

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

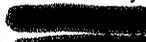
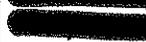
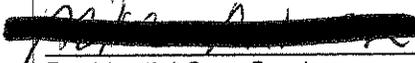
1331

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070
---	---

(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 Vashon Community Care Center on 11/12/13, 11/13/13, 11/14/13, 11/15/13 and 11/18/13. A sample of 15 residents was selected from a census of 29. The sample included 13 current residents and the records of two discharged residents.</p> <p>The survey was conducted by:  RN, MN  MSW  RN, BSN  RN, MN</p> <p>The survey team is from: Department of Social and Health Services Aging and Long-Term Care Services Administration Residential Care Services, Region 2, Unit F 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388</p> <p>Telephone: (253) 234-6000 Fax: (253) 395-5070</p> <p> 11-22-13 Residential Care Services Date</p>	F 000		
-------	---	-------	--	--

RECEIVED
DEC 09 2013
DSHS/ADSA/RCS Region 4

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Interim Administrator</i> 12/6/2013	TITLE	(X6) DATE
---	-------	-----------

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: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070		
(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 SS=E	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to allow four (#s 33, 5, 45, & 23) of four residents reviewed for choices, of the eight residents who were interviewed in Stage 1, the right to make choices regarding important daily routines, including accommodating preferences for the frequency and/or type of bathing. The facility's failure to accommodate resident choice placed these residents at risk for a diminished quality of life.</p> <p>Findings include:</p> <p>STAFF INTERVIEWS On 11/15/13 at 10:13 a.m., an interview was conducted with Staff D, a certified nursing assistant (CNA). She stated all CNAs were required to complete one resident bath per day so each resident received a weekly bath. If a resident requested or needed a change in their bath time, she stated "I would talk to the charge nurse to make sure the request is not going to cause a conflict with other schedules."</p> <p>Staff L, a licensed nurse (LN) was interviewed on</p>	F 242	<p>F 242 483.15(b) SELF DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>1) How the nursing home will correct the deficiency as it relates to the resident:</p> <ul style="list-style-type: none"> Residents #5, #23, #33 and #45 – their care plans were reviewed and each resident was interviewed and assessed to ascertain their ADL's choices to include bathing preferences for frequency and /or type of bathing. The care plans and the bathing schedules for residents #5, #23, #33 and #45 were updated to reflect their ADL choices to include bathing preferences. <p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> The facility will revise its skin nursing assessment form to include an assessment of bathing preferences. The facility will assess all residents to ascertain their ADL choices to include bathing preference. The facility will ensure that resident care plans are updated to reflect resident choice of bathing & ADL preferences. 		

RECEIVED

NOV 09 2013

DSHS/ADSA/RCS Region 4

CUB-11/16/13

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070		
(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	<p>Continued From page 2</p> <p>11/18/13 at 9:31 a.m. She stated residents were informed on admission they would receive one bath per week. Preference for a day or evening bath was determined at admission in addition to the resident's preferences for type of bath. Staff L stated this information would be transferred to the bath schedule for the CNAs to implement. Further, she stated any change required in the bath schedule would have to be cleared through the nurse, for example, if a resident missed their scheduled bath.</p> <p>An interview was conducted with administrative nursing Staff B on 11/15/13 at 10:34 a.m. concerning the facility's policy regarding resident bathing. When asked what accommodations were made for resident bathing preferences, she stated if a resident had a preference of time of day, the facility accommodated the preference. However, she stated, unless an incontinence episode occurred, residents were only offered some form of bath once a week stating "Because of our schedule we can only do it (bath) once a week and they (residents) were aware of that (when they were admitted.)"</p> <p>In a follow up interview at 11:09 a.m. on 11/15/13, Staff B stated residents had the choice between a shower or a bath which would be stated by the resident either at admission or to the individual CNA on the resident's bath day. When asked how resident choice/preference was accommodated for in the schedule, for example missed bath, non-communicative resident or wish for more than one bath per week, she stated "We've tried to adapt to it. We probably could increase the adaptability to it."</p> <p>RESIDENT #33</p>	F 242	<p>3) Measures the nursing home will take or systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> • The facility will implement newly revised skin nursing assessment form to ascertain a resident's bathing preferences. • Nursing admission assessment process reviewed and updated to include updated assessment form and requirements for individualized ADL's choices. • Training provided to all nursing staff on the following: <ul style="list-style-type: none"> ○ Revised skin nursing form and admission assessment process ○ Honoring resident bathing choices • Facilitated meeting by compliance manager to review current bathing schedule process "policy" and ways to improve service to residents that honor their 'choice'. <p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> • MDS nurses and charge nurses will monitor compliance by weekly auditing of a sample of residents' CareTracker "Bathing by Type" reports for one month and 	12/4/2013

RECEIVED

NOV 09 2013

DSHS/ADSA/RCS Region 4

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070	
(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	<p>Continued From page 3</p> <p>Resident #33 was admitted to the facility on [REDACTED]/12 with multiple medical diagnoses. According to her Annual Minimum Data Set (MDS) assessment dated 05/08/13 and her most recent Quarterly MDS dated 07/30/13, the resident was totally dependent on staff for all activities of daily living (ADLs) including [REDACTED]. Resident #33 was cognitively intact scoring a [REDACTED] out of 15 on the Brief Interview of Mental Status (BIMS) portion of the MDSs, however did have difficulties with [REDACTED] with others. Finally, both assessments indicated for Resident #33, it was very important to be have her preferences accommodated.</p> <p>On 11/14/13 at 11:35 a.m., an interview was conducted with the Durable Power of Attorney (DPOA) for Resident #33. During an extensive conversation, the DPOA stated: "In regard to bathing, my/our understanding when we decided to enter the Center, was (she would be receiving a shower) once a week. It was a known quantity. She (Resident #33) would like showers every day. I feel like this was known when we entered and we've brought it up (to the facility staff) . . . She's (Resident #33) made her wishes known. It has not been something we've been able to get them to accommodate . . . They indicated if she wanted more than (one shower per week) she could move to a different center."</p> <p>On 11/15/13 at 12:23 p.m., an interview was conducted with Resident #33. When asked if she got as many showers as she wished, she indicated no. When asked if when she missed a shower, she was offered a replacement, she indicated no.</p> <p>Review of Resident #33's medical record</p>	F 242	<p>randomly thereafter.</p> <ul style="list-style-type: none"> Charge nurses or designee will randomly audit new admission care plans to ensure they are individualized and reflect resident bathing choices The audit results will be reviewed by the DNS. <p>5) Dates when corrective action will be completed: January 1, 2014</p> <p>6) The title of the person responsible to ensure correction: [REDACTED], RN, MN Director of Clinical Services</p> <p style="text-align: right;">01/01/14</p> <p style="text-align: right;">[REDACTED] 12/16/2013</p>

