

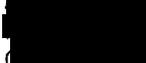
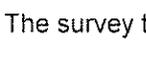
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505500	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/28/2013 <i>10-7-13</i> <i>fl</i> IDR AMENDED
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NAME OF PROVIDER OR SUPPLIER MISSION HEALTHCARE AT BELLEVUE	STREET ADDRESS, CITY, STATE, ZIP CODE 2424 156TH AVENUE NORTHEAST BELLEVUE, WA 98007
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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 Quality Indicator Survey conducted at Mission Healthcare on 06/20/13, 06/21/13, 06/24/13, 06/25/13, 06/26/13, 06/27/13 and 06/28/13. A sample of 36 residents was selected from a census of 112. The sample included 29 current residents and the records of 7 former/discharged residents.</p> <p>The survey was conducted by:</p> <p><i>Susan Abrigo</i>, MSW , RN, MN , MSW , RN, MN , RN, BSN</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Long Term Services Administration Residential Care Services, Region 2, Unit E 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388 Telephone: (253) 234-6000 Fax: (253) 395-5070</p> <p><i>Sinda Rao</i> Residential Care Services Date <i>10-7-13</i></p>	F 000	<p>RECEIVED OCT 17 2013 DSHS/ADSA/RCS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Silvia Babalgharian</i>	TITLE <i>Executive Administrator</i>	(X6) DATE <i>10/14/13</i>
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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 241 SS=D	<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, record review and interview, the facility failed to respond to verbal expressions of possible distress/pain for Resident #165, one of forty sample residents who was dependent on staff to recognize and respond to his needs. Failure by one staff member to respond to the resident's repeated calling out, and the lack of a prompt acknowledgement of the resident's verbalizations as well as lack of attempts to determine what the resident's needs might be, demonstrated a disregard of this resident's dignity.</p> <p>Findings include:</p> <p>Resident #165 was admitted on [REDACTED] 13. The resident was sent to the hospital on [REDACTED] 13 and was readmitted on [REDACTED]/13 with a diagnosis of a terminal condition and Hospice was started on [REDACTED]/13. Review of the care plan, dated 5/17/13 and revised on 6/26/13, revealed a directive to nurses and CNAs stating: "Anticipate the resident's need for pain relief and respond immediately to any complaint or s/s (signs/symptoms) of pain".</p> <p>On 6/25/13 from 8:20 am until 8:52 am, Resident #165 was observed during breakfast in the Rainier dining room. He was seated in his</p>	F 241	<p>The facility will 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><u>Immediate Action:</u> Resident #165 was attended to and provided with pain relief and comfortable position.</p> <p><u>Identification of Other Residents:</u> This involves all residents. All residents care has been reviewed for dignity. Random interviews and observations will be conducted to identify other residents with similar concerns.</p> <p><u>Measures / Systemic Changes:</u> Staff member involved has been inserviced about dignity and individual needs of the resident. All staff has been inserviced about importance of prompt response and acknowledgement of resident's needs. Care plans have been updated reflecting residents needs for dignity and respect of their privacy, choices, and autonomy.</p> <p><u>Quality Assurance Monitoring:</u> Periodic random interviews and observations will be conducted and resulting data will be reviewed and analyzed by the CQI committee.</p> <p><u>Title of Person Responsible to Ensure Compliance:</u> Executive Administrator and DNS will ensure compliance.</p>	10/14/13

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F 241	<p>Continued From page 2</p> <p>wheelchair. At 8:22 am, Resident #165 called out "ow" while seated at the table. A Certified Nursing Assistant (CNA - Staff G) seated next to him did not acknowledge the resident's verbalization by responding to him. At 8:24 am, Resident #165 called out "ow" twice in a distressed tone of voice. Staff G continued to offer him bites of food, but did not ask him what was wrong, if he needed help, or otherwise respond to his calling out.</p> <p>At 8:33 am and 8:36 am, Resident #165 again called out in a distressed manner while being fed by Staff G. Staff G continued to feed the resident in silence, without responding to him, or attempting to discern the reason for his distress. At 8:40 am, the resident refused further food or fluids. At 8:52 am, Resident #165 called out "Ow..." a sixth time. Staff G was at his table, clearing dirty dishes, but again did not ask the resident if he was in pain, or respond to him in any way. During the thirty minutes when Resident #165 was observed to call out in a distressed manner, Staff G did not talk to the resident, or inform licensed nursing staff about the resident's behavior, to request further assessment of his care needs.</p> <p>At 8:53 am, a Licensed Nurse (Staff H) approached Resident #165 and asked him if he was okay. He replied, "No, I want to go to my room".</p> <p>On 6/27/13 at 10:55 pm, the Resident Care Manager (RCM- Staff E) was interviewed. The observations of Staff G on the morning of 6/25/13 were described, including the lack of any verbal response or effort to determine what the resident needed, while the resident called out in a distressed tone of voice at least six times during</p>	F 241			

