

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

1354

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2013
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NAME OF PROVIDER OR SUPPLIER TOPPENISH NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 802 WEST THIRD STREET TOPPENISH, WA 98948
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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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INITIAL COMMENTS

This report is the result of an unannounced Quality Indicator Survey conducted at Toppenish Nursing & Rehab Center on 02/11/13, 02/12/13, 02/13/13, 02/14/13, 02/15/13 and 02/19/13. A sample of 41 residents was selected from a census of 59. The sample included 36 current residents and the records of 5 former and/or discharged residents.

The survey was conducted by:

____ RN
____ RN
____ RN
____ RN

The survey team is from:

Department of Social & Health Services
Aging & Disability Services Administration
Residential Care Services, District 1, Unit C
3611 River Road, Suite 100
Yakima, WA 98902

Telephone: (509) 225-2800
Fax: (509) 574-5597

[Signature] 2/27/13
Residential Care Services Date

F 151
SS=D

48310(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL

The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

F 000

F000 Initial Comments

"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Toppenish Nursing and Rehabilitation 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."

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It is the policy of Toppenish Nursing and Rehabilitation that the resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.

Received
Yakima RCS
MAR 12 2013

F 151

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Ralph K. Allen, Sr.</i>	TITLE Administrator	(X6) DATE 03/08/2013
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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 151	Continued From page 1 The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to protect and promote the rights for 1 of 1 residents (#6) reviewed in a sample of 41 for resident rights according to CFR 483.10(a). Resident #6 was not allowed to leave the facility which placed her at increased risk for depression and anxiety. Findings include: Resident #6 Initiated an interview on 2/15/13 at approximately 10:30 a.m. She stated she was not permitted to leave the facility with a friend during the previous evening. She stated she wanted to go on an outing with a friend to a Valentine's party. She stated she knew that she left the facility in the past on two occasions with friends and returned drunk, but the friend that wanted to take her out on 2/14/13 was not one that she drank with. She stated she was sad because of the missed event. She said she knew the facility was concerned, but if she gave her word not to drink on an outing, they should respect that and by not letting her go she felt like a prisoner. She said she knew the facility was actively assisting her to return to the community, but it would take about 5-6 more weeks to finalize the plans. She was visibly upset during the conversation and had tears at times. Per record review, Resident #6 admitted to the facility on [REDACTED] 12 with diagnoses which included: [REDACTED] history of [REDACTED]	F 151	Incident was reviewed with resident #6, and her rights were fully explained to her. Her care plan was updated based on this review and discussion with her. Care plan was updated to reflect her individual choices as well as measures put into place for the protection of the resident. Resident verbalized understanding and agrees with care plan. Interviews were completed with residents, family members and staff in attempt to identify any other issues related to this citation. No issues were brought forward. Director of Nursing completed re-education of all staff on resident rights, including the interpretive guidelines for F151. This re-education was completed on 2-15-13, 3-16-13 and 3-13-13. Social Services Director reviewed resident rights with residents present at resident council meeting on 3-19-13. Resident Care Managers will complete daily random resident/staff interviews to ensure resident rights have been maintained. Copy of audit(s) with findings (negative outcomes/trends/patterns) will be provided to the Administrator for review and follow-up as necessary. Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance.	

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F 151	<p>Continued From page 2</p> <p>██████y state, ████████ disorder and ████████ disorder. She was alert, oriented and responsible for herself.</p> <p>Per the most recent full assessment dated 11/5/12, Resident #6 required extensive assist of two caregivers for bed mobility and transferring. She was observed throughout the survey timeframe in the facility self-propelling in her wheelchair. In the interview on 2/15/13, she stated her friend was able to transfer her in/out of her personal vehicle.</p> <p>Per the plan of care most recently updated on 1/23/13, directives included resident would communicate when she wanted to leave the facility for outings. The plan identified the resident would benefit from a responsible party to accompany her.</p> <p>Per review of the record, Resident #6 left the facility on two previous occasions, 1/10/13 and 2/7/13 with friends. Upon return to the facility after each visit, Resident #6 had alcohol on her breath and became unresponsive which required transfer to the local emergency room for evaluation and treatment.</p> <p>In interview with the DON (Director of Nursing), on 2/15/13 at 12:00 p.m., she stated Resident #6 had a history of leaving the facility accompanied by friends and returned intoxicated. She stated after the incident of 2/7/13, the physician told the facility to issue a 30-day notice of intent to discharge and to not allow Resident #6 to leave the facility again unaccompanied. The DON stated the letter of intent to discharge was not issued, instead an active discharge plan was</p>	F 151		