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070		
(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	<p>Continued From page 4</p> <p>revealed an Activities of Daily Living Plan of Care dated 05/25/12 and last updated 09/18/13. The intervention for Bathing stated: "1 person total assistance for bathing. Staff to provide 1 shower weekly and [REDACTED] will provide additional showers at their house as she likes to shower 3 - 4 times per week." Review of the facility's computerized Care Tracker program showed Resident #3 received showers/tub baths every Monday and at no other time.</p> <p>In an interview on 11/15/13 at 10:34 a.m. Staff B said Resident #33 "Would like more frequent baths, the [REDACTED] were going to take her home to bath her, because of our schedule we can only do it once a week and they were aware of that. With their schedule they can't do that, so we are looking at what they can do to help her [REDACTED]"</p> <p>A Social Services Interdisciplinary Progress Note dated 10/06/13 was found concerning an "impromptu talk" held with Resident #33's [REDACTED] by Staff I, one of the facility's social workers. It noted "[REDACTED] requesting additional bath for (Resident #33). We explained (Resident #33) has one bath/week on Monday . . . and that is per nursing home requirements and what works with current staffing. It was wonderful when (Resident #33) could go home for additional bath, but due to her declining status, that is no longer practical. We stated that only [REDACTED] could provide additional bath . . . but (Resident #33) is not a candidate for [REDACTED] at this point."</p> <p>In an interview on 11/15/13 at 11:09 a.m. Staff B said, "I'd say as DNS (Director of Nursing Services) it's an area we need to be more accommodating, and for (Resident #33), to be offering another bath."</p>	F 242	<p style="text-align: center;">RECEIVED OCT 09 2013 DSHS/ADSA/RCS Region 4</p>	<p style="text-align: right;">[REDACTED] 12/6/2013</p>

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070	
(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 242	<p>Continued From page 5</p> <p>RESIDENT #5</p> <p>Resident # 5 was admitted to the facility on [REDACTED]/02 with multiple complex medical needs. According to 10/14/13 MDS, the resident indicated it was somewhat important for him to chose whether to have a tub bath, shower, or sponge bath.</p> <p>The care plan dated 07/03/13, indicated the resident required extensive assistance with [REDACTED]</p> <p>In an interview on 11/15/13 at 10:03 a.m., Resident #5 stated he would prefer a tub bath versus a shower. He stated, however, he has not been given a choice. "They (staff) just come in and announce that it's my shower day and take me in for a shower." The resident stated "I prefer tub baths because soaking in the warm water helps me relax."</p> <p>In an interview on 11/18/13 at 9:31 a.m. Staff L said if a resident hadn't previously "requested a tub bath, the CNAs should be asking them (the resident) every time they (CNAs) come in to take them."</p> <p>RESIDENT #45</p> <p>Resident #45 was admitted to the facility on [REDACTED]/13 with care needs related to a recent [REDACTED]. According to the 09/07/13 MDS, Resident #45 was assessed to be totally dependant on staff for bathing, had no memory problems and was able to understand and be understood in conversation.</p> <p>In an interview on 11/12/13 at 11:38 a.m.,</p>	F 242	<p style="text-align: center;">RECEIVED DEC 09 2013 DSHS/ADSA/RCS Region 4</p> <p style="text-align: right;">[REDACTED] 12/6/2013</p>

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070		
(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	<p>Continued From page 6</p> <p>Resident #45 indicated he did not get to choose how many times a week he took a bath or shower, stating, "I get one a week, I'd like one every day, but there's not enough people (staff) to do it." In an interview at 1:00 p.m. on 11/15/13, Resident #45 stated, "No they have never offered me a bath more than once a week." The resident elaborated, it was very important to be able to bath more than once a week because, "I took a shower every day before I came here." Failure to offer or provide showers more than once a week detracted from Resident #45's ability to make choices about aspects of his life which were significant to him.</p> <p>RESIDENT #23 Resident #23 was admitted to the facility [REDACTED]/13. According to the 10/21/13 MDS the resident required total assistance of one staff for bathing.</p> <p>In an interview on 1/12/13 at 10:47 a.m. when asked "Do you choose how many times a week you take a bath or shower?" Resident #23 replied, "No. I get once a week." The resident indicated his preference would be to be bathed twice a week. Resident #23 commented "They tell me when it's going to happen and I have nothing to say about it."</p> <p>In an interview on 11/18/13 at 9:31 a.m., Staff L was informed if offered the choice, Resident #23 would choose a shower twice a week and he did not feel the choice was his to make. Staff L replied "He often presents himself better than he is. He is offered a choice and may not remember." Similarly, in an interview on 11/18/13 at 10:32 a.m., Staff B stated "Do remember (Resident #23's) [REDACTED] term memory".</p>	F 242	<p style="text-align: center;">RECEIVED DEC 09 2013 DSHS/ADSA/RCS Region 4</p>	<p style="text-align: right;"><i>CLB 12/4/2013</i></p>

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070		
(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 7	F 242			
F 244 SS=D	<p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION</p> <p>When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to act upon the grievances and recommendations of the Resident Council. This failure placed the residents at risk of decreased quality of life.</p> <p>Findings include:</p> <p>A review was conducted on the Minutes of the Resident Council Meetings held from January until October 2013. Additionally, on 11/15/13 at approximately 9:30 a.m., an interview was conducted with an active resident participant of the Resident Council.</p> <p>Review of the Council Minutes showed no specific follow up to concerns raised by the</p>	F 244	<p>F 244 483.15(c) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION</p> <p>1) How the nursing home will correct the deficiency as it relates to the resident:</p> <ul style="list-style-type: none"> There were no specific residents identified in the summary statement of deficiencies. <p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> The facility will review all resident council minutes for 2013 and determine if there are any unresolved resident issues. All unresolved issues will be presented at the December 2013 resident council meeting for further discussion and follow-up will be documented in the minutes using the Change Acceleration Process of WWW (Who will do the follow up action, What will they do and When will they do it). This will be 	12/11/2013	

