

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

PRINTED: 01/06/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505206	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/23/2014
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB CTR VANCOUVER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 EAST 33RD STREET VANCOUVER, WA 98663	
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Kindred Transitional Care and Rehab - Vancouver on 11/21/2014 and 12/23/2014. A sample of 10 residents was selected from a census of 67. The sample included 7 current residents and the records of 3 former/discharged residents.</p> <p>The following complaints were investigated. #3050068 #3051043 #3051124 #3051751 #3053422 #3055163 #3056994 #3058443</p> <p>The survey was conducted by: Rebecca Christiansen, R.N., M.S. Catherine Litsiba, R.N., B.S.N</p> <p>From Department of Social & Health Services Aging and Long-Term Support Administration/ALISA Division of Residential Care Services P.O. Box 45819 Olympia, WA 98504-5819</p> <p>Telephone: 360-664-8432 Fax: 360-664-8451</p> <p><i>[Signature]</i> Date: 1/16/15 Residential Care Services</p>	F 000	<p>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.</p>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE ADMINISTRATOR (X8) DATE 01-16-2015

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 250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, and record review the facility failed to ensure social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 2 of 6 residents (#'s 1 & 2) when they failed to identify and seek ways to support residents who were possibly interested in a personal relationship. This failure placed the residents at risk for compromised well-being.</p> <p>Findings include:</p> <p>Resident #1 admitted on [REDACTED]. He was assessed as being alert, with some cognitive impairment, but was able to make his needs known. He used a wheel chair for mobility. Resident #1's family member was involved in decision making, but the resident was responsible for self.</p> <p>Resident #2 admitted on [REDACTED]. She was assessed as being alert and able to make her needs known. Resident #2 had a guardian to assist with financial and health care planning. Resident #2 was discharged to an adult family home on [REDACTED].</p> <p>On 11/13/14, another resident reported seeing</p>	F 250	<p>F-250</p> <p>How the nursing home will correct the deficiency as it relates to the resident:</p> <p>Resident #2 has been discharged. Resident #1 was interviewed and assessed. No evidence of psychological harm.</p> <p>How the nursing home will act to protect residents in similar situations:</p> <p>In-service Social Service manager on completion of psychological harm assessments after an event. Interview and document resident's interest for physical contact when they express interest in a relationship. Baseline audit of prior and current event summaries and Angel Care audits completed to evaluate additional need for psychological harm assessments. No additional residents identified.</p> <p>Measures the nursing home will take or the systems it will alter to validate that the problem does not recur.</p>		

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F 250	<p>Continued From page 2</p> <p>Resident #1 taking the hand of Resident #2 and "rub and pat his private parts with her hand" while both were seated in the hallway. The action was reported to the nurse.</p> <p>The facility response was to investigate the incident. Resident #1 was counseled on appropriateness of interaction in the hallway and both residents were re-directed to a private area. The guardian for Resident #2 was notified and felt activity between the two resident was alright as long as private space was provided. Resident #2 was not consulted about her wishes.</p> <p>On 11/14/14, the plan of care for each resident was adjusted to reflect the resident's relationship and called for the residents to have socialization and private time as desired by each resident. No documentation could be found relating to an assessment of either resident's wishes for physical contact prior to the incident, although they had been friendly for at least 2 months. No documentation was found related to the oversight and monitoring of the psychosocial well being of each resident.</p> <p>On 12/23/14, at 1:10 p.m., Licensed Nurse (LN) K stated "I was working on the evening when the incident was reported to me. I noted the residents were not together at that time. I talked to (Resident #1) and he stated they were just holding hands. I am the one who contacted (Resident #2's) guardian. She said it was fine for the residents to have personal contact with privacy. I did not talk to (Resident #2). The two residents (#1 & #2) had become attached about a week after (resident #1) moved in. For the last couple of months, they have been calling each other husband and wife."</p>	F 250	<p>DNS completed Social Service manager in-service on documentation of psychological harm and resident preferences when in a relationship. In-service completed for direct care staff on reporting an incident where potential psychological harm, privacy, dignity and abuse has occurred and to initiate alert charting.</p> <p>How the nursing home plans to monitor its performance to validate that solutions are sustained:</p> <p>Executive Director or designee to monitor events that potentially need psychological harm and or relationship documentation 5 days per week, during clinical rounds. Issues identified will be addressed in a timely manner and reviewed in PI (Performance Improvement) meetings monthly.</p> <p>Dates when corrective action will be completed and the title of the person responsible to validate correction:</p> <p>Executive Director.</p> <p>Date: January 23, 2015.</p>		

