

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

1353

PRINTED: 01/30/2014
FORM APPROVED
OMB NO. 0938-0391

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505341 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 01/23/2014 |
|--|--|--|--|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DISCOVERY NURSING & REHAB OF VANCOUVER | STREET ADDRESS, CITY, STATE, ZIP CODE 5220 NORTHEAST HAZEL DELL AVENUE VANCOUVER, WA 98663 |
|--|--|

| (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 Off-Hours Quality Indicator Survey conducted at Discovery Nursing and Rehabilitation of Vancouver on 01/19/14, 01/20/14, 01/21/14, 01/22/14 and 01/23/14. The survey included data collection on 01/19/14 from 7:00 p.m. to 9:15 p.m. and on 01/20/14 from 9:15 a.m. to 6:00 p.m. A sample of 28 residents was selected from a census of 68. The sample included 20 current residents and the records of 8 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████ MSW ██████████ RN, MSN ██████████ MCJ ██████████, PhD</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services District 3, Unit A, D & E P.O. Box 45819 Tumwater, Washington 98504-5819</p> <p>Telephone: 360.664.8429 Fax: 360.664.8451</p> <p><i>[Signature]</i> Residential Care Services Date 1/23/14</p> | F 000 | <p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Discovery Nursing and Rehab. does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p style="text-align: center;">RECEIVED FEB 18 2014 DSHS/ADSA/RCS</p> | |
|-------|---|-------|---|--|

| | | |
|--|------------------------|------------------------|
| LABORATORY, DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i> | TITLE Administrator | (X6) DATE 2/11/2014 |
|--|------------------------|------------------------|

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505341 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 01/23/2014 |
|--|--|--|--|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DISCOVERY NURSING & REHAB OF VANCOUVER | STREET ADDRESS, CITY, STATE, ZIP CODE 5220 NORTHEAST HAZEL DELL AVENUE VANCOUVER, WA 98663 |
|--|--|

| (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 166 SS=D | <p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure grievances were investigated and promptly resolved for 3 of 4 current sampled residents (#54, 42 & 129) reviewed for missing property. This failure violated resident's right when the facility failed to promptly resolve resident concerns regarding lost/missing personal property and placed residents at risk for diminished quality of life.</p> <p>Findings include:</p> <p>Facility Policy and Procedures entitled, "Resident's Rights," documented, "18. To keep and use personal clothing and possessions..."</p> <p>Facility Policy and Procedures entitled, "Resident Personal Items Safekeeping," documented, "It is the policy of this facility that residents' personal possessions will be safeguarded while they are a resident living in the facility." "8. If any personal item is lost during the resident's stay, an investigation will be completed by the facility and the results will be communicated to the resident and/or family/responsible party. The Administrator/designee will discuss the method of replacement for lost items with the resident and/or family/responsible party."</p> | F 166 | <p>F166</p> <p>Resident # 42 was interviewed and all lost items were identified. Belongings list was reviewed and many of the items identified were located. The items not located on this belongings list will be replaced by the facility to the resident's satisfaction.</p> <p>Resident # 129 is not interviewable. Her son reported glasses missing, however, they are not listed on the belongings list when admitted to this facility. No record of item being missing reported to social services for follow-up. The guardian reports resident is [REDACTED] and glasses would not be helpful so not to replace them at this time. She is not aware if glasses were ever in the facility related to resident's [REDACTED] which occurred prior to her admission to this facility. We are not replacing glasses related to resident/responsibility party preferences.</p> <p>Resident # 54 is not interviewable. Resident's daughter was contacted related to missing blanket. Grievance was</p> | |

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505341 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 01/23/2014 |
|--|--|--|--|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DISCOVERY NURSING & REHAB OF VANCOUVER | STREET ADDRESS, CITY, STATE, ZIP CODE 5220 NORTHEAST HAZEL DELL AVENUE VANCOUVER, WA 98663 |
|--|--|

| (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 166 Continued From page 2
1) Resident #42 was admitted to the facility on [REDACTED]/13 with diagnoses including [REDACTED], [REDACTED], [REDACTED] failure and [REDACTED] disease.

The resident's Minimum Data Set (MDS), an assessment tool, dated 10/22/13, indicated the resident was alert and oriented, required extensive assistance with activities of daily living (ADLs), and participated in the MDS assessment process. Per personal preferences, the MDS indicated it was very important to the resident to take care of personal belongings.

On 01/20/14 at 10:36 a.m., the resident stated when he was admitted to the facility he brought in 10 to 12 shirts and now after three months he had one. He brought in shorts and they were mostly gone. He brought in two pairs of pants and now only had one. The resident said, "This isn't my shirt. It's someone else's."