RECEIVED
11-29-2013
DSHS/ADSA/RCS Region 4

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070	
(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 244	<p>Continued From page 8</p> <p>Resident Council. For example, on 03/29/13, one resident brought up an issue about the quality of the food stating the SNF (skilled nursing facility) residents felt like "2nd class citizens" compared to the Assisted Living portion of the building when it came to the food. Review of the Minutes following this meeting found no follow up communication back to the Council concerning this issue.</p> <p>Additionally, during the 09/27/13 Council meeting, activities and the resident's desire's for activities such as field trips and visiting artists were discussed. The minutes documented one resident stated "Without activities we are just another nursing home." Review of the following month's Minutes found no further discussion of activities.</p> <p>On 11/18/13, at 9:00 a.m., an interview was conducted with administrative Staff A. When asked how she understood the process if an issue was brought up by the Council or from any other source, she stated the facility's "WWWW (Who, What, Where, Why) Form" would be completed and passed through the facility's investigative process.</p> <p>On 11/18/13 at 11:10 a.m., an interview was conducted with Staff I, the staff liaison to the Resident Council and the individual responsible for supporting the Council's Meetings. She stated there was an "informal process" by which the facility responded to issues brought up during the Council. She stated issues or concerns which had previously been identified were not re-discussed in the Council including the resolution the facility had arrived at for the issues. She stated she would sometimes talk to the</p>	F 244	<p>completed prior to the next scheduled meeting.</p> <ul style="list-style-type: none"> The facility will continue to invite all SNF residents to attend the monthly SNF resident council meeting. <p>3) Measures the nursing home will take or systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> The facility will review and revise its Resident Council policy. The facility will revise the format of the resident council Minutes form to include WWW/Actions/Resolutions. The facility will create an area on the SNF resident bulletin board where monthly resident council minutes will be posted. Resident Council members will be informed of revised policy and minutes form. <p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> The Resident Council Minutes to include WWW/Actions/Resolutions will be reviewed and monitored on a quarterly basis by the DNS and the SNF social services staff person for timely completion and follow-up. 	

RECEIVED

DEC 09 2013

DSHS/ADSA/RCS Region 4

11/16/2013

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070	
(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 244	Continued From page 9 resident who had brought up the issue on an individual basis but did not discuss with the Council as a whole. When asked if she utilized the facility's "WWW" process as outlined by Staff A, she stated "No." The facility's failure to acknowledge and respond to recommendations and concerns identified through the Resident Council could result in resident's feeling they have no input into resolution of issues which are important to them and could potentially impact the resident's quality of life.	F 244	<ul style="list-style-type: none"> The findings of the quarterly audit will be summarized on a form in the Resident Council Minutes binder. <p>5) Dates when corrective action will be completed: January 1, 2014</p> <p>6) The title of the person responsible to ensure correction: [REDACTED] VCC Social Services Manager</p>	01/01/14
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 ensure staff consistently implemented plans of care for three (#s 26, 20 & 9) sampled residents of the 13 residents who were included in the Stage 2 review. Failure to implement assessed, required care interventions placed residents at risk for unidentified dehydration, decreased vision, decline in range of motion and unnecessary medications. Findings include:	F 282	<p>F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>1) How the nursing home will correct the deficiency as it relates to the resident:</p> <ul style="list-style-type: none"> Resident #26 will have his intake and output consistently monitored and recorded by nursing staff. In addition staff will assure that resident has water at his bedside throughout the day. Resident #26 will have his [REDACTED] appointment rescheduled at the [REDACTED] Resident #20 Care Plan reviewed to ensure appropriate Restorative Program interventions are in place to maintain/improve ROM. Care Plan will be updated to include alternative approaches by staff if [REDACTED] 	12/6/2013

RECEIVED
DEC 09 2013
DSHS/ADSA/RCS Region 4

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070	
(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 10</p> <p>RESIDENT #23</p> <p>According to the 10/21/13 Minimum Data Set (MDS) assessment, Resident #23 required set up of one to eat. According to the 11/02/13 Nutrition and Hydration Care Plan (CP) staff were to "Push fluids to maximize urine output and patency of [REDACTED] catheter."</p> <p>In an interview on 11/12/13 at 10:56 a.m., when asked if he received the fluids he wanted between meals, Resident #23 said "No, nothing". The resident was observed with a glass of milk, and a cup of coffee left over from breakfast. There was no water pitcher at his bedside.</p> <p>Review of the resident's record revealed Physician's Orders (POs) dated [REDACTED]/13 to "Increase [REDACTED] to produce [REDACTED] daily." Review of the November Treatment Administration Record (TAR) revealed the order was listed, but not documented as followed. In an interview 11/18/13 at 9:18 a.m. Staff L, a licensed nurse (LN) indicated Care Tracker (CT) had the resident's [REDACTED] documented on the meal monitor and the [REDACTED] for the [REDACTED]</p> <p>In an interview on 11/18/13 at 12:30 p.m., Staff B said the resident was not on meal monitoring but provided the documentation in CT including the [REDACTED] Chart Detail Report from 08/01/13 through 11/17/13. The average [REDACTED] was [REDACTED], and the average [REDACTED] was [REDACTED]. Further review of the [REDACTED] Chart Detail Report from 08/12/13 through 11/17/13 revealed the resident's [REDACTED] was less than [REDACTED] of [REDACTED] a day on 64 of 98 days [REDACTED]. From 10/18/13 through 11/17/13 the resident's [REDACTED] was less than [REDACTED] a day on 23 of 31 days [REDACTED].</p>	F 282	<p>resident refuses to participate in Restorative Program</p> <ul style="list-style-type: none"> Resident #9 Care Plan and Care Tracker reviewed to ensure appropriate behavior monitoring interventions are in place. All responsible nursing staff will be informed of the reviewed/updated Care Plans for residents #23, 20, and 9 to include updated interventions and documentation requirements using IPN, MAR, TAR, and Care Tracker <p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> The facility will review and audit all applicable resident care plans to ensure appropriate interventions are in place for hydration, visual impairment, restorative, and behavior monitoring MDS nurse to review care plans at least quarterly to ensure the interventions are being acted on. MDS nurse to communicate to appropriate person to complete any outstanding care plan items. Caretracker to be updated with care plan changes. <p>3) Measures the nursing home will take or systems it will alter to ensure that the problem does not recur: [REDACTED]</p>

