

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505429	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER SHARON CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1509 HARRISON AVENUE CENTRALIA, WA 98531
--	--

(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 Quality Indicator Survey conducted at Sharon Care Center on 07/07/14, 07/08/14, 07/09/14, 07/10/14 and 07/11/14. A sample of 28 residents was selected from a census of 38. The sample included 21 current residents and the records of 7 former and/or discharged residents.</p> <p>The survey was conducted by: Marie Rose, RN, MN Candice Mohar, PhD, RN, MSN Shelly Darnell, BSS Dee Ann Taylor-Rivera, RN, BSN</p> <p>The survey team is from: Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services, District 3, Unit C & D 6639 Capital Boulevard SW P.O. Box 45819 Tumwater, Washington 98504-5819</p> <p>Telephone: 360.664.8420 Fax: 360.664.8451</p> <p><i>Joan Purice</i> 7-18-14 Residential Care Services Date</p>	F 000	<p>The Plan of correction is prepared and submitted as required by law. By submitting this plan of correction does not admit that the deficiencies listed exist nor does the community admit to any statements, findings, facts or conclusions that form the basis of the alleged deficiency. The community reserves the right to challenge in legal proceedings, all deficiencies, statements, findings, facts and conclusions that form the basis for the alleged deficiency.</p> <p>RECEIVED AUG - 1 2014 DSHS/ADSA/RCS</p>	
-------	---	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mark R. Weersingke</i>	TITLE Administrator	(X6) DATE 7-31-2014
--	------------------------	------------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505429	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SHARON CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1509 HARRISON AVENUE CENTRALIA, WA 98531
---	--

(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 282
SS=D

483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, it was determined the facility failed to provide services in accordance with each resident's written plan of care for 2 of 5 current sampled residents (#17 and 119) and 1 former resident (#58) reviewed for care plans. Failure to ensure qualified persons provided services according to assessments and care plans placed residents at risk for injury.

Findings include:
<Resident #17>

Resident #17 was admitted on [REDACTED] with diagnoses including [REDACTED]

The resident's Minimum Data Set, an assessment tool, dated 4/13/14, and the resident's care plan dated 2012 indicated the resident required a two person physical assist for transfers.

According to facility documentation on the "Event Report" sheet, on 6/22/14, a nursing assistant was transferring Resident #17, without help or assistance, from the bed to the wheelchair. The resident's paralyzed foot became caught underneath him and he was guided to the floor by

F 282

F282 – Services provided by the facility must be provided in accordance with each resident's written plan of care

Cited Resident:

Resident #17's care plan format has been revised to indicate his current needs and allow caregivers a better understanding of his needs. Resident #119 has been discharged. Resident #58 expired on [REDACTED]

All residents:

Residents' care plans have been revised to allow for a more condensed care plan that caregivers can follow.

Education/System Change:

All caregivers have been inserviced on reading care plans and following the care plan. All nursing staff have been inserviced on answering call lights and resident's calls for help within a timely manner.

Monitoring:

Care plans will be audited periodically by medical records and other nursing staff for accuracy and ease of reading/understanding by caregivers.

Responsibility:

The DNS or designee will ensure ongoing compliance.

8/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505429	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER SHARON CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 HARRISON AVENUE CENTRALIA, WA 98531		
(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 282	<p>Continued From page 2 the nursing assistant.</p> <p>On 7/9/14 at 12:59 a.m., Nursing Assistant (NA) C and NA D indicated that the resident transfer status was located in the care plan. The care plan information was excessive and NA D stated, "We have to go through a ton of information before you can find it {resident transfer information.} The DNS {Director of Nursing Services} is going to try and get us the information like transfer status and make it easier to locate and so we won't miss it."</p> <p>At 1:06 p.m., NA D stated Resident #17 was always a two person physical assist for transfers. Also, it was difficult for new nursing assistants to know the resident's transfer status. There is not enough time to sort through all the data entries in the care plan and also be expected to answer call lights. NA C interjected, "It's {looking through residents' care plans} a waste of valuable time."</p> <p>Resident #17's care plan had over 64 entries for a two year period, dating from 2012 to 2014.</p> <p>At 1:18 a.m., NA B stated, "It is not easy to access resident information in the care plan. Especially if the resident is brand new, for example, I had a new resident today and I haven't had a chance to go into the profile {tab under which the care plan is located on the computer} yet today. The care plan is not in an organized fashion." NA B stated if transfer information is not in the care plan for new residents then, "You use your gait belt and your good judgment and the grab bars {to transfer residents}."</p> <p>At 1:33 p.m., upon reviewed of Resident #17's care plan, Licensed Nurse (LN) A stated, "I've found there is a lot of stuff in here {Resident #17's</p>	F 282		

