02/27/13 - MFCU/Omb'd/HCS/Comp x 2. [illegible]

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

1265

PRINTED: 02/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505206	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB CTR VANCOUVER	400 EAST 33RD STREET VANCOUVER, WA 98663

(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	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Survey conducted at Kindred Vancouver on 02/21/2013. A sample of 7 residents was selected from a census of 73. The sample included 6 current residents and the record of 1 former and/or discharged resident. The following complaintsvwere investigated: #2756879 #2751849 #2757676 #2757608 #2757694 #2757814 #2757829 The survey was conducted by: [redacted] RN, MS The survey team is from: Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, District 3, Unit D 5411 East Mill Plain Blvd., Suite 203 Vancouver, WA 98661 Telephone: 360-397-9550 Fax: 360-992-7969 [signature] 2/26/13 Residential Care Services Date	F 000	**POC DATE CERTAIN EXTENTED TO 05/28/2013 PER REQUEST OF SCOTT PERLMAN** RECEIVED MAR 11 2013 DSHS/ADSA/RCS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Executive Director (X6) DATE 3/8/2013

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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to notify the legal	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *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 federal and state law.* F157 1. Resident #3 – event report investigated, abuse and neglect ruled out. Guardian aware. 2. All residents have the potential to be affected. 3. Staff Development Coordinator/Designee has in-serviced licensed staff on event procedure with special attention to notifying the appropriate parties after an event occurs. 4. Events are discussed at morning meeting, noting if physician and responsible parties have been notified. RCM/designee will verify. Events for the month will be reviewed at the Performance Improvement Committee Meeting monthly for 3 months, then at least quarterly. Executive Director responsible for overall compliance.	3/15/13

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F 157	Continued From page 2 representative of when a Resident sustained a fall for 1 of 7 residents (# 3). This failure placed the Resident at risk of not receiving timely intervention and placed the legal representative in a position of not being aware of the resident's fall until 1 week later. Findings include: Resident #3 was admitted to the facility on [redacted]2012 with diagnoses to include [redacted] and [redacted]. Because the Resident had a history of [redacted], the court had appointed a guardian. According to the Minimum Data Set (MDS), an assessment instrument, the Resident required assistance with activities of daily living and was able to communicate verbally with staff and other residents. On 02/08/2013 at 04:30 p.m., according to facility logs and medical records, the Resident sustained a witnessed fall from the wheelchair after leaning forward to pick up something from the floor. The Resident was assessed as having received no significant injury. The incident report noted the physician and POA {power of attorney} were notified of the accident at 05:00 p.m. that same day. On 02/21/13 at 05:45 p.m., the Director of Nursing stated "The guardian was not notified of the fall until about a week later when she came in to take the Resident to an appointment. I was out of town, so the accident didn't get investigated. I found the report on the administrator's desk just now." On 02/21/13 at 06:00 p.m., the Administrator	F 157		

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F 157	Continued From page 3 stated "The Resident fell on 02/08. The guardian was not notified of the fall until 02/14 when she came in to take the Resident to a medical appointment and the Resident complained to the guardian of falling. I had the incident report; I assumed since the notification of POA portion of the form was filled out, that the nurse did so. Our staff knew about the incident they didn't follow the correct steps to notify the guardian." Refer to F 225 and F 226	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *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 federal and state law.*	3/15/13
F 225 SS=E	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	F 225	F225 1. Resident #1, 3, 4, 5, & 7 – event was investigated, abuse and neglect ruled out. 2. All residents have the potential to be affected. 3. Staff Development Coordinator/Designee has in-serviced licensed staff on event procedure with special attention to notifying the appropriate parties after an event occurs. 4. The facility has established a tracking system to ensure timely and complete investigations and appropriate reporting requirements are met. The DNS will maintain this system and will report to the Executive Director on compliance. The Executive Director is responsible for ensuring compliance with this standard.	