RECEIVED
12/16/2013
DSHS/ADSA/RCS Region 4

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070	
(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 11</p> <p>On 11/15/13 at 9:15 a.m. Resident #23 was observed in the dining room feeding himself breakfast. When it was noted he was not wearing glasses, Resident #23 said "I'm not wearing them right now, I have them." Resident #23 then pulled glasses out of his pocket, put them on and smiled.</p> <p>In an interview on 11/18/13 at 9:18 a.m. Staff L said Resident #23 carried his glasses in his breast pocket but he doesn't wear them. He likes to have them on his person. We give them to him every day."</p> <p>According to the 10/21/13 MDS Resident #23 had [REDACTED] and diagnoses which included [REDACTED] or [REDACTED] and no glasses. Review of the 11/02/13 Annual MDS Nursing Note revealed "...His vision and hearing appointments had been canceled as he could not lie on his back for very long due to his [REDACTED]. Social Work (SW) has been contacted for resumption of those appointments...he lost his glasses in the past and doesn't see the need for them...was to have an eye clinic appt at the [REDACTED] on [REDACTED]/13 but this was canceled due to his need for a limited period of time on his [REDACTED]. Social Services is still trying to reschedule it."</p> <p>Review of the 11/02/13 Vision CP indicated "consent signed by DPOA (Durable Power of Attorney) for eye exam here at (facility) however may need to be seen at [REDACTED] ongoing investigation and scheduling SW coordinating appointments". The Ancillary Services CP indicated the resident needed [REDACTED] care to monitor [REDACTED] and [REDACTED] testing. "(Resident #23's) [REDACTED] health</p>	F 282	<ul style="list-style-type: none"> The facility's Care Plan and Nursing Assessment policies will be reviewed to ensure documentation requirements are outlined. All appropriate nursing staff will be educated on the Care Plan, Restorative, and Assessment policies to include documentation requirements. <p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> MDS nurses or designee will perform audits of documentation for residents who trigger on MDS under visual impairment, declining ROM, and behaviors affecting others. The audit results will be reviewed by the DNS. <p>5) Dates when corrective action will be completed:</p> <p>January 1, 2014</p> <p>6) The title of the person responsible to ensure correction:</p> <p>[REDACTED] RN, MN Director of Clinical Services</p>

RECEIVED

CC 09 2013

DSHS/ADSA/FCS Region 4

01/01/14

12/16/2013

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2013	
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070		
(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 12</p> <p>will be monitored annually by an [REDACTED] and [REDACTED] respectively, more often as needed." The approach listed was "SW is working on scheduling follow up appointments with respective clinics at [REDACTED] for vision."</p> <p>Review of the resident's record revealed no documentation indicating the [REDACTED] exam had been scheduled or planned. Review of the [REDACTED] Assessment Tool revealed Resident's #23's [REDACTED] which had prevented him from making his [REDACTED] 2/13 [REDACTED] appointment, had healed 07/25/13.</p> <p>In an interview on 11/18/13 at 10:01 a.m. Staff I said "the [REDACTED] contacts us when they want to see him, he had appointments for that but he had a wound so he couldn't sit up to go so they were all canceled, and he is now able...I've been off for the last 5 weeks so nothing has happened yet." Resident #23 had waited approximately four months for an [REDACTED] examination which was originally scheduled six months previously.</p> <p>RESIDENT #20</p> <p>In an interview on 11/12/13 at 2:24 p.m. Staff M indicated Resident #20 had [REDACTED] in both of her [REDACTED] and "She gets rolls put in, she takes them out at night", and "She gets [REDACTED] to other parts of her body."</p> <p>Review of the 10/20/13 MDS revealed the resident was assessed with [REDACTED] on one [REDACTED] and received zero days of restorative nursing and zero days of [REDACTED]. Similarly, the resident did not receive [REDACTED] during the look back periods of either the 05/01/13 or 07/22/13 MDSs'.</p>	F 282	<p style="text-align: center;">RECEIVED DEC 09 2013 DSHS/ADSA/RCS Region 4</p>	<p style="text-align: right;">[REDACTED] 12/11/2013</p>

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

PRINTED: 11/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070
---	---

(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 13</p> <p>Review of the 11/03/13 Restorative Programs CP, indicated the resident had [REDACTED] refused [REDACTED] care and needed [REDACTED] and/or [REDACTED] to maintain her current level of function. The listed goal was indicated despite resident's refusal to participate in restorative programs "we will attempt to help (Resident #20) maintain her current level of mobility and prevent her contractures from worsening." Approaches listed included "encourage resident to attend group exercise program as often as possible", "encourage resident to allow her hands to be held 2 x (times)/day so her fingers can be stretched gently," and "encourage active and passive lower extremity movement."</p> <p>The resident was not observed to attend exercise class during the days of the survey. Review of the Activity Report revealed from 11/01/13 through 11/18/13, seventeen days, the resident only attended exercise on 11/02/13.</p> <p>On 11/18/13 at 11:37 a.m., documentation was requested of staff attempts at performing ROM exercises including hand held gentle stretching. The facility was unable to provide any. In an interview at 12:30 p.m. on 11/18/13, Staff B indicated the staff do not document it and they should be following the plan of care.</p> <p>RESIDENT #9 Review of the 09/12/13 Mood/Behavior CP revealed approaches included, "care staff and LN to document behaviors on Care Tracker (CT), IPN (Interdisciplinary Progress Notes) and MAR (Medication Administration Record)." Review of the physician orders (POs) revealed a [REDACTED] /06 order for "[REDACTED]"</p>	F 282	<p style="text-align: center; opacity: 0.5;">RECEIVED NOV 09 2013 DSHS/ADSA/RCS Region 4</p>	<p style="text-align: right;">12/1/2013</p>
-------	---	-------	--	---

