident to her wheel chair with portable oxygen applied.</p> <p>Review of Resident #1's appointment packet cover sheet revealed information that the resident's family would meet the resident at the clinic. This was confirmed during interview with Staff C (social service) on 5/15/14 at 11:20 a.m. Staff C had made the arrangements with the</p>	F 224	<p>Changes in resident appointment scheduling are made through this system.</p> <p>4. The DNS or designee will monitor this process through the daily (M-F) interdisciplinary process. Problems will be reviewed with the PI committee monthly x 3 months and as needed thereafter.</p> <p>Refer to the plan of correction on page 2 of 7.</p>		

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F 224	<p>Continued From page 3 family.</p> <p>Telephone interview with the resident's legal representative on 5/15/14 at 2:05 p.m. revealed on 4/29/14 she was on her way to meet Resident #1 at the clinic when she was notified by the clinic that the resident's appointment was cancelled. On the way home, she received a call notifying her the resident was at the clinic. She stated when she arrived at the clinic, the resident was upset, confused and in a lot of pain. She stated she did not know how long the resident was in the lobby and was concerned because she did not have the strength to push herself around in the wheel chair to get assistance if she needed it.</p> <p>During telephone interview on 5/20/14 at 2:20 p.m. with Staff H (community office nurse) revealed on 4/29/14, another patient came to their office and reported seeing Resident #1 alone in the lobby. He reported she was upset and crying and appeared to be in pain. Staff H confirmed when she went to the lobby, she observed the resident was crying, upset and in pain. Staff H stated the resident was upset, asking why she was just "dropped off".</p> <p>Review of the facility's investigation of alleged neglect dated 4/30/14 revealed Staff E confirmed he spoke with Staff G (hospice) on 4/29/14 and reported his concerns to her that the resident was weak and in pain during the night. Staff E stated he "did not do anything about it and did not pass on his concerns; the hospice nurse should call back so I did not pass it on".</p> <p>The facility's investigation concluded Staff E was neglectful in not communicating the above information.</p>	F 224	Refer to the plan of correction on page 2 of 7.	
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F 281 SS=G	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure care and services met professional standards related to communication of changes in the status of 1 of 4 residents (Former Resident #1) reviewed for coordination of appointments in the community.</p> <p>Staff E had knowledge that Resident #1's appointment in the community was cancelled and failed to report the information to oncoming staff.</p> <p>This failure resulted in psychological harm for Resident #1 who suffered emotional distress when she was left in the lobby of the community building for an undetermined amount of time. The failure also potentially placed Resident #1 at risk for an undetected change of medical condition while alone in the lobby.</p> <p>Findings include:</p> <p>Washington State Standards of Nursing Conduct or Practice (WAC 246-840-700) (3) (a) - "The registered nurse shall communicate significant changes in the client's status to appropriate members of the health care team. This communication shall take place in a time period consistent with the client's need for care".</p> <p>The "Lippincott Manual of Nursing Practice", ninth edition, described the nursing process as "a</p>	F 281	<ol style="list-style-type: none"> Staff E is no longer employed by the facility. All residents could potentially be affected by omissions in nursing communications. The facility has and will continue to expect that the professional nurses employed will perform at a level that meets the Washington State Standards of Nursing Practice and communicate significant changes in the client's status to appropriate members of the health care team in a timely manner. Licensed nurses were reminded of their responsibility to communicate changes in care and conditions to meet the needs of the resident. The DNS is responsible for the overall coordination of care of the 	6-19
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F 281	<p>Continued From page 5</p> <p>deliberate, problem-solving approach to meeting the health care and nursing needs of patients. Implementation includes coordinating health care needs with other team members".</p> <p>Record review revealed Resident #1 admitted to the facility during [REDACTED] 14 with medical diagnoses including [REDACTED] disease.</p> <p>Review of the resident's most recent comprehensive assessment dated 4/4/14 revealed the resident required 1 person assistance for mobility in the wheel chair. Review of a physician order dated 3/29/14 revealed an order for oxygen at 2 liters per minute to maintain oxygen saturation levels above 90%.</p> <p>Telephone interview with hospice staff (G) on 5/14/14 at 11:50 a.m. revealed she called the facility early in the morning on 4/29/14 and spoke with Staff E (RN). She stated she was concerned about the resident making the trip to her appointment because of a decline in the resident's terminal illness. Staff E reported the resident had a "bad night" and stated she would not be able to make the appointment. Hospice staff (G) informed Staff E she would cancel the resident's appointment which she did. Staff E did not inform Staff D (day shift RN) that the appointment was cancelled.</p> <p>During interview on 5/15/14 at 10:15 a.m., Staff D (day shift RN) revealed she received report and Resident #1's appointment packet from Staff E on 4/29/14. Staff E did not report concerns about the resident and did not inform her that hospice was going to cancel the appointment.</p>	F 281	<p>patients/residents in the facility. The DNS or designee will monitor the nursing department for appropriate use of communication avenues available through the daily (M-F) interdisciplinary process. Problems with this process will be dealt with timely and reported to the PI committee.</p> <p>Refer to the plan of correction on page 5 of 7.</p>	
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F 281	<p>Continued From page 6</p> <p>Telephone interview with the resident's legal representative on 5/15/14 at 2:05 p.m. revealed on 4/29/14 she was notified by the clinic that the resident's appointment was cancelled while on her way to the clinic. She received a call later notifying her the resident was at the clinic. She stated when she arrived at the clinic, the resident was upset, confused and in a lot of pain. She stated she did not know how long the resident was in the lobby and was concerned because she did not have the strength to push herself around in the wheel chair to get assistance if she needed it.</p> <p>During telephone interview on 5/20/14 at 2:20 p.m. with Staff H (community office nurse) revealed on 4/29/14, another patient came to their office and reported seeing Resident #1 alone in the lobby. He reported the resident was upset and crying and appeared to be in pain. Staff H confirmed the resident was crying, upset and in pain. Staff H stated the resident was upset asking why she was just "dropped off."</p> <p>Review of the facility's investigation of the alleged neglect dated 4/30/14 related to the above incident revealed Staff E confirmed he spoke with Staff G (hospice) on 4/29/14 and reported his concerns to her that the resident was weak and in pain during the night. Staff E stated he "did not do anything about it and did not pass on his concerns; the hospice nurse should call back so I did not pass it on".</p> <p>Refer to F224.</p>	F 281	Refer to the plan of correction on page 5 of 7.		