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F 225	Continued From page 4 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that a thorough investigation was done on 5 of 7 (# 1, 3, 4, 5 & 7) residents regarding falls, injuries of unknown origin, and resident to resident altercation. The lack of a thorough investigation to determine and identify potential causes to prevent further incidents, assist in implementing appropriate interventions and measures placed the residents at risk for possible future abuse, neglect or mistreatment. Findings include: <Resident #1 - Fall with fracture> Resident #1 was admitted to the facility on [redacted]2011 with diagnoses to include [redacted], [redacted] and [redacted] on [redacted] of the [redacted]. According to the Minimum Data Set (MDS), an assessment instrument, dated 12/19/12, the Resident was dependent on staff for all activities of daily living. The Resident was not able to walk, but was able	F 225		

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F 225	Continued From page 5	F 225		
	to feed self when items were within reach. The Resident was alert, but had short term and long term memory problems. The plan of care indicated the resident was to have personal items within reach.			
	According to facility documents, on 02/17/13 at 04:45 p.m., the Resident was found on the floor complaining of pain in the [redacted] and [redacted] The Resident was sent to the hospital where a [redacted] to the [redacted] was identified. The nurse on duty on 02/17 had noted "Dressing change was done at 1530 {03:30 p.m.} and resident was repositioned. Resident pleasant after dressing change, fall matt next to bed. After fall, resident told CNA {nursing assistant} she was trying to get up. The overbed table had a drink and food on it. Resident may have been trying to reach for the food."			
	No further information was available regarding the location of the overbed table at the time of the fall or whether additional staff had seen or attended to the resident between 03:30 p.m. and 04:45 p.m. No additional information was available regarding whether abuse/neglect or mistreatment had been ruled out or whether other residents were affected.			
	On 02/18/13, training was provided to several staff members on "Fall prevention/residents at risk" which included "Personal items are within reach" and "Call lights within reach."			
	On 02/18/13, Resident #1's plan of care was updated to read "Anticipate and meet {the Resident's} needs by providing table within reach			

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F 225	Continued From page 6	F 225		

and items resident needs such as water, and food after providing care."

On 02/12 at 03:45 p.m., the Director of Nursing stated "I think the overbed table was beside the bed. We completed an in-service about what needs to be done as you leave the resident's room. The Resident couldn't' really way what happened. Because of falls in the past, the bed was in low position and fall mats were in place. I don't have any other information."

<Resident #3 - falls with minor injury>
Resident #3 was admitted to the facility on [redacted]2012 with diagnoses to include [redacted] and [redacted]. Because the Resident had a history of [redacted], the court had appointed a guardian. According to the MDS dated 1/21/13, the Resident required assistance with activities of daily living, was able to communicate verbally with staff, but had short term and long term memory problems.

According to facility documents, on 01/26/13 at 04:15 p.m., the Resident sustained a fall from the wheelchair with bruise and abrasion to the right forearm. The incident report reflected : "Just a scrape on right forearm which would probably form into a bruise. No other complains from resident. She feels fine and said 'For being here for so long I should know better to put the brakes on'."

On 02/08/13 at 04:30 p.m., the Resident sustained a non-injury fall from the wheelchair. A statement from the licensed nurse reflected "Resident was in dining room, stated she was trying to open the door and 'kept going'.

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F 225	Continued From page 7	F 225		

No information was found regarding additional investigation in to possible causative factors or whether measures to prevent falls were considered.

<Resident #4 - skin abrasion>
Resident #4 was admitted to the facility on [redacted]/11 with diagnoses to include [redacted], [redacted] and [redacted]. According to the MDS dated 12/05/12, the Resident was dependent on staff for ADL care, but was alert and oriented.

Facility documents dated 02/10/13 show the Resident sustained an abrasion to the right hip area. The charge nurse gave a statement reflecting "Called to bedside to assess 2 inch abrasion to [redacted] area where brief line should be. Stated that in removing brief that the abrasion occurred."

On 02/11/13, an addendum was attached to the incident report that reads: "Open all fasteners before removing brief and apply barrier cream for protectant. Talked to aides and unclasping brief before removing to prevent injury."

No additional information was found regarding investigation into possible causative factors, whether other residents were affected, and whether staff required additional training or disciplinary action.