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070	
(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	Continued From page 14 elaborate in prog(ress) notes." Review of the behavior monitoring section of the MAR from February 2013 through October 2013 revealed no documented behaviors exhibited by the resident. In addition, behaviors documented as occurring in the IPNs were not consistently reflected in the CT behavior monitoring. For example, review of the IPNs revealed a 03/01/13 note, "CNA reports that for the last 4 noc's (nights) resident has been increasingly resistant to care..." The behavior described was not documented in CT by the care staff. In contrast, behaviors documented in CT were not consistently elaborated upon in the progress notes. A 04/06/13 progress note indicated "during lookback, (Resident #9) resisted care two times, each time around 1:00 a.m. I was unable to interview NAC from that shift to learn the nature of the resistance, and the documentation did not go into detail."	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced	F 314	F 314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 1) How the nursing home will correct the deficiency as it relates to the resident: • Residents #13 and #14 had already been [REDACTED] from the facility at the time of this survey. 2) How the nursing home will act to protect residents in similar situations:	

RECEIVED
NOV 09 2013
DSHS/ADSA/RCS Region 4

11/18/2013

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070	
(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 314	<p>Continued From page 15</p> <p>by: Based on interview and record review, it was determined the facility failed to conduct timely ongoing assessments to evaluate resident clinical condition, recognize standards of practice, monitor and re-evaluate the impact of interventions and/or revise interventions appropriately to provide timely necessary treatment and services for two (#13 & 38) of two residents reviewed for [REDACTED]. This failure had the potential to result in delayed interventions and the development of a [REDACTED] for Resident #38.</p> <p>Findings include:</p> <p>RESIDENT #13 Resident #13 was admitted to the facility on [REDACTED]/13 with diagnoses which included [REDACTED] and [REDACTED]. This resident was reviewed as a closed record and was unavailable for observation or interview.</p> <p>According to a nursing Admission form dated [REDACTED]/13, Resident #14 was identified with a [REDACTED] on admission. According to the [REDACTED]/13 and [REDACTED]/13 Minimum Data Sets (MDS) the resident was assessed as having an [REDACTED] and was at risk for developing [REDACTED]. This MDS indicated the most severe [REDACTED] had "[REDACTED] or [REDACTED] with [REDACTED] appearance."</p> <p>According to the facility "[REDACTED] Care Protocol", upon identification of any alteration in [REDACTED] integrity other than a monitor [REDACTED] or [REDACTED], nursing staff were directed to: "Start a [REDACTED] Assessment Tool (SAT- a tool on which staff</p>	F 314	<ul style="list-style-type: none"> Facility will review all residents currently with any type of pressure sore, audit their PUSH tools for accuracy, reinforce measurable documentation with nursing in both PUSH tool and IPN notes. Care Plans will also be reviewed to ensure completeness of clinical documentation. The facility will review all Care Plans for any current residents identified as high-risk for skin breakdown to ensure appropriate intervention are in place. Any resident who is identified as having a pressure sore(s) or skin breakdown will have their care plan reviewed for completeness of interventions. Skin Assessment policy will be reviewed and updated to include; measurement, documentation of on-going assessment and monitoring of interventions. <p>3) Measures the nursing home will take or systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> See F242 The day charge nurse will perform weekly audits of the PUSH Tools for all residents with a pressure sore or skin breakdown to ensure

RECEIVED

REC 09 2013

DSHS/ADSA/RCS Region 4

12/18/13- [REDACTED]

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070	
(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 314	<p>Continued From page 16</p> <p>document the size, condition and appearance of wounds) form..."; "The (SAT) is...completed weekly: If a wound does not improve or worsens after two weeks of treatment, the nurse consults with the physician to obtain further orders on any treatment changes."; and "Each week... the charge nurse completes the (SAT) form and a brief progress note, using the Skin Assessment progress note template is completed."</p> <p>Record review revealed no objective clinical assessment of the [redacted] wound until the SAT form was completed on 05/20/13, five days after the wound was initially identified and was described as a, "[redacted] x [redacted]" In an interview on 11/14/13 at 2:05 p.m., Staff B (Director of Nursing) indicated, "They (nursing staff) are suppose to (measure) them (wounds) when they identify them" and confirmed there was a five day delay in completing the SAT.</p> <p>Staff failed to assess the wound again until over two weeks later on 06/04/13 when staff documented on the SAT the wound was, [redacted] There was no indication in the record facility staff recognized the wound had worsened or consulted with the physician according to facility policy and recognized standards of practice. Failure to identify and report non-healing of a wound placed the resident at risk for delayed healing and worsening of wounds.</p> <p>According to the SAT for the [redacted] facility staff again failed to assess the wound for over two more weeks until 06/20/13. In an interview on 11/14/13 at 2:05 p.m. Staff B confirmed staff should have, but did not, assess the wound every week. Staff B confirmed there were no wound assessments between 05/20/13 and 06/04/13,</p>	F 314	<p>completeness and accuracy on the resident's scheduled bath/shower day each week.</p> <ul style="list-style-type: none"> Any resident who is admitted with an orthotic will have an initial skin assessment by the RN admitting the resident. The results of this assessment will be documented on the Nursing Admission forms for skin and will be communicated to therapy staff. Licensed nurses and therapy staff will receive additional education on the PUSH tool to include tissue type scoring, clinical documentation and interventions for pressure sores. <p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> The charge nurse will monitor a resident's PUSH Tool(s) on a weekly basis on the resident's scheduled bath/shower day. The MDS nurse will review the PUSH tool each time a MDS is completed. The DNS will be notified if a PUSH tool is not being done on a consistent basis and if further documentation is needed. The audit results will be reviewed by the DNS. 	

RECEIVED

NOV 09 2013

DSHS/ADSA/RCS Region 4

12/16/2013

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070		
(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 314	<p>Continued From page 17 stating, "...they are suppose to be measuring (every week) according to our policy..." Staff B also confirmed there were no assessments of the wound from 06/20/13 to the date of discharge on [REDACTED]/13. Consistent failure to conduct ongoing wound assessments placed the resident at risk for unidentified worsening of the wound and possible delayed interventions.</p> <p>Similar findings were identified for a [REDACTED] wound which was identified, according to a SAT form, on 05/27/13. According to this SAT, the wound was measured on 05/27/13, but not assessed again until 10 days later on 06/06/13. Facility staff again failed to provide ongoing assessment of the wound until two weeks later on [REDACTED]/13. Staff B confirmed there were also no assessments of this wound from [REDACTED]/13 to the date of discharge on [REDACTED]/13.</p> <p>RESIDENT #38 Resident #38 was admitted to the facility on [REDACTED]/13 with care needs related to a recent [REDACTED]. This resident was reviewed as a closed record and was unavailable for observation or interview. According to the 05/24/13 MDS the resident was identified with one [REDACTED] and [REDACTED] and at risk for developing [REDACTED].</p> <p>According to the Nursing Admission Assessment dated 05/17/13, staff identified the resident with a "[REDACTED]" to the [REDACTED] area and a "[REDACTED]" from [REDACTED] on [REDACTED]-irritation" to the [REDACTED] area. Staff identified on this form, "a few spots to watch on his [REDACTED] r/t (related to) [REDACTED]."</p> <p>Review of SAT documents revealed staff first</p>	F 314	<p>5) Dates when corrective action will be completed: January 1, 2014</p> <p>6) The title of the person responsible to ensure correction: [REDACTED] RN, MN Director of Clinical Services</p>	01/01/14