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F 241 F 327 SS=D	<p>Continued From page 3</p> <p>a half hour period. Staff G also did not make any effort to inform the licensed nurse of the resident's distress. Staff E said she would expect care staff to tell the nurse if a resident was calling out and appeared to be in pain.</p> <p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure adequate fluids were offered and tracked for Resident #165, one of one sample residents reviewed for hydration.</p> <p>Findings include:</p> <p>Resident #165 was re-admitted on [REDACTED]/13 after hospitalization. He had impaired memory and was rarely able to respond to questions about his care or care needs. A progress note by a Physician's Assistant dated 5/17/13 identified the resident as having a recent history of dehydration and treatment with intravenous fluids during the hospitalization. On 6/17/13, Hospice services were started for this resident. An initial Hospice note, dated 6/17/13 also identified a recent history of dehydration.</p> <p>A nutritional assessment by the Registered Dietitian, dated 5/13/13, (prior to his hospitalization) stated Resident #165 needed a mechanical soft diet and was able to drink thin</p>	F 241 F 327		

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F 327	<p>Continued From page 4</p> <p>(unthickened) liquids. She documented he needed 1,817 to 2,181 cubic centimeters (about 2 liters) of fluid per day to maintain adequate hydration. An initial care plan, dated 6/27/13, identified factors that placed the resident at risk for dehydration.</p> <p>When observed on 6/24/13 at 10:20 am, Resident #165 was observed seated in his room. His lips were dry. On 6/26/13 at 7:15 am, when he was observed in bed, his lips again appeared dry. When observed prior to meals on 6/25/13 at 8:20 am and 12:05 am, and on 6/27/13 at 8:00 am, this resident was not served fluids prior to the meal, even though he was able to drink thin liquids without assistance. Meal trays served to this resident on 6/25/13 and 6/27/13 included 360 cc's of fluid with breakfast, and 240 cc's of fluid at lunch.</p> <p>On 6/28/13, review of documentation of Resident #165's fluid intake revealed the facility had three different forms to document/monitor fluid intake and output (I&O): "Daily Intake and Output Flowsheet", "Intake and Output Record", and "Follow Up Question Report". Review of these documents for the resident's daily fluid intake since 6/17/13 revealed that the "Daily Intake and Output Flowsheet" and Intake and Output Record" were consistently incomplete and none of the three records showed the resident received even the minimal amount of recommended fluids.</p> <p>Documentation of his fluid intake was inconsistent on a daily basis. For example, on 6/24/13 and 6/26/13, CNAs documented Resident #165's fluid intake with meals was 720 cc's, but on the "Intake and Output Record" for all three shifts on those days, Resident #165's total fluid</p>	F 327	<p>The facility will ensure that each Resident will be provided sufficient fluid intake to maintain proper hydration and health.</p> <p><u>Immediate Action:</u> Resident #165 was provided with ice water and assistance to access a water pitcher.</p> <p><u>Identification of Other Residents:</u> All residents were reviewed for hydration and adequate fluid intake. All care plans were reviewed for accuracy.</p> <p><u>Measures / Systemic Changes:</u> Hydration protocol was reviewed and the following interventions were confirmed to be in place: Adequate fluid intake monitor at meal times, fluids offered at activities and during therapy, cups available at each drinking fountain, and fluids offered with the med pass. To assist residents with hydration light weight water pitchers are provided to each resident. All staff was in-serviced about the importance of hydration program.</p> <p><u>Quality Assurance Monitoring:</u> As part of quarterly Interdisciplinary Team meeting, or with change of condition, interventions will be reviewed and updated as needed. Executive Administrator and DNS will ensure compliance.</p> <p style="text-align: right;">RECEIVED OCT 17 2013 DHHS/ADSA/RCS</p>