<Resident #5 - skin tear>
Resident #5 was admitted to the facility on [redacted]/09 with diagnoses to include [redacted] and [redacted]. The Resident had a history of

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F 225	Continued From page 8 fractures. The MDS dated 11/10/12 showed the Resident dependent on staff for several ADLs, and was alert, with short term and long term memory problems. On 01/30/13 at 09:00 p.m., the resident was found to have a 1 centimeter skin tear on the left forearm. The Licensed Nurse wrote in a statement: "Resident states she remembered bumping her arm on something, but didn't know it was bleeding." No other information was found regarding whether staff or other residents were interviewed or if any rough edges were noted in the area of the Resident's recent activity. On 02/01, the plan of care was updated to "Provide resident with geri gloves to protect arms from future skin tears." On 02/21, the Resident was observed to have bruising on the backs of both hands and on the left forearm. The Resident was not wearing geri gloves. <Resident #7 - resident to resident conflict> Resident #7 was admitted to the facility on [redacted]/12 with diagnoses of [redacted] and [redacted]. The MDS reflected the Resident required extensive assistance with ADL care, but was alert and oriented. Facility documents dated 02/18/13 reflect at 01:00 p.m., another resident went into Resident #7's room, closed the door and screamed at the resident that the "TV was too loud". Resident # 7 then yelled in return. Investigation showed	F 225		

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F 225	Continued From page 9 "Resident likes her TV on loud and does not like her door closed. Ear phones resident currently has do not work. Daughter informed and has agreed to buy new head phones and bring them in. Resident put on alert for psychological harm for 72 hours related to verbal altercation. Requested an order for hearing exam." No other information was found regarding whether other residents had been affected or how resident safety would be ensured in the immediate future. Refer to F 226	F 225	*This Plan of Correction is the center's credible allegation of compliance.* *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 federal and state law.*	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement policies related to abuse prevention when they failed to ensure staff in a position to manage decisions regarding abuse/neglect were adequately trained. This failure placed residents at risk of continuing abuse or neglect when nurse managers could not define their role in abuse/neglect prevention. Findings include: According to the facility policy on Abuse	F 226	F226 1. Resident #1 – event was investigated, abuse and neglect ruled out. 2. The DNS/designee, reviewed investigations conducted over the past two months to assure full implementation of the facility's policies was achieved. Counseling and in-servicing was conducted on any noted discrepancies. 3. The staff has been in-serviced on the center's policies & procedures regarding event management with special focus on notifying responsible parties. 4. Events will be reviewed as they occur for investigation and conclusion. Events for the month will be reviewed at the Performance Improvement Committee Meeting monthly for 3 months, then at least quarterly. Executive Director responsible for overall compliance.	3/15/13

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F 226	Continued From page 10 Prevention, dated March 2003, point 5, Investigation: The facility will conduct an investigation of an alleged abuse/neglect or misappropriation of resident property in accordance with State law. The facility will investigate patterns, trends or events that suggest the possible presence of abuse, neglect or misappropriation of property." Point 6 calls for the "Protection of a resident during an investigation. A staff member(s) implicated in an abuse/neglect situation, regardless of discipline, will be immediately rescheduled from any resident contact, interviewed and version of event documented and suspended pending investigation results. Resident #1 was admitted to the facility on [redacted]/2011 with diagnoses to include [redacted] and [redacted] following a[redacted] According to the Minimum Data Set (MDS), an assessment instrument, dated 12/19/12, the Resident was dependent on staff for all activities of daily living. The Resident was not able to walk, but was able to feed self if items were within reach. The Resident was alert, but had short term and long term memory problems. The plan of care indicated the resident was to have personal items within reach. According to facility documents, on 02/17/13 at 04:45 p.m., the Resident was found on the floor complaining of pain in the [redacted] and [redacted] The Resident was sent to the hospital where a fracture to the right leg was identified. The nurse on duty on 02/17 had noted "Dressing change was done at 1530 (03:30 p.m.) and resident was repositioned. Resident pleasant after dressing	F 226		

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change, fall matt next to bed. After fall, resident told CNA (nursing assistant) she was trying to get up. The overbed table had a drink and food on it. Resident may have been trying to reach for the food."

On 02/21/13 at 04:30 p.m., Resident Care Manager A stated "The nurse had just finished cleaning and changing the dressing for the Resident (#1). Because the nurse had just been in there, the table was not within the Resident's reach. The Resident said she was trying to get out of bed. I do believe she was trying to reach something on the table that was out of reach". When asked how she had ruled out neglect during her investigation, RCM A replied: "I don't decide if neglect or abuse occurred, that is up to the state to decide. That is why we call the Hot Line."

At 06:30 p.m., the Director of Nursing stated "We have provided training for all of our staff recently regarding abuse, neglect and reporting."

Refer to F 225