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

PRINTED: 07/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505429	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER SHARON CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 HARRISON AVENUE CENTRALIA, WA 98531		
(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 282	<p>Continued From page 3</p> <p>care plan} and LN D {the Previous Director of Nursing Services} said at one time they {the facility} were going to do a reprogramming thing where they {the staff} could get to the information they need, like transfers."</p> <p>At 2:13 p.m., LN D stated, "Care plans are a real cumbersome process. I am working on the system."</p> <p>The failure to implement the written plan of care placed residents at risk of not having their needs met. <Resident #119></p> <p>Resident #119 was admitted on [REDACTED] with diagnoses including [REDACTED]</p> <p>The resident's Minimum Data Set, an assessment tool, dated 6/9/14, indicated the resident had short and long-term memory problems and had severely impaired decision making skills. The resident required a two person physical assist for bed mobility and transferring.</p> <p>Resident #119's care plan, updated on 6/17/14 after a recent fall, indicated to place resident down in bed and provide for rest period after meals as resident allows.</p> <p>On 7/9/14 from 8:40 a.m. to 3:15 p.m., the resident was not placed in bed after breakfast or lunch for rest periods.</p> <p>At 3:25 p.m., Resident #119 looked tired and was slowly propelling her wheelchair in the hall while leaning to one side. When asked about the</p>	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505429	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER SHARON CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 HARRISON AVENUE CENTRALIA, WA 98531		
(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 282	<p>Continued From page 4</p> <p>resident's care plan in regards to rest periods, Nursing Assistant (NA) B stated, "We keep her up in her wheelchair as much as possible." NA B stated, "The care plan is not always updated, it's not a 100 percent, so I go and talk with therapy {physical therapy.}"</p> <p>At 3:45 p.m., NA B stated, "There's not enough time in the day to lie down every resident between meals with other call lights going off. If she {Resident #119} goes by me I ask her if she is tired, she can answer you."</p> <p>At 3:50 p.m., Resident #119 remained in wheelchair in the hall and when asked if she was tired or wanted to go to bed, Resident #119 stated, "Yes" she wanted to go to bed.</p> <p>At 4:24 p.m., interview with Physical Therapy Assistant (PTA) about lying Resident #119 down after meals, PTA stated, "It depends if she is tired. Well I don't know if she would stay in bed."</p> <p>At 4:49 p.m., Licensed Nurse (LN) B stated, "Nursing aides should follow the care plan."</p> <p><Resident #58></p> <p>Former Resident #58 was admitted to the facility on [REDACTED] from the hospital following surgical repair of his left hip. The resident had multiple medical diagnoses including [REDACTED]</p>	F 282		

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

PRINTED: 07/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505429	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER SHARON CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 HARRISON AVENUE CENTRALIA, WA 98531	
(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)
F 282	<p>Continued From page 5</p> <p>The Nursing Note dated 3/11/14 and assessments indicated the resident required the help of two people for transfers due to [REDACTED]</p> <p>The 3/12/14 care plan indicated the resident would remain free of injuries by admitting him to a room across from the East unit nurse's station for closer observation, by keeping the bed in the lowest position and by having the call light within reach at all times.</p> <p>On 3/15/14 at 2:15 a.m., the resident was found by Nursing Assistant (NA) C with his head on the floor and his feet on the bed. According to the NA's documentation, she was working on the West unit and could hear the resident calling out for help from his room. On her way to respond to the resident's calls for help, the NA passed the East unit Licensed Nurse (LN) E, a registered nurse, who was sitting at the nurse's station across from the resident's room and did not respond to the resident's calls.</p> <p>On 7/10/14 at 12:00 p.m., during interview with the Director of Nursing Services regarding the resident's fall, she provided documentation of her discussion with LN E, who was responsible for the resident at the time of his fall, that indicated LN E failed to follow the resident's care plan and did not respond to the resident's calls for help.</p>	F 282	
F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an</p>	F 441	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505429	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SHARON CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1509 HARRISON AVENUE CENTRALIA, WA 98531
---	--

