

1333

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505376	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/22/2013
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NAME OF PROVIDER OR SUPPLIER MT BAKER CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2905 CONNELLY AVENUE BELLINGHAM, WA 98225
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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 Mt. Baker Care Center on 02/21/13 and 02/22/13. A sample of 4 residents was selected from a census of 43. The sample included 2 current residents and the records of 2 former and/or discharged residents.</p> <p>The following were complaints investigated as part of the survey: 2724455 2746041 2746244</p> <p>The survey was conducted by: [REDACTED], MS, RN</p> <p>The survey team is from: Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, Region 2, Unit B 3906 172nd Street NE, Suite 100 Arlington, WA 98223</p> <p>Telephone: (360) 651-6850 Fax: (360) 651-6940</p> <p><i>Robert A Crawford</i> 3/5/13 Residential Care Services Date</p>	F 000	<p>Preparation, and or execution of this Plan of Correction does not constitute the provider's admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and or executed solely because it is required by the provisions of federal and state laws</p> <p><u>Correction of the deficiency, as it relates to the resident.</u></p> <p>The staff member involved in the incident was immediately placed on suspension. The police were notified.</p> <p>A full investigation was completed at the time of the incident.</p> <p>An inservice on 1/30 for all direct care staff, emphasized a gentle approach and directions to stop, when the resident says please stop, to prevent any unintended pain.</p>	
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RECEIVED
MAR 14 2013
ADS/RCS
Smokey Point

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Indira P. Quash</i>	TITLE Administrator	(X6) DATE 3-13-13
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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.

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F 225
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483.13(c)(1)(ii)-(iii), (c)(2) - (4)
INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

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.

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).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

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.

F 225

Protection of residents in similar situations.

Any allegations of physical or verbal abuse will be immediately investigated, using guidelines in the "Purple Book" and the MBCC policy on abuse.

Individual interviews will be conducted for those staff involved in an incident.

The 3/7/2013 inservice for all staff, reviewed the regulations for the mandatory reporting of resident complaints and/or any allegations of mistreatment or abuse.

Measures taken or systems altered, to ensure that the problem does not recur.

All incidences/allegations of abuse, will be investigated by the Resident Care Manager, with a follow-up by the Director of Nursing.

[Handwritten Signature]
3-13-13

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

PRINTED: 03/04/2013
FORM APPROVED
OMB NO. 0938-0391

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This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to conduct a complete investigation on one of six investigations reviewed. Failure to perform a thorough investigation for allegations of abuse of Resident 4 placed residents at risk of possible abuse/neglect.

Findings include:

Resident 4 was admitted in [REDACTED] 2010 with diagnoses including [REDACTED], history of a [REDACTED] with resultant weakness on her [REDACTED], and [REDACTED]. She had extensive hearing loss, and staff must speak slowly while facing her for Resident 4 to understand what is said. Her most recent Minimum Data Set (MDS) assessment, dated 02/06/13, identified her memory and recall as very good (13/15 points on the memory assessment tool). She required a mechanical lift with 2 person assist for transfer between the bed and wheelchair.

On 01/27/13 sometime between 9 and 10 p.m., Nursing Assistants (NA) 1 and 2 used a mechanical lift to move Resident 4 from the wheelchair to the bed for the night. During repositioning in the bed, Resident 4 stated, "ouch" to NA 2, who had his hand on her thigh. He did not move his hand, so she repeated "ouch" and kicked at him. He moved his hand away from her thigh and exited the resident's room. After some time passed, NA 2 returned to the room and completed all bedtime care for Resident 4. He did not report the incident to any other staff.

F 225

Plan to monitor performance, to ensure that solutions are sustained.

Incidents/allegations of abuse, with the completed incident report and all investigations, will be reported to the Quality Assurance Committee, for review and comment as appropriate.

Date when corrective action will be completed.

March 12, 2013

Title of the person responsible to ensure correction.

Director of Nursing Services

Handwritten signature
3-13-13

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F 225

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F 225

About 11 p.m. that same night, Resident 4 told the oncoming night shift NA 3 of the incident. Resident 4 pointed to her thigh. NA 3 noted a mark on the skin and notified the night Licensed Nurse (LN) 1. LN 1 assessed Resident 4's skin and noted four "very faint discolorations" on the top of Resident 4's thigh near her knee. One was 3x1 centimeters (cm) and three were 1x1 cm in size. LN 1 questioned Resident 4 about the incident and notified the State Hotline of the allegation of abuse.

On 02/22/13 at 11:35 a.m., Resident 4 initially made a facial grimace when asked about the incident. She reported NA 2 hurt her when he was turning her in the bed. She thought he "dug his fingers and fingernails into my hip." She recalled "It was painful. I said "ouch", but he did not stop. He kept doing it and it hurt. I tried to kick him, but I missed. Then he stopped. He seemed angry and he left the room."

At 1:15 p.m., the Director of Nursing Services (DNS) and LN 2 reported they conducted the investigation of the allegation from Resident 4. They did not have the NAs perform a reenactment of what occurred. The DNS stated she did not follow-up on the skin marks to determine when they appeared and what caused them. Neither the DNS nor LN 2 interviewed NA 1 after she wrote her statement; a statement that failed to mention details Resident 5 and NA 2 wrote. Thus, neither the DNS nor LN 2 knew whether NA 1 was present when the incident occurred. Neither the DNS nor LN 2 asked NA2 for all details of his written statement. Additionally, the DNS reported she had no

JDR
3-13-13

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F 225	<p>Continued From page 4</p> <p>information why no one followed up with Resident 5 regarding her written statement allegation that NA 2 "had been rough before ...rough with my shoulder."</p> <p>Review of the facility investigation revealed no evidence of documentation of reenactment of the incident. No clarification or follow-up of written statements from Resident 5, NA 1 or NA 2 was found. There was no monitoring of the skin "discolorations" on Resident 5's thigh. There was no follow-up on behavior (kicking) by Resident 5. Additionally, although NA 2 no longer provided care services to Resident 5, not all staff participated in the in-service for transferring residents to prevent reoccurrence of such incidents.</p>	F 225		

JBR
3-13-13