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F 327	<p>Continued From page 5</p> <p>intake documented by staff was 120 cc's. According to the varying records, the resident received approximately half to two-thirds of the fluids he was assessed to need on 10 of the 11 days documented by staff between 6/17/13 and 6/27/13.</p> <p>On 6/27/13 at 11:05 am, Staff E was interviewed about potential dehydration concerns for Resident #165. He had multiple risk factors for dehydration, and was not offered fluids before meals even though he could drink thin liquids. He was offered (but drank less than) a maximum of 360 cc's with his meals, plus approximately 240 to 360 cc's more per day with medications, so was offered about 1,500 cc's of fluid per day. The RD's assessed fluid goal, and concern that he wasn't offered an amount of fluids daily to meet this goal was also discussed. During this discussion, Staff E acknowledged fluids should be available to this resident.</p> <p>On 6/28/13 at 10:20 am, Staff E was asked how staff evaluated if a resident was adequately hydrated. She replied this was done by monitoring their intake at meals; if there was an issue (with hydration), it should trigger with weight loss by a resident or with their labs. When asked which staff was responsible for documenting a resident's fluid intake, she said the CNA was responsible for reporting fluid intake to the licensed nurse and to document intake in the computerized tracking system. Staff E also said nurses were to be in dining rooms and should be observing resident during meals to identify problems with poor intake.</p> <p>Review of a binder containing I&O forms found 2 of the 3 forms used by staff to document fluid</p>	F 327	<p style="text-align: right;">RECEIVED OCT 17 2013 DSHS/ADSA/RCS</p>	

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F 327	Continued From page 6 used to document fluid I&O, Staff E responded, "That's a good question", then said one of the forms was for output only, and the second was to have fluid intake for all 3 shifts added up and reviewed by night shift staff to determine a daily total fluid intake for residents. Review of these sheets for Resident #165 since 6/20/13 found inconsistent daily totals of his fluid intake which staff had not clarified.	F 327	<u>Addendum:</u> <u>Measures/Systemic Changes:</u> Intake and Output monitoring policy has been reviewed and updated. The process of gathering and analyzing data regarding residents' fluid intake has been revised. All nursing staff has been in services regarding the importance of accurate documentation and monitoring of fluid intake and output to ensure proper hydration. <u>Quality Assurance monitoring:</u> Daily I&O documentation review and weekly medical chart reviews will be performed to ensure accuracy and proper documentation. Executive Administrator and DNS will ensure compliance.	10/14/13
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to maintain complete and accurate medical records for Residents #331, 321, 26, 327, 326, and 176, six of 36 residents records reviewed in Stage 2 of the survey. Facility failure to ensure documents, including weekly skin assessments, physician	F 514		

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F 514	<p>Continued From page 7</p> <p>including weekly skin assessments, physician assessments, social services assessments and pneumococcal vaccination verification were complete and accurate placed the residents at risk for unmet needs.</p> <p>Findings include:</p> <p>INCOMPLETE SKIN ASSESSMENTS DOCUMENTATION</p> <p>The facility provided two undated, unsigned documents titled, "Weekly Skin Assessments". Under "Procedure:" for one document read, "1. Weekly skin assessments are on the treatment sheet for each resident. If there is a skin issue, the treatment sheet will be marked with a --. If there is a no skin issue the treatment sheet will be marked with a+." The second document read, "1. Weekly skin assessments should be on the treatment sheet for each resident and checked with a '+' (sic) if there is a problem a '-' if there is no problem." These two documents are in conflict with each other.</p> <p>On 6/27/13 at 10:15 a.m. Staff A stated she had spoken to 5 other LN staff and 4 of 5 said they documented a minus sign for a negative finding and did not document specifics on the TAR. The fifth LN, a new employee, understood documentation was to be a plus sign for a skin issue and a minus sign if no skin issues were noted on the assessment. In interview, Staff B (DNS) stated she was unsure which protocol was used at this building.</p> <p>This policy, as well as the Treatment Assessment Record (TAR), had printed instructions directing staff to record details of any skin issues on the back of the TAR, in a space specifically for the</p>	F 514	<p>The facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p><u>Immediate Action:</u> Medical records for residents #331, #321, #26, #327, #326, and #176 were corrected.</p> <p><u>Identification of Other Residents:</u> All residents' medical records have been reviewed for accurate documentation.</p> <p><u>Measures / Systemic Changes:</u> Skin assessment documentation policy has been clarified. Nursing personnel has been in-serviced about importance of proper documentation of skin assessment. Documentation accuracy issue was addressed with Medical Director. Social Workers have been in-serviced regarding proper discharge planning documentation.</p> <p><u>Quality Assurance Monitoring:</u> Weekly medical chart reviews will be performed to ensure accuracy and proper documentation.</p> <p><u>Title of Person Responsible to Ensure Compliance:</u> Executive Administrator, Medical Director, and DNS will ensure compliance.</p> <p>10/14/13</p>