When asked if the resident had reported the missing items to the facility staff, the resident indicated he had and stated, "It doesn't seem to do much good. They don't have time for it. If she (nursing staff) hears about it, she'll run down to the laundry to look. All my clothing had my name in them. They don't seem too concerned about getting my stuff back."

When asked if staff were looking for the resident's missing clothing, the resident stated, "I've asked several times. Staff have looked in my drawers sometimes, but if they don't find it they don't say or do anything else."

Record review of the facility's Grievance Log showed an entry for Resident #42 on 01/10/14

F 166 filled out and blanket was being looked for. This item has not been located as of survey date. Resident's daughter contacted and stated item did not need to be replaced. She also stated she did not want reimbursed as it was a gift from the facility to resident Christmas 2012. Resident was given another donated blanket to replace this on one 1/31/2014.

Residents in facility have the potential to be affected.

Residents in facility will be interviewed to identify any lost and missing items. A grievance form will be filled out and follow up will be completed to the resident/family satisfaction.

Residents and family members will be educated on reporting lost items.

Staff to be re-educated proper method to report lost and missing items.

Social Services will be responsible to track and trend lost items every month. These

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

PRINTED: 01/31/2014
FORM APPROVED
OMB NO. 0938-0391

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505341 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 01/23/2014 |
|--|--|--|--|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DISCOVERY NURSING & REHAB OF VANCOUVER | STREET ADDRESS, CITY, STATE, ZIP CODE 5220 NORTHEAST HAZEL DELL AVENUE VANCOUVER, WA 98663 |
|--|--|

| (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 166 | <p>Continued From page 3 regarding missing "██████████." No entries were found in the Grievance Log, from October 2013 to present, regarding the resident's missing clothing.</p> <p>Record review of an occupational therapy note, dated 01/04/14, documented, "Noted increased agitation during session when pt (resident) unable to locate belongings."</p> <p>On 01/22/14 at 8:14 a.m., the resident stated he told staff about the missing articles of clothing. The aides told him they had looked but have not found his clothing. He had heard the laundry had a rack of donated clothing and a rack of residents' clothing. The aides can take clothing from the donated rack for residents. The resident thinks things get confused in the laundry and maybe aides take from the wrong rack.</p> <p>On 01/22/14 at 10:50 a.m., the Director of Nursing Services (DNS) said the facility policy is for the facility staff who learn of a resident's missing personal items to either write a note or fill out a grievance form and give the completed form to the DNS. The grievance notes and forms are then given to Social Services and put into the Grievance Log, which is reviewed and signed off by the Administrator.</p> <p>The DNS stated whenever a resident reports a loss, the staff will "immediately start looking" for the item. For missing clothing they look in the laundry on two racks, one with unmarked clothing and one for donations. Families are invited to look as well. If the missing items are not found, the facility will purchase replacement items within a day or two.</p> <p>2) Resident #129 was admitted to the facility on</p> | F 166 | <p>findings will be reported at the QA meetings to identify opportunities for performance improvement.</p> <p>The Administrator will monitor to ensure compliance.</p> <p>Compliance Date 02/20/2014</p> | |
|-------|---|-------|--|--|

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505341 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 01/23/2014 |
|--|--|--|--|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DISCOVERY NURSING & REHAB OF VANCOUVER | STREET ADDRESS, CITY, STATE, ZIP CODE 5220 NORTHEAST HAZEL DELL AVENUE VANCOUVER, WA 98663 |
|--|--|

| (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 166 | <p>Continued From page 4</p> <p>_____/13 with diagnoses including _____, _____, _____, _____, _____ weakness, _____, _____, and _____s.</p> <p>The resident's MDS, dated 01/02/14, indicated the resident had severe _____ impairment, had short and long term memory problems, and was severely impaired in daily decision making skills. The MDS indicated it was very important to the resident to take care of personal belongings, required extensive to total dependence with ADLs, and the resident participated in the MDS assessment process with a legal representative.</p> <p>On 01/20/14 at 2:08 p.m., the resident's family member stated the resident's eyeglasses were missing and the facility staff had been made aware. The family member stated it was not clear how the staff tracked the reporting of missing items, "notes or mental notes."</p> <p>Record review of the facility's Grievance Log, October 2013 to present, did not show any entries regarding the resident or the resident's missing eyeglasses.</p> <p>3) Resident #54 was admitted to the facility on ____/12 and had diagnoses including _____ disease, _____, _____, _____, and _____ disorder.</p> <p>The resident's MDS, dated 10/27/13, indicated the resident was severely cognitively impaired, required extensive assistance with ADLs, and had a significant other participated in the MDS assessment process.</p> | F 166 | | |