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F 151	Continued From page 3 initiated. She stated on 2/14/13, approximately 9:00 p.m. when Resident #6 announced her intent to leave the facility, the Licensed Nurse on duty contacted the Resident Care Manager who advised her to tell the resident she could not go out with her friend and if she went out it would be against medical advice and she could not return. Per the record, there was no documentation of physician involvement on 2/14/13 with the decision making process to not allow Resident #6 to leave the facility. As a result, Resident #6 did not go out on 2/14/13 with her friend.	F 151	157 It is the policy of Toppenish Nursing and Rehabilitation that the facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is- An accident involving the resident which results in injury and has the potential for requiring physician intervention; A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or A decision to transfer or discharge the resident from the facility. The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is- A change in room or roommate assignment; or A change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Physician for resident #6 was updated regarding issue, as well as discussion with the resident and representative to review the issue.		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident	F 157			

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F 157	<p>Continued From page 4</p> <p>and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to obtain physician involvement related to the intent to discharge 1 of 1 sampled residents (#6). This failure disallowed the physician an opportunity to make discharge recommendations and/or assist the resident in decision making. Findings include:</p> <p>Refer to findings under F151</p> <p>On 2/14/13 at approximately 9:00 p.m., Resident #6 informed the Licensed Nurse on duty that she was leaving the facility for an outing. The Licensed Nurse contacted the Resident Care Manager who advised the nurse to tell Resident #6 she could not go out with her friend and if she went out, it would be against medical advise and she could not return to the facility.</p> <p>Per the record there was no documentation to support the Licensed Nurse or the Resident Care Manager contacted the physician of the resident's plan to leave the facility.</p>	F 157	<p>Residents requesting to leave the facility are at risk related to this citation.</p> <p>Director of Nursing Services re-educated licensed nurses regarding notification of changes, and also reviewed procedures specifically related to this incident as well as actual discharges against medical advice. This re-education was completed on 2-15-13, 3-6-13 and 3-11-13.</p> <p>Director of Nursing Services or designee will review daily during MACC process any issues regarding resident request to leave the facility. If issues are discovered DNS/designee and Social Services Director will review and ensure all appropriate steps were taken and policies were followed.</p> <p>Copy of audit(s) with findings (negative outcomes/trends/patterns) will be provided to the Administrator for review and follow-up as necessary. Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance.</p> <p>F 246 It is the policy of Toppenish Nursing and Rehabilitation that a resident has a right to – reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p>	

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F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 2 sampled residents (#11,42) preferring a tub bath were accommodated with this means of bathing. This caused residents choices to be limited as a tub was unavailable in the facility. Findings include:</p> <p>Resident #11 was admitted with diagnosis of [REDACTED]. The resident was unable to be interviewed due to her inability to answer questions.</p> <p>On 02/13/13 the resident's family member was interviewed at the facility. She stated the family lived out of state and she was visiting. When asked about the resident's bathing preferences, the family member said the resident was used to taking a bath "all of her life." Her routine was to get up in the morning early, have coffee, read the paper, fix breakfast and "then take a bath." That was how she started her mornings." The family member said a shower was not what the resident was used to and now, with [REDACTED] she was not able to understand the showering process. At times, when the resident took a shower, the staff</p>	F 246	<p>Resident # 11 has discharged from the facility. Resident # 42 care plan was updated to include preference for a bath.</p> <p>Residents preferring to have a bath versus a shower are at risk related to this citation. Residents have been interviewed regarding their preferences and care plans have been updated.</p> <p>Administrator re-educated staff regarding accomodation of needs and resident preferences for bathing versus showers on as soon as it arrives it will be installed for resident use. We will move forward to ensure all preferences are documented on care plan and will be able to fully implement those preferences once the tub is installed.</p> <p>Director of Nursing Services or designee will complete daily audits to review new admissions have shower/bathing preferences on care plan.</p> <p>Director of Nursing Services re-educated interdisciplinary team 3-13-13. on completion of section F of MDS- preference for customary routine and activities, and use of the information to capture resident preferences on plan of care.</p> <p>A new tub has been ordered and This daily audit will also include random audits of completed MDS/ care plans to ensure that preferences have been documented, care plan is updated and staff are following the resident preferences.</p> <p>Copy of audit(s) with findings (negative outcomes/trends/patterns) will be provided to the Administrator for review and follow-up as necessary.</p>	