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F 250	Continued From page 3 At 1:25 p.m., the Director of Nursing (DNS) stated "The 2 residents had developed a relationship. It's like they were friends. They could frequently be seen hanging out in the hallway and talking." When asked if the residents had been consulted about their preferences regarding the relationship, the DNS stated "She (resident #2) never asked for alone time. They both seemed content with hanging out in the hallway. They both had physical limitations, so I don't think they could manage a physical relationship." At 2:00 p.m., the Social Services Director (SSD) stated "I was not here when the incident happened. I think we talked to the guardian (for resident #2) and she gave permission for the residents to have alone time. (Resident #1) was responsible for himself. The two had called each other husband and wife since shortly after he admitted. They had no contact of a sexual nature before this. They would hold hands in the hallway. I don't think the event actually happened, considering the source (the reporting resident). I am sure both residents were monitored following the event." The SSD was unable to locate any documentation regarding either resident being monitored for psychosocial well-being. It appeared the facility had an awareness for about 2 months that a relationship was developing between a male and a female resident. The facility did not discuss the relationship with either resident or with the guardian until an event of a possible sexual nature was reported. The facility then discussed the issues with Resident #1 and with Resident #2's guardian, but did not ask Resident #2 about	F 250			

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F 250	Continued From page 4 her preferences. Neither resident was monitored for well-being after the reported event.	F 250		
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure 3 residents of 6 (#s 3, 4 & 5) received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with a comprehensive assessment and plan of care. The failure to comprehensively and consistently assess residents for mental health issues when medications were discontinued or changed placed the residents at risk for a decline in mental health and/or quality of life. The failure to complete the assessments required to administer medications placed the residents at risk for receiving unnecessary medications and decline in their health.</p> <p>Findings include:</p> <p>Resident #3 was re-admitted to the facility on [REDACTED]. She had physician orders to include</p>	F 309	<p>F-309</p> <p>How the nursing home will correct the deficiency as it relates to the resident:</p> <p>Consent completed for Resident # 3. Resident # 4 interviewed and assessed for signs/symptoms of anxiety and no signs/symptoms identified. Resident #5 was assessed for signs/symptoms of depression and no signs/symptoms identified. Blood Pressure and Pulse were assessed and were within normal range and not below holding parameters per MD order.</p>	

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F 309	<p>Continued From page 5 ██████████ (antidepressant).</p> <p>Resident #3 had been assessed by the facility as being alert, oriented and able to make her needs known and able to make appropriate decisions.</p> <p>Review of the medical record, indicated the facility administered ██████████ to the resident without providing the resident with the risks and benefits and obtaining consent.</p> <p>Resident #3 was interviewed in her room on 11/21/14 and she had no concerns regarding her care or her medications.</p> <p>On 11/21/14 in an interview with LN K she stated she was unaware there had not been a consent for the ██████████ completed. She agreed the information regarding risks and benefits and the consent to administer was supposed to be completed prior to the medication being administered. She stated she would go and speak to the resident, provide her with the risks and benefits and get the consent to administer the medication.</p> <p>Resident #4 was a long term resident of the facility. He had diagnoses to include anxiety disorder. Review of the medical record indicated the resident had been medicated with ██████████ (to treat anxiety) 1mg two times a day.</p> <p>The Medication Record for October indicated the resident did not receive any ██████████ after 10/19/14 and the medication had been discontinued.</p>	F 309	<p>How the nursing home will act to protect residents in similar situations:</p> <p>In-service Licensed Nurses to complete consent for psychotropic medication when a new medication is started and charting of signs/symptoms when a medication is adjusted or discontinued. In-service Licensed Nurses on documenting Blood Pressure and Pulse on the MAR prior to administering medication per MD order.</p> <p>Measures the nursing home will take or the systems it will alter to validate that the problem does not recur:</p> <p>New admit medication orders and new physician orders will be reviewed 5 times per week during the clinical morning meeting to verify psychotropic consents are completed and signs/symptoms related to new, reduced or discontinued medications are monitored times 72 hours.</p>	
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F 309	<p>Continued From page 6</p> <p>According to Mosby's Nursing Drug Reference, 2003 pages 275-276 [REDACTED] is a benzodiazepine and nurses need to assess for physical signs of withdrawal when the medication was suddenly discontinued.</p> <p>In a review of the medical record, there was no evidence the resident was assessed by staff for increased anxiety or possible withdrawal symptoms related to the sudden stoppage of the [REDACTED]. There was no evidence the resident or his representative were notified when the [REDACTED] was discontinued and what the possible side effects could be.</p> <p>According to the Anti-anxiety flow sheet found in the medical administration book for the Resident during the month of November the resident was being assessed for the medication [REDACTED] and possible side effects of the medication administration.</p> <p>Resident #5 had diagnoses to include high blood pressure and depression. She had physician orders for [REDACTED] 6.25mg two times a day. The order directed the [REDACTED] be held if the blood pressure was less than 110/80 or the pulse less than 60. She also had orders for the anti-depressant [REDACTED] which was ordered on 10/20/14. On 11/11/14 there was an order to discontinue the anti-depressant [REDACTED].</p> <p>In a review of the Medical Record it was noted the assessment of the blood pressure and pulse was not being completed as ordered even though the resident was given the medication. Also there was no evidence the resident was assessed for changes in behavior or change in level of</p>	F 309	<p>How the nursing home plans to monitor its performance to validate that solutions are sustained:</p> <p>DNS or designee to monitor MAR's and documentation of Blood Pressure, Pulse and medication administration, weekly. Any issues will be corrected and identified trends brought up in PI (Performance Improvement) meetings monthly.</p> <p>Dates when corrective action will be completed and the title of the person responsible to validate correction:</p> <p>DNS or designee.</p> <p>Date: January 23, 2015.</p>		

