

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

1284

PRINTED: 11/01/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505214	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/16/2013
NAME OF PROVIDER OR SUPPLIER KINDRED NURSING AND REHABILITATION - ARDEN			STREET ADDRESS, CITY, STATE, ZIP CODE 16357 AURORA AVENUE NORTH SEATTLE, WA 98133		
(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 Kindred Nursing And Rehabilitation - Arden on 10/10/2013, 10/11/2013 and 10/16/2013. A sample of 3 current residents were selected for review from a census of 64 current residents.</p> <p>The following complaints were investigated as part of this survey:</p> <p>complaint #2850135</p> <p>The survey was conducted by:</p> <p>██████████, RD, MS</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, Region 2, Unit C 20425 72nd Ave S, Ste 400 Kent, WA 98032</p> <p>Telephone: (253) 234-6000 Fax: (253) 395 5071</p> <p><i>[Signature]</i> 11-1-2013 Residential Care Services Date</p>	F 000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE Executive Director (X6) DATE 12.13.13

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.

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F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that the care plan accurately identified interventions to assist a resident with managing anxiety. This placed the resident at risk for unmet care needs.</p> <p>Findings include: During an interview on 10/10/13 at 9:30 a.m., Resident #1 was observed lying in bed wearing a brief and a shirt. The resident reported she was</p>	F 280	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p> <ol style="list-style-type: none"> As it pertains to the resident: <ul style="list-style-type: none"> Resident #1: Care plan has been reviewed and updated to accurately reflect her needs. As it pertains to residents in similar situations: <ul style="list-style-type: none"> Residents in similar situation's care plans have been reviewed and updated as needed. Preventative Measures: <ul style="list-style-type: none"> Staff has been educated on appropriate care planning procedures related to behaviors. Facility reviewed support services in place for appropriateness. Staff have been educated on non-pharmacological interventions. Ongoing Monitoring: <ul style="list-style-type: none"> Residents with anxiety issues will be monitored via the Gradual Dose Reduction reviews and clinical progress meeting. Residents with anxiety issues will have their care planned reviewed quarterly with the MDS. Facility will audit the resident's with anxiety issues for accuracy of care planning monthly for 3 months. Then as needed. 	
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F 280

Continued From page 2
"stuck in her room" unless she asked to go somewhere and she reported she was not routinely invited to activities. The resident then stated "I feel like my room is a prison."

During the interview the resident expressed fear of having to be "hospitalized again" and explained she was admitted to a psychiatric treatment unit in the past. During the interview the resident reiterated her fear of having to return to the psychiatric unit on several occasions.

Clinical record review verified the resident had been hospitalized and readmitted to the facility from a psychiatric unit on [REDACTED]/2012. The clinical record documented the resident was followed by a Mental Health provider and received regular visits from a social worker and psychiatrist. The resident's current medication orders included three different classifications of psychotropics including anti depressants, an antipsychotic, and an antianxiety.

Resident #1's last comprehensive assessment, dated 01/09/2013 documented the resident had no behavioral symptoms and /or mood issues. The interview conducted to assess the resident's cognition indicated the resident was alert and oriented. The assessment indicated the resident needed extensive assistance from staff for most activities of daily living, (i.e. dressing, grooming, mobility and locomotion.) No behavioral issues were reported.

Subsequent quarterly assessments, dated 04/04/13, and 06/28/13 documented the resident had no behavioral issues, refusals of care or behavior that disrupted the resident environment. The next quarterly assessment dated 09/25/13,

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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.

presented at the monthly PI Meeting.
• The SSD, DNS & ED will be responsible for ongoing monitoring.

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F 280	<p>Continued From page 3</p> <p>noted the resident was verbally abusive to others (for 1-3 days of the 7 day assessment period,) and documented the behaviors had no impact on the residents care, other residents and did not disrupt the environment.</p> <p>The facility care plan section entitled behavior /mood care plan, indicated the resident had "anxious type behaviors, AEB seeing things that are not there, increased paranoia, feelings of fear, obsessive attachments to staff, and or "ideas" in her head about something, and hx (history) of making false statements."</p> <p>The care plan interventions included the following; "... 2) My behavior has resulted in being moved to a hospital to learn how to behave in ways that will allow me to live in medical facilities without conflict. 3) Arden has accepted me back and it is the only place that accepts me as a resident ... 7) if I argue with or accuse staff or others residents, I will return to my room and stay quietly by myself: ... " A separate paragraph documented the following: " Resident has a habit of using the call light for attention seeking behaviors, staff to remind resident of what call light is for,..."</p> <p>The only technique identified under the intervention section of the care plan noted "suggest breathing exercises when feeling worried, angry, or afraid, and suggestions on relaxing her muscles."</p> <p>On 10/11/13 at 11:00 a.m., the facility Social Worker (SW) was asked why the assessment's did not identify any behavioral symptoms the social worker stated the resident had not</p>	F 280		

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F 280	<p>Continued From page 4</p> <p>displayed any behaviors during the 7 day assessment periods. However review of the of the June behavior monitor noted the resident had displayed behaviors the seven day assessment period, included displaying a sad pained facial expression, and displayed "unreasonable demands' during the week ending 06/28/2013.</p> <p>On 10/11/13 at 9:15 a.m., the Licensed Nurse, Staff A who was assigned to the unit where the resident resided was interviewed about the Resident and her behavior. When asked how she responded to the resident displays of anxiety, she was able to identify non medications, offer the resident fluids, reading materials, sitting with her and conversing with her, were interventions that could be implemented. Although the nurse was able to state some techniques that could be used the care plan did not identify them.</p> <p>On 10/16/2013 at 2:00 pm, the Administrator was interviewed about the resident's care. The Administrator aknowledged the information identified in the care plan directives was not appropriate.</p> <p>Assessment did not accurately describe the resident behaviors, nor did the care plan include the non medication interventions the Nurse was able to state. In additon the care plan noted the resident would be isolated if she "argued" or complained about the staff. Not ensuring the care plan provided guidance to staff to assist with management anxiety and behaviors placed the resident at risk for unmet and unidentified care needs.</p>	F 280		
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