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F 514	<p>Continued From page 8 skin assessment notes.</p> <p>RESIDENT #327: Resident #327 was admitted to the facility on 06/04/13 with care needs related to a progressive terminal illness and a Stage III pressure ulcer.</p> <p>Review of the TAR revealed the LN initialed the skin assessment was completed with negative findings (minus sign) on 06/04/13, 6/11/13, 6/18/13 and 6/25/13. No further information was documented on the back of the TAR to describe the specific negative findings. The weekly skin assessment designated for 05/28/13 was left blank.</p> <p>Review of the multidisciplinary progress notes on between 6/4/13 through 6/27/13 revealed no notation of a skin assessment corresponding to the dates of the scheduled weekly assessment.</p> <p>On 6/27/13 at 10:15 a.m. Staff A stated Staff L, the LN, had documented a negative finding on the TAR and Staff A assumed it corresponded with the Wound Care Flow Sheet.</p> <p>On 6/27/13, review of the Wound Care Flow Sheet completed by the facility's Skin Committee revealed a detailed description of the presence of a Stage III pressure ulcer on Resident #327's coccyx. This was not consistent with assessments of the resident's skin dated 06/11/13, 6/18/13 and 6/25/13.</p> <p>Additionally, review of documentation by a Physician Assistant (PA-C Staff M), revealed assessments completed on 6/4/13 and 6/14/13 noted no skin ulcers.</p>	F 514	<p style="text-align: center;">RECEIVED OCT 17 2013 DSHS/ADSA/RCS</p>	
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F 514	<p>Continued From page 9</p> <p>On 6/28/13 at 9:15 a.m. Staff M confirmed this skin assessment documentation for Resident #327 was inaccurate.</p> <p>RESIDENT #331: Resident # 331 was re-admitted to the facility on [REDACTED]/13 with care needs related to a fracture as well as shingles and a Stage III pressure ulcer.</p> <p>Record review of the TAR revealed weekly skin assessments dated 6/4/13, 6/11/13, 6/18/13 and 6/25/13 were initialed as completed by the LN and noted to have a negative finding (minus sign). No documentation of the negative findings was found on the back of the TAR or corresponding multidisciplinary progress note, except wound drainage noted on 6/25/13.</p> <p>Record review of a document titled "Pressure Ulcer Record" noted skin assessment completed by Staff F, ADNS, did not correspond with the weekly skin assessments noted on the TAR.</p> <p>A physical exam documented by the Resident #331's physician (Staff N), dated 6/07/13, noted the resident's skin was clear, with no rashes, lesions or ulcers. Physical exam documentation completed by Staff M, PA-C, dated 6/11/13 and 6/18/13 was identical to the notation on 06/07/13.</p> <p>On 6/28/13 at 9:15 a.m. Staff M confirmed this skin assessment documentation for Resident #331 was inaccurate.</p> <p>RESIDENT #26: Resident # 26 was re-admitted on [REDACTED]/13 with care needs related to anticoagulant therapy for a heart condition and a rash in the lower trunk area.</p>	F 514	<p>RECEIVED OCT 17 2013 DSHS/ADSA/RCS</p>

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

PRINTED: 10/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505500	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/28/2013 <i>10-7-13</i> <i>JL</i> IDR AMENDED
NAME OF PROVIDER OR SUPPLIER MISSION HEALTHCARE AT BELLEVUE		STREET ADDRESS, CITY, STATE, ZIP CODE 2424 156TH AVENUE NORTHEAST BELLEVUE, WA 98007		
(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 514	<p>Continued From page 10</p> <p>Observation on 06/21/13 at 10:55 a.m. revealed bruises on the top of his left hand.</p> <p>Review of his care plan dated 10/5/12 revealed nursing staff were to monitor/ document/report signs and symptoms of anticoagulant therapy such as bruising.</p> <p>Record review of the scheduled skin assessments dated 06/06/13 and 6/13/13 noted they were completed by licensed staff negative findings, but no further documentation of the problems observed.</p> <p>On 06/27/13 at 10:50 a.m. Staff A confirmed Resident #26 was receiving treatment for the rash. She stated if the treatment was discontinued it was assumed the rash was resolved.</p> <p>INACCURATE PHYSICIAN ASSESSMENTS DOCUMENTATION: In addition to the inaccurate physician's skin assessment documentation described above, review of the Physician documentation regarding falls experienced by Residents #327 and #321 were transposed.</p> <p>On 06/28/13 at 10:30 a.m., Staff M and Staff F confirmed the documentation by the PA-C dated 06/14/13 which described the fall in the chart of Resident #327 was actually a description of the fall experienced by Resident #321. Staff M and F further confirmed the documentation in the chart of Resident #321 described the fall experienced by Resident #327.</p> <p>LACK OF SOCIAL SERVICE ASSESSMENT Resident #326 was admitted on 5/24/13 with care</p>	F 514	<p>RECEIVED OCT 17 2013 DSHS/ADSA/RCS</p>	

