

1283

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505508	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/18/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ROCKWOOD AT HAWTHORNE	STREET ADDRESS, CITY, STATE, ZIP CODE 101 EAST HAWTHORNE ROAD SPOKANE, WA 99218
--	---

(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 was the result of an unannounced Quality Indicator Survey conducted at Rockwood at Hawthorne on 4/15/13, 4/16/13, 4/17/13, and 4/18/13. A sample of 18 residents was selected from a census of 19. The sample included 18 current residents.</p> <p>The survey was conducted by:</p> <p>_____, R.N., B.S.N. _____, B.S.W. _____, R.N., B.S.N.</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging and Long-Term Support Administration (AL TSA) Division of Residential Care Services, District 1, Unit B 316 West Boone Avenue, Suite 170 Spokane, WA 99201-2351</p> <p>Telephone: (509) 323-7300 Fax: (509) 329-3993</p> <p><i>[Signature]</i> Residential Care Services Date</p>	F 000	<p>Please refer to the detailed Plan of Correction written on subsequent pages next to the corresponding F-tag.</p> <p style="text-align: center;">RECEIVED MAY 07 2013 DSHS AL SA RCS SPOKANE WA</p>	
-------	---	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jack Subbental</i>	TITLE <i>Administrator</i>	(X6) DATE <i>05/04/13</i>
--	-----------------------------------	----------------------------------

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: 04/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505508	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/18/2013
NAME OF PROVIDER OR SUPPLIER ROCKWOOD AT HAWTHORNE		STREET ADDRESS, CITY, STATE, ZIP CODE 101 EAST HAWTHORNE ROAD SPOKANE, WA 99218		
(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 164 SS=E	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined the facility failed to keep personal information confidential related to resident council meetings for the past 6 months for 15 residents who attended resident council meetings in a</p>	F 164	<p>The cited resident council minutes were removed from the bulletin board on April 17, 2013 when the survey observation was disclosed. With the intention of protecting potential personal resident information from disclosure, the format of all future resident council minutes will be revised to include the number of residents attending with a separate sheet that will identify the residents by name and code. Only the minutes will be circulated or posted for perusal. Any resident statements recorded in the council meeting will be identified by the resident code to prevent unintended public disclosure of personal observations that might be perceived as confidential personal information.</p> <p>Other regular resident gatherings for which records are kept that may record resident observations will use a comparable format separating the written record from a separate sheet containing the identifier of residents in attendance and a designated code. The identifier sheet will not be posted or circulated publicly.</p>	04/17/13

99

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505508	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/18/2013
NAME OF PROVIDER OR SUPPLIER ROCKWOOD AT HAWTHORNE			STREET ADDRESS, CITY, STATE, ZIP CODE 101 EAST HAWTHORNE ROAD SPOKANE, WA 99218		
(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 164	Continued From page 2. sample of 18. Findings include: On 4/15/13 at 10:30 a.m., the resident council minutes were observed posted in the hall across from the nurse's station. The minutes included a "round robin" question with the residents about whether there was enough staff available to provide care for the residents. There were 8 residents listed with their names and responses to the question. Per review of the resident council minutes for the last several months, there was a "round robin" question for each month. The questions were about pain, having a private place to meet with visitors, getting enough to drink in between meals and choice regarding when to get up in the morning. For each month there were resident's names listed and their response to the question in quotations. In an interview on 4/17/13 at 11:15 a.m., the resident council representative was interviewed regarding the resident council minutes being posted for visitors and other residents. The resident said she was not asked permission for the minutes to be posted or for her responses to questions about the care at the facility to be printed with her name. In an interview on 4/18/13 at 11:00 a.m., Staff #B confirmed the resident council minutes were posted with resident names and responses to questions about care without permission to do so from the residents. The facility failed to ensure residents' privacy and confidentiality were protected when attending resident council and providing information about their care.	F 164	The Social Services Director, who has responsibility for staffing and facilitating meetings such as the resident council and other such resident gatherings that may involve record-keeping will have the responsibility for maintaining compliance with the privacy protection of the written records.	04/19/13	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES	F 242			