(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 441	<p>Continued From page 6</p> <p>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record</p>	F 441	<p>F441 – Infection control, prevent spread, linens Cited Resident: No resident was cited.</p> <p>All Residents: All laundry rooms and linen storage rooms have been properly cleaned. All linens have been folded without touching contaminated materials.</p> <p>System Review/Education: Staff have been inserviced on wearing disposable gowns if folding linens that would touch their clothing during the process. The laundry room and linen storage rooms are on a scheduled cleaning rotation.</p> <p>Monitoring: The Director of Housekeeping will monitor the areas and staff for compliance.</p> <p>Responsibility: The DNS and Director of Housekeeping will ensure ongoing compliance.</p>	9/18/2014
-------	--	-------	--	-----------

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

PRINTED: 07/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505429	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER SHARON CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 HARRISON AVENUE CENTRALIA, WA 98531		
(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 441	<p>Continued From page 7</p> <p>review, it was determined the facility failed to ensure laundry was processed under sanitary conditions. This failure placed residents at risk for exposure to infectious organisms.</p> <p>Findings include:</p> <p>On 7/9/14 at 10:23 a.m., the top of the two washing machines in the laundry room were covered in dust and debris and two used gloves turned inside out along with a used paper towel half covered in a pinkish dried solution were found behind the washing machines. When asked how often the top and the area behind the two washing machines were cleaned, Laundry Assistant (LA) A stated, "Never, I never clean behind there." LAA stated that she had not been told to clean the top of and behind the two washing machines. LAA was not sure who is responsible for the cleaning but could retrieve the information.</p> <p>At 10:33 a.m., LAA was observed folding a clean towel, a sheet, an incontinent pad and a resident's personal night gown. All these clean items touched the LA's uniform. When informed, LAA stated, "I know I did that and I have to catch myself some times."</p> <p>At 10:50 a.m., Laundry Supervisor (LS) indicated the top and the area behind the two washing machines were not regularly cleaned. LS stated, "I will get it done {clean behind and on top of the two washing machines} and then get it into a schedule."</p> <p>LS stated, "They {staff} know that, if it {clean laundry} touches the floor or it touches their uniforms they have to rewash it."</p>	F 441		

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

PRINTED: 07/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505429	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2014
NAME OF PROVIDER OR SUPPLIER SHARON CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1509 HARRISON AVENUE CENTRALIA, WA 98531		
(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 441	Continued From page 8 During review of facility policy entitled "Handling of Clean Linen", LS stated that the policy did not include clean laundry coming into to contact with staff uniforms and planned to rewritten the policy to include this practice.	F 441		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 505429	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 7/11/2014
--	--------------------------	--	---------------------------------------

NAME OF PROVIDER OR SUPPLIER SHARON CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1509 HARRISON AVENUE CENTRALIA, WA
--	--

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 272	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:</p> <ul style="list-style-type: none"> Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to accurately and comprehensively assess 1 of 14 current sampled residents (#104) reviewed for care and services. This failure placed the resident at risk of not receiving necessary care related to urinary incontinence.</p> <p>Findings include:</p> <p>Resident #104 was admitted to the facility on [REDACTED] with diagnoses including [REDACTED]</p>

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 505429	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 7/11/2014
NAME OF PROVIDER OR SUPPLIER SHARON CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1509 HARRISON AVENUE CENTRALIA, WA		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
---------------	-----------------------------------

F 272	<p>Continued From Page 1</p> <p>The resident's Minimum Data Set (MDS), an assessment tool, dated 5/12/14, indicated the resident was moderately cognitively impaired and required extensive assistance with personal hygiene and toileting, and was always continent of bladder. The resident's bladder record and MDS, dated 5/5/14 to 5/12/14, showed a pattern of frequent urinary incontinence.</p> <p>On 7/8/14 at 2:45 p.m. and 7/9/14 at 1:12 p.m., the resident was observed lying on his bed and smelled of urine.</p> <p>On 7/9/14 at 4:50 p.m., Nursing Assistant (NA) A stated the resident was incontinent of urine and wore disposable briefs.</p> <p>On 7/10/14 at 11:50 a.m., NAB stated, "He {Resident #104} is a heavy wetter. He is almost always wet when we check him."</p> <p>At 2:40 p.m., Licensed Nurse (LN) A and the surveyor reviewed Resident #104's bladder record and the resident's comprehensive assessment. LN A stated that based on the resident's documented urinary incontinence, the resident's MDS was inaccurate.</p> <p>At 4:01 p.m., the Director of Nursing Services stated, "I saw that. I just modified his MDS."</p>
--------------	---