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

PRINTED: 01/31/2014
FORM APPROVED
OMB NO. 0938-0391

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505341 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 01/23/2014 |
|--|--|--|--|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DISCOVERY NURSING & REHAB OF VANCOUVER | STREET ADDRESS, CITY, STATE, ZIP CODE 5220 NORTHEAST HAZEL DELL AVENUE VANCOUVER, WA 98663 |
|--|--|

| (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 166 | <p>Continued From page 5</p> <p>On 01/20/14 at 4:41 p.m., Resident #54's family member stated, "Since Christmas, [the resident] has had a missing blanket. I volunteered to go look in the laundry, but they (facility staff) said they would look." The family member also indicated she had brought in clothing for the resident which are now missing. The family member said she had asked the facility where the resident's clothes are, and stated, "A lot of the clothes she (the resident) has in her closet are those that were donated" to the facility.</p> <p>Record review of the facility's Grievance Log, October 2013 to present, did not show any entries regarding the resident or the resident's missing blanket and clothing.</p> <p>On 01/23/14 at 10:42 a.m., the DNS stated when there is missing property on the closed unit (Expressions), the facility tries to find them. The facility had new clothes donated for the residents in Expressions, and that was probably what Resident #54 was wearing. The DNS stated she did not know anything about the missing blanket and said, "When there is something missing, the facility will replace the item."</p> <p>On 01/23/14 at approximately 11:00 a.m., the Social Service Director (SSD) indicated she was unable to find the missing items documented on the Grievance Log. The SSD stated, "Staff are probably not filling it (grievance form) out." The SSD said the staff who are notified of missing property are suppose to fill out a grievance form. They are to go and look for the item, call the family, and get a description. Staff then look in the laundry and in the resident's room. The SSD stated she makes sure the grievance is resolved and makes notes.</p> | F 166 | | |
|-------|--|-------|--|--|

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505341 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 01/23/2014 |
|--|--|--|--|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DISCOVERY NURSING & REHAB OF VANCOUVER | STREET ADDRESS, CITY, STATE, ZIP CODE 5220 NORTHEAST HAZEL DELL AVENUE VANCOUVER, WA 98663 |
|--|--|

| (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 166 F 241 SS=D | <p>Continued From page 6</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure respect and dignity were maintained for 1 of 28 current sampled residents (#53) reviewed for the dignity. This failure placed residents at risk for not receiving the necessary care and services needed to enhance and/or maintain dignity and respect while eating.</p> <p>Findings Include:</p> <p>Resident #53 was admitted to the facility on [REDACTED]/13 with diagnoses including [REDACTED] disease, [REDACTED], and [REDACTED].</p> <p>The resident's Minimum Data Set (MDS), an assessment tool, dated 12/1/13, indicated the resident was severely cognitively impaired in daily decision making skills.</p> <p>On 1/20/14 at 1:09 p.m. Resident #53 was observed pouring out thickened liquids onto the table and clothing protector. The incident was brought to the staff's attention and the plate was moved out of the way. The thickened liquid still remained on the table and Resident #53 wiped</p> | F 166 F 241 | <p>F241</p> <p>Resident # 53's care plan has been updated to reflect her current individual eating pattern.</p> <p>Residents who reside in the center have the potential to be affected.</p> <p>Staff have been re-educated on dignity and respect. This education to include the importance of maintaining an environment that enhances each resident's dignity and respect as well as their individuality.</p> <p>Resident Care Manager will monitor dining rooms randomly to observe eating and feeding patterns of residents. Care plans will be updated to reflect changes.</p> <p>RCM will bring findings to QA meetings to identify opportunities for performance improvement.</p> <p>DNS will monitor for compliance.</p> <p>Compliance Date 02/20/2014</p> | |

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505341 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 01/23/2014 |
|--|--|--|--|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DISCOVERY NURSING & REHAB OF VANCOUVER | STREET ADDRESS, CITY, STATE, ZIP CODE 5220 NORTHEAST HAZEL DELL AVENUE VANCOUVER, WA 98663 |
|--|--|