RECEIVED
DEC 09 2013
DSHS/ADSA/RCS Region 4

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070	
(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 314	Continued From page 18 assessed/measured the [REDACTED] on 05/22/13, five days after it was identified. Failure to timely and objectively measure identified wounds detracted from staff's ability to identify worsening of a wound. Staff monitored the wound on 05/29/13, then not again until 06/08/13 when staff identified the wound as, "area is scabbed over." There was no indication of a description of the scab, how large it was, nor was there further monitoring of the wound until 06/17/13 when staff identified the wound was healed. There was never a SAT completed for what staff identified on admission was a [REDACTED] to the [REDACTED] and no indication staff further assessed the [REDACTED] for fit until, on 05/26/13, staff initiated a SAT for a [REDACTED] from [REDACTED]. Review of the SAT for the [REDACTED] indicated staff did not monitor the wound for a period of over two weeks, from 05/29/13 to 06/17/13. Consistent failure to conduct ongoing wound assessments placed the resident at risk for unidentified worsening of the wound and possible delayed interventions. In an interview on 11/18/13 at 9:15 a.m., Staff B confirmed facility staff were not completing weekly skin assessments nor measuring and documenting wound appearance upon identification.	F 314		
F 329 SS=E	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including	F 329	F 329 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 1) How the nursing home will correct the deficiency as it relates to the resident:	11/16/2013

RECEIVED
DEC 09 2013
OSHS/ADSA/RCS Region 4

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2013	
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070		
(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 329	<p>Continued From page 19</p> <p>duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure three of five residents (#s 4, 45, & 9) reviewed for unnecessary medications were free of unnecessary medications related to adequate indications for use, use of non-pharmacological interventions prior to the use of an as needed psychotropic medication, consistent monitoring of the medication and lack of gradual dose reductions.</p> <p>Findings include: RESIDENT #4</p>	F 329	<ul style="list-style-type: none"> Residents #4. This resident's [redacted] was reduced on 11/15/13. Resident's sleep and behaviors were monitored for two weeks beginning 11/6/13. The monitoring included the primary symptoms of insomnia. Care plan updated accordingly. Resident #4. The resident has been on [redacted] since 06/19/11. The resident's physician will provide [redacted] or [redacted] statement with specific symptoms that will recur. Care plan will be updated accordingly. Resident #45 was prescribed [redacted] at [redacted] strength on 08/31/13. A request has been made to the physician to try a [redacted] to [redacted]. Further recommendations to reduce will be requested following the drug recommendations. Resident #45 was given [redacted] for sleep instead of for anxiety. The staff person has been counseled regarding administration of [redacted] without adequate indication for use. Resident #9's [redacted] dose was resumed back to [redacted] when nursing staff did not have evidence of behavior monitoring for [redacted] or [redacted] 	12/11/2013

RECEIVED
DEC 09 2013
DSHS/ADSA/RCS Region 4

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070	
(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 329	<p>Continued From page 20</p> <p>According to the 04/16/13 Minimum Data Set (MDS), Resident #4 had care needs related to [REDACTED] and [REDACTED] with [REDACTED] or [REDACTED] features. According to this MDS, Resident #4 was assessed to be [REDACTED] with significant [REDACTED] problems. The 04/16/13, 07/15/13 and 10/13/13 MDSs reflected the resident had no trouble falling or staying asleep, or sleeping too much.</p> <p>Record review revealed Resident #4 had received the antianxiety medication [REDACTED] twice a day for anxiety since 06/19/11 and the antidepressant medication [REDACTED] each evening for sleep and anxiety since 04/05/11.</p> <p>Record review revealed staff did not monitor the resident's sleep or the effect [REDACTED] had on the resident's sleep. In an interview on 11/18/13 at 9:17 a.m., Staff B indicated staff should have, but had not, monitored sleep for Resident #4. Failure to adequately monitor the target behaviors identified which required the use of [REDACTED] prevented staff from determining effectiveness of the medication.</p> <p>Further record review revealed there was no indication in the record the resident exhibited target behaviors which required the continued use of [REDACTED] for sleep or anxiety or [REDACTED] for anxiety. However, there was no indication facility staff considered any gradual dose reduction for these medications.</p> <p>Review of Physician notes dated [REDACTED]/13 indicated, "(Resident) apparently has been stable...It sounds like her [REDACTED] and [REDACTED] issues have been stable. No changes in</p>	F 329	<p>[REDACTED] Behavior monitoring for these target behaviors have been initiated and will be reported to the physician with a request for gradual dose reduction of the [REDACTED] Care plan reviewed to include alternative approaches for care.</p> <p>2) How the nursing home will act to protect residents in similar situations:</p> <ul style="list-style-type: none"> The Consultant pharmacist will audit records monthly and requesting GDR for psychotropic drugs Audit of all current resident MAR's who are prescribed psychotropic medications to ensure compliance with regulation # 329. Follow up with physician for dose reductions or contraindication statement (if indicated per their evaluation). <p>3) Measures the nursing home will take or systems it will alter to ensure that the problem does not recur:</p> <ul style="list-style-type: none"> Licensed nurses will receive an in-service on the facility's Chemical Restraints/Psychotropic Medication Policy with focus on "target behaviors" and "non-pharmacological intervention" documentation.

