

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

PRINTED: 11/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505417	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/08/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SAINT ANNE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3540 NORTHEAST 110TH STREET SEATTLE, WA 98125
---	---

(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

F 000

This report is the result of an unannounced Abbreviated Survey conducted at St. Anne Nursing and Rehabilitation Center on 11/08/12. A sample of five residents was selected from a census of 40. The sample included four current residents and the record of one discharged resident.

The following complaint was investigated as part of this survey:

#2698419

The survey was conducted by:

Lisa Foster, MN, R.N.

The survey team is from:

Department of Social and Health Services
Aging and Disability Services Administration
Residential Care Services, District 2, Unit F
20425 72nd Avenue South, Suite 400
Kent, WA 98032-2388

Telephone: (253) 234-6000
Fax: (253) 395-5070

RECEIVED

NOV 27 2012

DSHS/ADSA/RCS

Marta [Signature] 11-14-2012
Residential Care Services Date

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Marta [Signature]</i>	TITLE <i>Administrative</i>	(X6) DATE <i>11/25/12</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505417	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/08/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SAINT ANNE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3540 NORTHEAST 110TH STREET SEATTLE, WA 98125
--	---

(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 497 483.75(e)(8) NURSE AIDE PERFORM
 SS=D REVIEW-12 HR/YR INSERVICE

The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

This REQUIREMENT is not met as evidenced by:
 Based on interviews and record reviews, the facility failed to ensure they developed and maintained a system by which four of four Nursing Assistants (Staff D, E, F and G) reviewed and who had been employed for over a year had documentation showing they received 12 hours of in-service training per year. Additionally, the facility failed to ensure a system by which annual performance reviews were completed for one of four Nursing Assistants (Staff G). This failure placed residents at risk to receive inadequate care related to lack of staff knowledge.

Findings include:
 All interviews and record reviews occurred on 11/08/12.
 In an interview at 2:15 p.m., Staff A said the

F 497

The following is the plan of correction for Saint Anne Nursing and Rehabilitation Center in reference to form 2567, dated 11/08/2012.
 This will also serve as our allegation of compliance effective 11/30/2012

DISCLAIMER STATEMENT:
 Preparation and/or execution of this plan of correction does not constitute the provider's admission of or agreement with the facts or deficiencies 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 provision of federal law.

F 497 Nursing Aide Performance Reviews
 Performance reviews for all nursing assistants have been completed and reviewed with appropriate staff. Signatures have been obtained.
 All CNAs are current in their requirements for continuing education.
 Facility has assigned a nursing designee to assist with scheduling and completion of training and evaluating efficacy of training.

Received Time Nov. 28. 2012 8:36AM No. 4787

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505417	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/08/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SAINT ANNE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3540 NORTHEAST 110TH STREET SEATTLE, WA 98125
--	---

(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 497	<p>Continued From page 2</p> <p>facility offered both mandatory in-services and in-services which were pertinent to the current needs of staff. Staff A indicated the in-service hours were inputted into a computer tracking program by Staff C.</p> <p>Review of the "Employee Training Taken" records with Staff C revealed the following:</p> <p>Staff D, hired on 4/11/08, completed 1.25 hours of in-service training from 4/01/11 through 3/31/12.</p> <p>Staff E, hired on 9/29/04, completed three hours of in-service training from 9/01/11 through 8/03/12.</p> <p>Staff F, hired on 11/14/02, completed 0.50 hours of in-service training from 11/01/11 through 10/31/12.</p> <p>Staff G, hired on 3/11/03, completed six hours of in-service training from 3/01/11 through 2/29/12.</p> <p>In an interview at 2:32 p.m., Staff B provided a file containing nursing in-service records for 2012 which had not been input into the computer. At 2:45 p.m., Staff A provided Fire Safety In-services which had occurred but not entered into the computer. With those additional hours the four staff members still had not met the required minimum 12 hours of training. Staff A had completed 1.5 hours, Staff E completed 5.5 hours, Staff F completed two hours, and Staff G completed 7.25 hours. In addition, none of the four Nursing Assistants reviewed had completed all seven facility required mandatory in-services.</p> <p>In an interview at 3:30 p.m., the Administrator confirmed that the facility did not have an adequate system to keep track of the Nursing Assistants' in-service hours.</p>	F 497	<p>Internal systems have been modified to track status of all performance reviews and training needed to meet regulatory requirements. BOA will notify team leaders of upcoming performance evaluations and any training that still needs to be completed. Team leaders or their designees will complete performance reviews and will communicate any additional training needs to the staff development nurse designee.</p> <p>Policies have been reviewed and revised with new system procedures in place to ensure that all staff has the training they have received documented and recorded in a format that maintains compliance. Administrator will ensure compliance of program. 11/30/2012</p>	
-------	---	-------	---	--

Received Time Nov. 28. 2012 8:36AM No. 4787

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505417	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/08/2012
---	---	--	--

NAME OF PROVIDER OR SUPPLIER SAINT ANNE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3540 NORTHEAST 110TH STREET SEATTLE, WA 98125
--	---

(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 497 Continued From page 3

F 497

In an interview at 2:15 p.m., Staff A said the staff's Performance Evaluations were conducted on an annual basis and included information regarding the number of in-service hours the staff had completed. If the staff had not completed the required hours it would be reflected on the evaluations.

Review of Staff D, E and F's Performance Reviews included instructions to "List in-service hours since last anniversary date." A "score" of n/a (not applicable) was listed and the comments section listed "12". In reviewing Staff D's Performance Evaluation, Staff C indicated she entered "n/a" because "She didn't have any so I didn't put them in." Staff A was unable to determine how the evaluator had concluded the staff members had completed 12 hours of training.

In an interview at 2:32 p.m., Staff B said although she completed the Nursing Assistants Performance Evaluations, she did not review the evaluations with the employee unless there was a problem. Review of the Performance Evaluations in the employee records with Staff A revealed Staff D, E and F's evaluations were dated as completed late on 12/28/11 but none of the evaluations contained confirmation that the information was discussed with the employees, which Staff A indicated was an expectation. In addition there was no 2011 annual Performance Evaluation completed for Staff G.