| (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 241 | <p>Continued From page 7</p> <p>fingers through the spilled liquid and then put fingers into mouth.</p> <p>At 1:15 p.m., Licensed Nurse (LN) A stated the expectation would be for the aide to have removed the plates, cleaned up the spilled mess and replaced the liquids.</p> <p>On 1/21/14, during the noon meal, Resident #53 was observed eating liquids with fingers by putting fingers into cup and then putting fingers in mouth. Resident #53 then spilt the liquids onto the table and used fingers to wipe the table and then put the fingers in mouth.</p> <p>At 1:17 p.m., Resident #53 was observed sitting at a dining table with a cup of partially melted sherbet and a spoon. Resident #53 spilt some of the melted sherbet onto the table and made a puddle. Nursing Assistant (NA) A sat beside Resident #53 and assisted another resident with eating. Resident #53 held the cup of sherbet and with her fingers scooped sherbet into mouth and licked the fingers. NAA looked over at Resident #53 and said, "Are you going to eat that?" Without verbal response, Resident #53 attempted to eat the sherbet off the table by wiping fingers through the puddled sherbet and then licking the fingers. No attempt was made to intervene and assist the resident with eating.</p> <p>Review of Resident #53's care plan on 1/21/14 did not reveal any evidence the resident was to use her fingers to eat.</p> <p>At 1:24 p.m., NAA said Resident #53 played with her food when eating. NAA indicated Resident #53 was not care planned for eating with fingers or playing with food during dining. NAA indicated</p> | F 241 | | |
|-------|--|-------|--|--|

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505341 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 01/23/2014 |
|--|---|--|---|

| | |
|---|--|
| NAME OF PROVIDER OR SUPPLIER DISCOVERY NURSING & REHAB OF VANCOUVER | STREET ADDRESS, CITY, STATE, ZIP CODE 5220 NORTHEAST HAZEL DELL AVENUE VANCOUVER, WA 98663 |
|---|--|

| (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 241 | Continued From page 8 the level of assistance with eating needed by the resident varied from day to day. On 1/22/14 at approximately 11:00 a.m., the resident was observed in the dining room eating with her fingers. No assistance and/or cueing with eating was provided for Resident #53. On 1/23/14 at 9:11 a.m., LN B stated when Resident #53 was observed eating off the table and licking food off fingers, staff should have intervened and assisted the resident with eating. LN B said it was not dignified that the resident had eaten off the table and licked the food from the table off her fingers. LN B reported Resident #53 required extensive assistance with one person for physical assistance with eating. | F 241 | F-282 Resident # 53's comprehensive care plan has been updated. Resident's who reside in the center have the potential to be affected. Staff has been re-educated on the importance of following individual care plans as well as the "In Room Care plans" to promote the highest quality of life and individuality. | |
| 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 follow the care plan for assistance with eating for 1 of 23 current sampled residents (#53) reviewed for implementation of care plans. Failure to follow the comprehensive care plan placed residents at risk for dehydration, malnutrition and decreased quality of life. | F 282 | Resident Care Manager will monitor individual care and dining room assistance to ensure care is being provided in compliance with the care plan and an adequate level of assistance is provided. Any changes necessary will be identified and adjusted. RCM will bring findings to the QA meetings to identify opportunities for performance improvement. DNS will monitor for compliance Compliance Date 02/20/2014 | |

| | | | |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505341 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 01/23/2014 |
|--|--|--|--|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DISCOVERY NURSING & REHAB OF VANCOUVER | STREET ADDRESS, CITY, STATE, ZIP CODE 5220 NORTHEAST HAZEL DELL AVENUE VANCOUVER, WA 98663 |
|--|--|

| (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 9</p> <p>Findings Include:</p> <p>Resident #53 was admitted to the facility on [REDACTED] 13 with diagnoses including [REDACTED] disease, [REDACTED], and [REDACTED].</p> <p>The resident's Minimum Data Set (MDS), an assessment tool, dated 12/1/13, indicated the resident was cognitively impaired, and had possible signs and symptoms of a swallowing disorder. The MDS indicated the resident needed extensive assistance with one person for physical assistance with eating and received a mechanically altered diet.</p> <p>The "In Room Care Plan," updated on 12/5/13, documented Resident #53 needed extensive assistance with eating. A note at the bottom of the form documented the resident "requires cueing and assistance with meals. Offer her snacks/fluids when in dining room."</p> <p>During observations on 1/20/13 at 1:09 p.m., 1/21/14 at the noon meal, 1/21/14 at 1:17 p.m., and 1/22/14 at approximately 11:00 a.m., the resident was observed eating and/or drinking without the required dining assistance and/or cueing needed from staff.</p> <p>On 1/23/14 at 9:11 a.m., LN B reported the level of assistance a resident needed was identified by aides when care was provided and that information was documented in the computer and was then placed on the resident's care plans. LN B reported extensive assistance with one person for physical assistance with eating meant, "spoon to mouth, feeding the resident." LN B stated the resident needed extensive assistance with one person for physical assist and cueing when</p> | F 282 | | |
|-------|---|-------|--|--|

