

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

PRINTED: 05/21/2013
FORM APPROVED
OMB NO. 0938-0391

1324

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505507	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/16/2013
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NAME OF PROVIDER OR SUPPLIER SHELTON HEALTH & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 153 JOHNS COURT SHELTON, WA 98584
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Shelton Health & Rehabilitation Center on 05/16/13. A sample of 5 residents was selected from a census of 65. The sample included 5 current residents.</p> <p>The following complaint(s) were investigated as part of this survey:</p> <p>#2805992</p> <p>The survey was conducted by:</p> <p>██████████, BSN, RN</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, District 3 P.O. Box 45819 Tumwater, WA 98504</p> <p>Telephone: (360) 664-8428 Fax: (360) 664-8451</p> <p><i>Jan Pierce</i> 5-21-13 Residential Care Services Date</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 505507	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 5/16/2013
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NAME OF PROVIDER OR SUPPLIER SHELTON HEALTH & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 153 JOHNS COURT SHELTON, WA
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 225	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to report a resident to resident altercation in accordance with state law and 42 CFR 483.13 (c)(2) for 2 of 5 current sampled residents reviewed for incidents and investigations. Failure to report resident to resident altercations placed residents at risk for further abuse.</p> <p>Findings include:</p> <p>According to "NURSING HOME GUIDELINES AKA "THE PURPLE BOOK, " What Should be Reported for Incidents Involving Resident To Resident Altercations? 1) Report to the Department: Requirements for reporting resident to resident assaults to the Department are the same as the reporting requirements for any incident of physical assault against a resident. 2) Report to Law Enforcement: An incident of physical assault between residents must be reported to law enforcement if (c) there is a pattern of physical assault between the same residents or involving the same residents.</p> <p>Resident #2 was admitted to the facility in December 2012 with diagnoses which included [REDACTED]. The Minimum Data Set (MDS)an assessment tool, dated 12/27/12 and 3/19/2013 documented Resident #2 required an extensive assist with Activities of Daily Living (ADLs), had abnormal behavior, easily annoyed</p>
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The above isolated deficiencies pose no actual harm to the residents

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F 225

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(nearly every day) and had impaired thought process. The resident also was documented having behavioral outbursts directed toward others, that occurred 4 to 6 days a week. The behaviors were identified by the facility for placing other residents at risk for physical injury. Resident #2's exhibited behavior significantly disrupted care and/or the living environment and interfered Resident #2s care 4 to 6 days weekly.

According to the facility documentation from 4/17/13-5/7/13, Resident #2 had a physical contact incident involving another resident. The facility had logged the incident but failed to notify the State Hotline as required.

Resident #2 was interviewed on 05/16/13 at 12:35 pm. She did not recall the physical altercations involving the other residents.

The facility incident log had logged in the resident to resident altercation between Resident #1 and Resident #2 on 04/12/13.

The DNS (Director of nurses) and the administrator were interviewed on 05/16/13. They both said they had followed the state "Purple Book" guideline for reporting and since no physical or psychological harm could be determined from the investigation they did not call the state complaint hotline because there was no noted physical injury.

The facility failed to report a physical altercation where another resident struck another resident as required by the "Purple Book" to the required state agency.