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NAME OF PROVIDER OR SUPPLIER MISSION HEALTHCARE AT BELLEVUE		STREET ADDRESS, CITY, STATE, ZIP CODE 2424 156TH AVENUE NORTHEAST BELLEVUE, WA 98007		
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F 514	<p>Continued From page 11</p> <p>needs related to a fracture. Review of her initial Minimum Data Set assessment (MDS) dated 5/31/13, revealed she was alert and able to identify her preferences regarding discharge and other aspects of her care.</p> <p>On 6/7/13, Resident #326's physician wrote an order stating she could be transferred to a facility in another county. Review of nursing progress notes and social service documentation found information faxed to the new facility, but no documentation of Social Service contacts with the resident regarding plans for the proposed move.</p> <p>On 6/27/13 at 12:25 pm, the social worker (Staff D) assigned to work with Resident #326 during her stay was interviewed. When asked when an initial social service assessment for residents should be completed, she said she tried to do it within the first 72 hours after a resident's admission. Review of Resident #326's closed record found no initial Social Service assessment or notes of contacts with this resident regarding discharge plans or other psychosocial issues.</p> <p>After reviewing the closed record and searching through a file in her office, at 12:50 pm, Staff D reported she was unable to locate an initial assessment or evidence of contacts with the resident regarding discharge plans.</p> <p>PNEUMOCOCCAL VACCINATION VERIFICATION Resident #176 was admitted to the facility on [REDACTED] 13. Upon admission, the resident or representative were to document whether or not they had received, or wanted to receive,</p>	F 514		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505500	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/28/2013
NAME OF PROVIDER OR SUPPLIER MISSION HEALTHCARE AT BELLEVUE			STREET ADDRESS, CITY, STATE, ZIP CODE 2424 156TH AVENUE NORTHEAST BELLEVUE, WA 98007		
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F 514	Continued From page 12 vaccination for pneumococcal pneumonia. Record review on 06/27/13 revealed the forms for this were not completed with the required information. On 6/28/13 at 1:30 pm, interview with Staff F revealed the family of Resident #176 requested to defer completion of the pneumococcal vaccination form until they conferred with a family physician. The admitting nurse affirmed there was no follow-up and the information was not completed.	F 514			

10-7-13
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06/28/2013

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OCT 17 2013
DSHS/ADS/RCS

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFS	PROVIDER # 505500	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE 6/28/2013
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NAME OF PROVIDER OR SUPPLIER MISSION HEALTHCARE AT BELLEVUE	STREET ADDRESS, CITY, STATE, ZIP CODE 2424 156TH AVENUE NORTHEAST BELLEVUE, WA
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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F 285	<p>483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR</p> <p>A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.</p> <p>A nursing facility must not admit, on or after January 1, 1989, any new residents with:</p> <p>(i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission;</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>For purposes of this section:</p> <p>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).</p> <p>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.</p> <p>This REQUIREMENT is not met as evidenced by: Resident #258 was admitted with a diagnosis of [REDACTED] Review of the Level I PASRR showed two Level I assessments dated 02/25/13 and 05/19/13. Both indicated Resident #258 had a diagnosis of a [REDACTED], but documented this resident, did not require a Level II evaluation for Specialized Rehabilitative Services. The resident's Level I evaluations did not have any categorical exclusion endorsed (which would have made a Level II evaluation unnecessary). A referral to the Mental Health Authority for a Level II evaluation was needed, but had not been done.</p> <p style="text-align: center;">RECEIVED JUL 29 2013 DSHS/ADSRVCS</p> <p style="text-align: right;"><i>[Signature]</i> 6/28/13</p>
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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

The above isolated deficiencies pose no actual harm to the residents