gg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505508	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/18/2013
NAME OF PROVIDER OR SUPPLIER ROCKWOOD AT HAWTHORNE			STREET ADDRESS, CITY, STATE, ZIP CODE 101 EAST HAWTHORNE ROAD SPOKANE, WA 99218		
(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 242	Continued From page 3 The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure 1 of 3 residents (#9) were able to make choices about their care in a sample of 18. Findings include: Resident #9 had diagnoses including history of a stroke . Per record review, the resident required extensive assistance with most activities of daily. The resident had some bedtime memory problems and needed reminders and cueing at times. In an interview on 4/16/13 at 11:55 a.m., the resident said she wished she could go to bed at 6:30 p.m., but she was the only one who liked to go to bed that early. The resident said it takes a long time to get to lay down, she likes to lay down at 6:30 p.m., but they don't get me to bed until 8:00 p.m. Per review of the resident's care directive(plan of care posted inside the resident's closet) on 4/17/13, the resident preferred to go to bed at 6:30 p.m. During an observation on 4/17/13, the resident was brought to her room after an activity at 6:50 p.m. The resident sat in her wheelchair and	F 242	The written care plan for resident #9 was updated to better identify resident's preferences for bedtime with additional instructions to staff to "check with me" as to desire to be assisted to bed., and documented appropriately with the nursing staff briefed on the care plan change. The "delivery guide" in the care plans of other residents were reviewed and changed accordingly to address preferences of bedtime in each appropriate to the resident's preferences. Nursing staff were in-serviced as to the changes made in the care plan of resident #9 as well as any others changed related to addressing preferences. The Charge Nurse on each shift is responsible for managing the daily compliance with the care plan preferences of each resident. The Director of Nursing and the RN Nurse Manager will be responsible for monitoring ongoing compliance with care plans and the process of changing care plans as resident preferences change.	04/26/13	

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

PRINTED: 04/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505508	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/18/2013
NAME OF PROVIDER OR SUPPLIER ROCKWOOD AT HAWTHORNE			STREET ADDRESS, CITY, STATE, ZIP CODE 101 EAST HAWTHORNE ROAD SPOKANE, WA 99218		
(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 242	Continued From page 4 started falling asleep. At 7:15 p.m., the resident was observed in her room in her wheelchair visibly tired, falling asleep. In an interview on 4/17/13 at 7:30 p.m., Staff #C was asked how the nursing assistants know when resident's prefer to go to bed. Staff #C said most of the time they just start with whoever didn't get to lay down in the afternoon, and lay them down first. Staff #C said there were no residents who had a particular bed time. Staff #C also stated, Resident #9 would usually come out in the hallway and ask the staff to put her to bed when she was ready. On 4/17/13 at 7:40 p.m., the resident was still in her wheelchair in her room falling asleep. Staff were aware the resident wanted to lay down early and identified it on the resident's care directive. The resident was able to make decisions but had some memory problems and needed cueing and reminders at times. The facility was not proactive in assisting the resident to fulfill her choices.	F 242			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431	The referenced two liquid medication bottles with indistinct labels were promptly replaced by the pharmacy, and as an added precaution, to reduce smudging of labels, are being stored upright in the refrigerator. An audit was performed to be certain that no other medications being administered to residents had indistinct labeling. The Charge Nurses, who are responsible for		04/17/13

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

PRINTED: 04/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505508	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/18/2013
NAME OF PROVIDER OR SUPPLIER ROCKWOOD AT HAWTHORNE			STREET ADDRESS, CITY, STATE, ZIP CODE 101 EAST HAWTHORNE ROAD SPOKANE, WA 99218		
(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 431	<p>Continued From page 5</p> <p>instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to properly label medication for 2 of 2 residents (#7, and 20) in a sample of 20 residents reviewed for medication storage. This failure placed the residents at risk for not receiving prescribed medications in accordance to the five principals of medication administration; the right resident, right route, right drug, right dose, and right time. Findings Include: Accompanied by Staff #A on 4/17/13 the facility medication storage room was inspected. The locked medication refrigerator included liquid medications for residents. One bottle of Ativan (anxiety medication) was observed with no</p>	F 431	<p>dispensing medications, were in-serviced on the responsibility to inspect labeling of all prescriptions for clarity on a routine basis.</p> <p>The Consulting Pharmacist, the Director of Nursing, and the RN Nurse Manager will have primary responsibility for randomly monitoring ongoing accuracy of medication labels and initiating instructions for reordering any prescriptions in which labels are potentially smudged or obliterated.</p>	04/17/13	

99

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

PRINTED: 04/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505508	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/18/2013
NAME OF PROVIDER OR SUPPLIER ROCKWOOD AT HAWTHORNE		STREET ADDRESS, CITY, STATE, ZIP CODE 101 EAST HAWTHORNE ROAD SPOKANE, WA 99218		
(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 431	Continued From page 6 identifying information. A second bottle of Ativan for Resident #20 had a handwritten label only. When asked by surveyor regarding the unlabeled medication, Staff #A identified the first bottle was for Resident #7. Staff #A confirmed that the resident received the medication as needed and scheduled each night. Staff #A then said the new labels would be ordered for both residents. The failure to label medications and dispense medications in accordance to the principals of medication administration placed the residents at risk for receiving unnecessary medication, doses and side effects of improperly prescribed drugs.	F 431		04/17/13