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F 246	Continued From page 6 had called to "calm" the resident and encourage her to take their shower. On 2/14/13 at 1:30 p.m. a Licensed Nurse, Staff Member E, stated the resident "gets upset all the time when she is going to have a shower." The nurse did not know the resident preferred a tub bath. The resident's usual shower time was during the evening shift. She stated she knew evening shift had a difficult time with showering the resident. She stated she thought staff on that shift had called the resident's family to help them talk the resident into the shower at times. The nurse also stated the facility did not have a tub, just showers for the residents. Facility staff were not providing the resident's bathing preferences for morning tub baths as per her past routine. Resident #42. Between 02/12/13 and 02/15/13, the resident was self-propelling her electric wheelchair throughout the facility and visiting with residents and staff members. On 02/12/13 at 9:50 a.m., the resident stated she liked to take showers several times a week. "We don't have a tub. If there was a tub here, I would use it to soak in." During an environmental tour with Staff Member F, the maintenance director, on 2/14/13 at 10:00 it was verified through observation and interview that no tub for immersion was available on site. He stated there were two tubs in the past, but they were removed and not replaced.	F 246	Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance. F 280 It is the policy of Toppenish Nursing and Rehabilitation that the resident has the right to- unless adjudged incompetent or otherwise incapacitated under the laws of the State- participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be - Developed within 7 days after the completion of the comprehensive assessment; Prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and , to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and Periodically reviewed and revised by a team of qualified persons after each assessment. Resident # 68 care plan was updated following care planning review with interdisciplinary team. Residents requiring assistance with oral care are at risk related to this citation. Care plans were reviewed and updated as needed in relation to oral care, all changes were made with agreement and participation from resident and interdisciplinary team.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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F 280	<p>Continued From page 7</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the plan of care was updated for oral care needs of 1 of 1 (#68) resident in the sample who required extensive assistance to brush his teeth. Without the updated directions for staff, they were inconsistent in the manner of assistance they were providing. Findings include:</p> <p>Resident #68. Admitted with complicated medical diagnoses which caused [REDACTED] and the need for bedrest.</p> <p>On 02/11/13 at 3:00 p.m., the resident stated he</p>	F 280		