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F 309	Continued From page 7 depression when she had her medications for depression changed. Resident #5 was interviewed on 11/21/14 in her room. She was in no obvious distress and denied concerns with her care or treatment.	F 309			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure Residents were free of significant medication errors for 3 of 6 residents (#s 1, 3 & 4) reviewed for medication administration. This failure to ensure medications were administered as ordered placed residents at risk to not receive benefits of the medication, worsening of their condition and/or receiving medication when they did not meet the parameters for administration. Findings include: Resident #1 had diagnoses to include high blood pressure. He had physician orders for [REDACTED] (blood pressure medication) 12.5mg two times a day. The order directed the medication be held for a systolic blood pressure less than 100 or a heart rate less than 60. In a review of the Medication Record it was noted the assessment for the systolic blood pressure	F 333	F-333 The summary of the citation identified Residents #1, 3, and 4. In the body of the citation Residents #1, 4, and 5 are identified. Residents #1, 4, and 5 are addressed in the Plan of correction. How the nursing home will correct the deficiency as it relates to the resident: Resident #1 Blood Pressure and Pulse were obtained and were within normal range and not below holding parameters per MD order. Resident #4 Licensed Nurse contacted MD office to verify the date [REDACTED] was discontinued and a telephone order was written. Resident #5 Blood Pressure and Pulse were assessed and were within normal range and not below holding parameters per MD order.		

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F 333	<p>Continued From page 8</p> <p>and heart rate were not completed as ordered to determine whether the [REDACTED] needed to be held or not.</p> <p>Resident #4 was a long term resident of the facility. He had diagnoses to include anxiety disorder. Review of the medical record indicated the resident had been medicated with [REDACTED] (to treat anxiety) 1mg two times a day.</p> <p>The physician orders for November 2014 included the order for [REDACTED] 1mg two times a day. According to the Resident's Medication Record the [REDACTED] was discontinued. There was no date written on the Medication Record for November to indicate when the medication had been discontinued. There was no written telephone order to discontinue the medication found in the medical record. The Medication Record for October indicated the resident did not receive any [REDACTED] after 10/19/14 and the medication had been discontinued.</p> <p>In an interview on 11/21/14 with Licensed Nurse (LN) K she did not know why or when the [REDACTED] had been discontinued but would look into it.</p> <p>In an interview on 11/21/14 with LN J she said when doing recaps (replacing previous months medication record with current months medication record) if there was a discrepancy between the medication records, the orders needed to be checked and verified. If an order could not be found the physician needed to be notified for clarification.</p>	F 333	<p>How the nursing home will act to protect residents in similar situations:</p> <p>Licensed Nurses in-serviced on documenting Blood Pressure and Pulse on the MAR prior to administering medication per MD orders. In-service Licensed Nurses to complete telephone order and document the change in medication orders on the MAR by documenting the date of the medication change on the MAR next to the last dose received. In-service Licensed Nurse completing recaps to verify orders when discrepancy is found. A baseline audit was completed to identify other residents at risk and new admit and new telephone orders are reviewed 5 times per week during clinical meeting.</p>		

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F 333	<p>Continued From page 9</p> <p>The Director of Nurses provided to the investigator a fax from the physician on 11/21/14 dated 11/21/14 in which the physician stated the [REDACTED] had been discontinued since 10/20/14. He had no explanation why there was not a physician order for the discontinuation of the [REDACTED] in the medical record except to say the nurse who dealt with the issue in October no longer worked in the facility. There was no explanation as to why the procedure for recaps was not followed.</p> <p>Resident #5 had diagnoses to include high blood pressure. She had physician orders for [REDACTED] 6.25mg two times a day. The order directed the [REDACTED] be held if the blood pressure was less than 110/80 or the pulse less than 60.</p> <p>In a review of the Medical Record it was noted the assessment of the blood pressure and pulse was not being completed as ordered even though the resident was given the medication.</p> <p>In separate interviews with LNs A, L and S on 11/21/14 they stated assessments ordered to determine whether a medication needed to be held or not would be documented on the Medication Record at the time the medication was administered. There was no explanation as to why this was not consistently being done.</p>	F 333	<p>Measures the nursing home will take or the systems it will alter to validate that the problem does not recur:</p> <p>System implemented for shift to shift review of new orders or change in orders by reviewing the order compared to the MAR. During recap of medication orders the Licensed Nurse will verify discontinued medications have the correct date indicating an order change as well as a complete written order from the MD.</p> <p>How the nursing home plans to monitor its performance to validate that solutions are sustained:</p> <p>DNS or designee to monitor 3 times per week times 1 month, then 1 time per month for 2 months. Issues will be corrected and identified trends presented to PI (Performance Improvement) meetings.</p> <p>Dates when corrective action will be completed and the title of the person responsible to validate correction:</p> <p>DNS or designee.</p> <p>Date: January 23, 2015.</p>	