RECEIVED
11/18/2013
DSHS/ADSA/RCS Region 4

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070		
(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 329	<p>Continued From page 21</p> <p>medications at this time." Physician Notes dated [redacted]/13 indicated, "(resident) appears to be clinically stable. I see no indication to change her medications at this time." Similar Physician notes were noted on [redacted]/13 and [redacted]/13. On [redacted]/13 the Physician agreed to a dose reduction of the antidepressant [redacted], a medication the resident had received for over two years with no dose reduction, but declined consideration of altering doses for the [redacted] or [redacted].</p> <p>According to IPN (Interdisciplinary Progress Notes) associated with the MDS, dated 04/18/13, "It appears that (resident's) depression and anxiety, especially at night has stabilized with the combination of her [redacted] (depression), [redacted] (anxiety, [redacted] (depression and helpful for sleep), getting to bed a bit earlier and staffs ability to redirect (Resident #4) and support her emotionally... (Doctor) has been working with her three psychotropic medications: [redacted] and [redacted]. He would like her medications to remain the same, as she is stable, pleasant, has bright affect..." Similar notes were made on 07/29/13 and 10/27/13, in correlation with the MDS assessments.</p> <p>In an interview on 11/18/13 at 9:17 a.m., Staff B indicated that staff had not attempted to reduce the [redacted] or [redacted] according to guidelines. Staff B indicated the physician had repeatedly declined pharmacy recommendations for dose reductions in the absence of behaviors which would warrant their continued use. Staff B indicated the facility, "could do a better job to ensure GDRs (Gradual Dose Reductions) are performed according to guidelines."</p>	F 329	<ul style="list-style-type: none"> The facility has revised it's policy and procedure for target behavior monitoring and documentation to ensure adequate assessment and evaluation. <p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> The DNS and consultant pharmacist will review GDR requests to ensure timeliness and follow-up. MDS nurses to review psychotropic medication efficacy, GDR timelines, nursing notes and psychotropic note summaries and report any need for follow up. When GDR requests are not approved by physician due to the physician finding that the GDR is clinically contraindicated, the denial will be reviewed by MDS nurses, the QI committee and/or medical director. <p>5) Dates when corrective action will be completed:</p> <p>January 1, 2014</p> <p>6) The title of the person responsible to ensure correction:</p> <p>[redacted] RN, MN Director of Clinical Services</p>	01/01/14

RECEIVED
FEB 09 2013
DSHS/ADSA/RCS Region 4

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070	
(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 329	<p>Continued From page 22</p> <p>RESIDENT #45 Resident #45 was admitted to the facility on [REDACTED] /13 with care needs related to a recent [REDACTED]. According to the 09/07/13 MDS, the resident was able to understand and be understood in conversation and had no memory impairment.</p> <p>Review of Physician Orders revealed the resident was admitted with an order for [REDACTED] every day.</p> <p>Observation on 11/15/13 at 1:01 p.m. revealed Resident #45 lying in bed, resting. The resident stated at that time, "I used to smoke [REDACTED] or [REDACTED] cigarettes a day...no one has talked about reducing the dose of the [REDACTED]."</p> <p>According to the drug insert packet for the [REDACTED] "If you smoke more than 10 cigarettes per day: Begin with [REDACTED] use the [REDACTED] for 4 weeks, then [REDACTED] for 2 weeks, and [REDACTED] for 2 weeks." This insert further directs, "If you smoke 10 or less cigarettes per day: Do not begin with [REDACTED] [REDACTED]...begin with [REDACTED] patch for 4 weeks, and [REDACTED] patch for 2 weeks."</p> <p>Facility staff did not follow recommendations for the lower dose [REDACTED] or consider reduction at any time during the nine weeks the resident received the [REDACTED] mg dose. In an interview on 11/18/13 at 12:10 p.m., administrative nursing Staff B stated staff should have, but did not address/consider the reduction of the [REDACTED]</p> <p>Additionally, the resident had Physician Orders for as needed (PRN) [REDACTED] for "anxiety due to [REDACTED]"</p>	F 329		

RECEIVED
NOV 09 2013
DSHS/ADSA/RCS Region 4

[REDACTED] 12/16/2013

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070		
(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 329	<p>Continued From page 23</p> <p>██████████ withdrawal." Record review revealed facility staff administered the ██████████ on 08/31/13 for "sleep" at same time as a PRN of ██████████ ██████████ was administered for constipation. In an interview on 11/18/13, Staff B indicated staff should administer medications to treat the conditions for which they were intended. Administration of ██████████ without adequate indication for use constitutes the use of an unnecessary medication.</p> <p>RESIDENT #9 According to the 09/22/13 MDS, Resident #9 was diagnosed with ██████████ required total assistance of staff for ██████████ sometimes ██████████ others, was ██████████ ██████████ by others, and received antipsychotic and antidepressant medications daily. According to this MDS, the resident exhibited no behaviors and no rejection of care. However, according to Care Tracker Behavior Monitoring (CTBM), on 09/20/13 at 1:54 a.m. the resident, "resists/rejects care and was not easily altered."</p> <p>According to the 09/12/13 Mood/Behavior Care Plan (CP), Resident #9 had received the antipsychotic medication ██████████ (twice a day) since 03/17/13. A GDR was attempted in 01/13 but according to facility documentation, it had "failed." Approaches listed on the CP included, "Care staff and LN to document behaviors on care tracker, IPN (Interdisciplinary Progress Notes) and MAR (Medication Administration Record)."</p> <p>Review of the MAR Behavior Monitoring records from February 2013 through October 2013 revealed the resident exhibited none of the</p>	F 329	<p style="text-align: right;">RECEIVED NOV 09 2013 DSHS/ADSA/RCS Region 4</p> <p style="text-align: right;">██████████ 12/6/2013</p>	