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F 280	Continued From page 8 had lower but hardly any top teeth (2 top teeth were observed) He said the aides were to help him set up his supplies so that he could brush his own teeth, but "They have not been helping me." He wanted his teeth brushed daily. On 02/14 and 02/15/13 at approximately 3:00 p.m., the resident stated he had not been given assistance to brush his teeth on either day. When interviewed on 02/15/13, three nursing assistants on day and evening shifts said they were not providing oral care as the resident had no teeth. One evening shift nursing assistant stated she had given him a toothette (a square of foam on a stick impregnated with mouthwash) to wash his mouth out. Comprehensive assessments dated 01/23/12, 11/19/12 and 12/03/12 documented he required extensive assistance from staff for personal hygiene, which included brushing his teeth. Staff were to set up oral care items in order for him to do his own oral care. The plan of care directed staff that he "has own teeth; set up and assist with oral care." However, the plan was not specific as to when, how and/or what was included in assisting the resident to ensure his teeth were brushed routinely.	F 280	Director of Nursing Services re-educated nursing staff on standards of oral care as well as following care plan interventions in place in relation to oral care. This re-education was completed on 2-16-13. Resident Care Manager or designee will complete daily audits for two weeks to ensure care planned interventions for oral care are being followed. To ensure ongoing compliance random audits will be completed weekly for 1 month, to ensure care planned interventions have been followed. Copy of audit(s) with findings (negative outcomes/trends/patterns) will be provided to the Administrator for review and follow-up as necessary. Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312	F 312 It is the policy of Toppenish Nursing and Rehabilitation that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Resident #68 care plan was reviewed and revised to meet resident care needs. Residents who need extensive assistance or total assistance for oral care are at risk related to this citation. Residents that meet this criterion have been reviewed and care plans updated as necessary.	

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F 312	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure oral care was provided for 1 of 1 (#68) sampled resident who required 'extensive assistance'. This caused the lack of oral hygiene and the potential for dental caries. Findings include: Resident #68. Admitted with complicated medical diagnoses which caused [REDACTED]. The resident's physician placed him on bedrest for wound management. The 12/03/12 comprehensive assessment documented a need for extensive assistance from staff for personal hygiene, including brushing his teeth. Staff were to set up oral care items in order for him to do his own oral care. The plan of care directed staff that he "has own teeth; set up and assist with oral care." On 02/11/13 at 3:00 p.m., the resident was upright in his bed. He stated he had his bottom teeth but hardly any top teeth. He smiled so his two top teeth and all his bottom teeth could be observed. He stated he was not able to get out of bed and the aides were to help him so that he could brush his own teeth daily. "They have not been helping me." He denied he had any tooth pain or chewing problems at present. On both 02/14/13 at 10:00 a.m. and 02/15/13 at 11:00 a.m., the resident stated he had not had his teeth brushed yet.	F 312	Director of Nursing Services completed re-education with nurses on documentation of oral status upon admission and with completion of RAI process, up to and including care planning. This re-education was completed on 2-16-13. Director of Nursing Services and Staff Development Coordinator completed re-education with nursing assistants on oral care, and following individual care plan. Director of Nursing Services or designee will complete daily audits for 2 weeks to ensure oral care completed for residents requiring extensive or total assistance for oral care. The daily audits will be done on either day shift or evening shift. After 2 weeks the DNS or designee will complete random daily audits to ensure oral care has been completed. Copy of audit(s) with findings (negative outcomes/trends/patterns) will be provided to the Administrator for review and follow-up as necessary. Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance. Our date of compliance is March 21, 2013.	

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

PRINTED: 02/27/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/19/2013
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F 312	<p>Continued From page 10</p> <p>On 02/15/13 at approximately 3:00 p.m., the resident stated he had not been given assistance to brush his teeth that day. When asked, he said that "sometimes" on the evening shift, he was given "a deal with a sponge on it" (toothette) to rinse his mouth out with, but not all the time.</p> <p>On 02/15/13 at 10:30 a.m., a day shift nurse aide, Staff Member A, was asked about what oral care she provided the resident. She stated she did not "do anything for him unless he asks," and he usually did not ask.</p> <p>On 02/15/13 at 11:00 a.m., a day shift nurse aide, Staff Member B stated the resident "has no oral care, I don't believe. He only has a few teeth. He doesn't have any dentures."</p> <p>On 02/15/13 at 2:30 p.m., an evening shift nurse aide, Staff Member C stated after dinner she had gotten a toothette (a square of foam with mouthwash on a stick) to wash his mouth out with since "he has no teeth."</p> <p>On 02/15/13 at 3:00 p.m., an evening shift nurse aide, Staff Member D stated if the resident asked, then he would be given something to brush his teeth.</p> <p>Although staff were directed to provide assistance with oral care for the resident, according to the the nursing assistants and the resident, he failed to receive the care as directed.</p>	F 312		
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