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070		
(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 329	<p>Continued From page 24</p> <p>identified target behaviors indicated for use of [REDACTED] and [REDACTED]. Review of the 03/26/13 MDS indicated the resident exhibited no [REDACTED] or rejection of care.</p> <p>Review of (CTBM) from 01/01/13 forward, revealed Resident #9 did not exhibit any behaviors until 03/01/13 when the resident "resists/rejection of care." Review of IPNs during the same time period also revealed Resident #9 had not exhibited any behaviors until a 03/01/13 when, "resident has been increasingly resistant to care." Review of CTBM indicated the resident exhibited rejection of care on 03/04, 05, and 06/13, respectively.</p> <p>Record review revealed a 03/06/13 fax to the resident's physician from nursing, documenting "On [REDACTED]/13 (Resident #9's) [REDACTED] dose was taken down [REDACTED] (every) a.m. and [REDACTED] q p.m. to [REDACTED] (twice daily.) She has become increasingly more resistant to care, especially in the evening and noc. She is also spitting every meals. is there any way we could get the PM dose increased again to [REDACTED] and a note written for the State that she has failed her dose reductions." The physician subsequently [REDACTED] despite no increase in the target behaviors which required the use of the [REDACTED].</p> <p>Further review of the IPN noted a 03/12/13 entry which noted the caregiver "reports that resident is continuing to be resistive..." On 03/17/13, it is noted "She (Resident #9) has become more resistant and combative with care since her decrease of [REDACTED]. It was increased back to [REDACTED] in the evening 10 days ago with no real improvement noted. MD notified and [REDACTED]."</p>	F 329			

RECEIVED

DEC 09 2013

OSHS/ADSA/RCS Region 4

[REDACTED] 12/11/2013

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070		
(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 329	<p>Continued From page 25</p> <p>was increased to [REDACTED] " The medication was again increased, despite no increase in the target behaviors associated with the use of [REDACTED]</p> <p>In an interview on 11/18/13 at 9:18 a.m., Staff L confirmed the facility identified target behaviors indicating the continued use of the [REDACTED] were [REDACTED] and [REDACTED] and described the behaviors exhibited by the resident in the event the resident were experiencing either. When informed record review revealed no documented [REDACTED] or [REDACTED] by Resident #9, Staff L said the behavior sheets were "a work in progress."</p> <p>In an interview on 11/18/13 at 10:01 a.m., Staff I indicated prior to completion of the MDS, even though the MAR behavior sheets were reviewed, "They are not the best source of information." In an interview on 11/18/13 at 10:49 a.m., Staff B stated the current behavior monitoring system was "not effective."</p> <p>On 11/18/13 at 9:18 a.m., when asked without the identification of the target behaviors of "[REDACTED] and [REDACTED] identified in the facility documentation, what was the basis for the increase in [REDACTED] for Resident #9, Staff L said "combativeness", "resistive to care, strike out or body tight." Staff L agreed as these were not the identified target behaviors designated for the use of the [REDACTED] medication, there was no support to increase the [REDACTED]</p>	F 329			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	12/16/2013	

RECEIVED
NOV 09 2013
OSHS/ADSA/RCS Region 4

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070	
(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 26 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (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. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	1) How the nursing home will correct the deficiency as it relates to the resident: • There was no specific resident referenced in the citation. 2) How the nursing home will act to protect residents in similar situations: • The laundry person was counseled on universal precautions, proper glove use, use of barrier, cross contamination and its prevention. • A return demonstration of staff competency to be witnessed by DNS. • The source of mixed laundry (pads and linen) located and procedure implemented to separate linen. 3) Measures the nursing home will take or systems it will alter to ensure that the problem does not recur: • In-service for housekeeping and laundry personnel on universal precautions to include; proper glove use, barriers, cross contamination and its prevention. • Laundry room to be provided with hand sanitizer and disposable barrier aprons. • Infection control policy reviewed and updated if appropriate	12/16/2013

RECEIVED

NOV 29 2013

DSHS/ADSA/RCS Region 4

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070		
(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 27</p> <p>Based on observation, interviews, and record review, it was determined the facility failed to ensure linens and personal clothing were handled and transported in a manner which would prevent contamination and the spread of infection for residents who had their personal clothing laundered and delivered by facility staff.</p> <p>Findings include:</p> <p>According to facility linen distribution system guidelines, all personnel handling soiled linens are to be properly protected (they should wear appropriate PPE (protective items or garments worn to protect the body or clothing from hazards which can cause injury), etc.). In addition, proper hand washing procedures should be adhered to by all staff handling soiled linens.</p> <p>On 11/13/13 at 9:49 a.m. Staff J, a laundry aide, was observed with uncovered linen stacked on top of a laundry cart. As Staff J proceeded up the hallway, several items fell off the cart onto the floor. Staff J was observed to pick the items up and place the now soiled linens on the lower part of the cart with resident personal clothing. Staff J then proceeded to deliver the personal clothing to residents. In an interview on 11/18/13 at 10:05 a.m., Staff K (Housekeeping Supervisor) stated if items become contaminated it is expected those items would be returned to the laundry room and re-laundered.</p> <p>On 11/18/13 at 9:15 a.m. Staff J was observed to enter the soiled utility room with soiled personal clothing. Staff J was noted to sort the soiled clothing, which came into contact with her personal clothing, without the use of any type of barrier between her personal clothing and the</p>	F 441	<p>4) How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <ul style="list-style-type: none"> • Monthly observation of laundry personnel by manager to ensure compliance with universal precautions to include use of barriers, gloves, and proper techniques to avoid cross contamination. <p>5) Dates when corrective action will be completed:</p> <p>January 1, 2014</p> <p>6) The title of the person responsible to ensure correction:</p> <p>[REDACTED] Administrator</p> <p>RECEIVED DEC 09 2013 DSHS/ADSA/RCS Region 4</p>	<p>01/01/14</p> <p>12/12/2013</p>

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

PRINTED: 11/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505399	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2013
NAME OF PROVIDER OR SUPPLIER VASHON COMMUNITY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 15333 VASHON HIGHWAY SOUTHWEST VASHON, WA 98070		
(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 28</p> <p>soiled items. Staff J was then observed to place the soiled items into the washing machine. Staff J went directly from loading the washing machine into the clean area to fold and sort personal laundry. At no time did she wash her hands between the two tasks.</p> <p>According to Staff J, in an interview at the time of the observation, she brought an apron from home for this purpose but rarely wore it. Staff J stated she only used a barrier (apron) for protection if she felt items were soiled. Additionally, Staff J stated she was not trained or informed she should use a barrier gown or apron when handling soiled items.</p> <p>In an interview on 11/18/13 at 10:05 a.m. Staff K, stated it was expected staff should wear barriers when sorting soiled items. Staff K, also stated, it was expected hand washing occur as staff moved from one task to another. Failure to ensure linen and personal clothing were handled and processed in a manner which prevented contamination and cross contamination placed residents at risk for the spread of infection.</p>	F 441			

RECEIVED
NOV 09 2013
DSHS/ADSA/RCS Region 4

11/16/2013