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

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FORM APPROVED
OMB NO. 0938-0391

1371

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505216	A. BUILDING _____ B. WING _____	C 01/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIDALGO CARE CENTER	1105 27TH STREET ANACORTES, WA 98221

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F 000	INITIAL COMMENTS	F 000		

This report is the result of an unannounced Abbreviated Survey conducted at Fidalgo Care Center on 12/19/12 and 01/09/13. A sample of 2 residents was selected from a census of 44. The sample included 2 current residents.

The following complainants were investigated as part of this survey:

2708127
2728525

The survey was conducted by:

Robin Boyer, R.N., M.S.

The survey team was from:
Department of Social and Health Services
Aging and Disability Services Administration
Residental Care Services, Region 3, Unit B
3906 172nd Street NE, Suite 100
Arlington, WA 98223
Telephone: (360) 651-6850
FAX: (360) 651-6940

Robert A Crawford 1/15/13
Residential Care Services Date

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Joe Sluderil EXECUTIVE DIRECTOR 1/26/13

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 SS=D	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	The facility will investigate all allegations of abuse/neglect in a timely manner. Facility will identify and conduct a complete investigation, develop plans to prevent reoccurrence if deemed necessary and report in timely manner to protect our residents from the risk of possible abuse/neglect. All incident reports have been logged as required and been investigated for potential of abuse and/or neglect. Director of Nursing (DON) discussed in survey has left her position effective 1/26/13 and facility has begun hiring search. In the interim, facility Assistant Director of Nursing/MDS Coordinator (ADON) has been made acting DON and will assist facility Administrator in investigating alleged violations mistreatment, neglect, abuse, misappropriation of funds, and injuries of unknown origin. Staff Development Coordinator (SDC) will also assist in monitoring process of investigating incidents in a timely fashion and if deemed necessary reporting to the appropriate State agencies. Both ADON and SDC are familiar with Washington State law and have reviewed the "Purple Book" guidelines for investigations. This would include the timeliness of the investigation and meeting 5-day requirement per State guidelines. In addition until permanent replacement for DON is found, technical assistance in investigating incidents will also be sought if needed from DON of our sister facility.	2/23/13 And Ongoing

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F 225	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct full investigations of allegations of abuse/neglect in a timely manner. Affected were two of two residents whose allegations were reviewed. Failure to identify, conduct a complete investigation, develop plans to prevent reoccurrence, and report to the appropriate authorities in a timely manner placed residents at risk of possible abuse/neglect. Findings include: 1. Resident 1 was admitted in 2011 with diagnoses of lymphoma cancer and osteoporosis. Her care plan identified she needed a two-person assist for transfer. On 11/03/12 during the evening shift, Nursing Assistant (NA) 2 failed to follow the care plan for two-person assist for transfer. Resident 1 suffered a fractured rib during that transfer. The resident reported pain to the staff on 11/04/12 and 11/06/12. The facility initiated an investigation of the incident on 11/06/12. On 12/19/12 at 11:50 a.m., the Director of Nursing Services (DNS) reported she did not have NA 2 re-enact the transfer technique of "hug transfer" used during the incident. The DNS did not know how NA 2 learned the hug transfer technique or whether she used it with other residents. She did not interview Resident 1's spouse, who witnessed the incident. Nor did she interview other residents of the facility to identify whether they received the appropriate transfer technique and assistance. The DNS reported	F 225	During resident interviews where resident's primary language is not English, facility will provide interpreter when deemed necessary to insure thoroughness and understanding of response. Incidents will be reviewed at daily "stand up" and tracked for potential follow- up and additional investigation. Facility has reviewed all current residents plan of care (POC) for accuracy of current care plan and "IP" for accuracy. Facility staff has been in-serviced on importance of following each individual POC to provide appropriate care for each resident. Abuse and neglect in-services that included information requiring notification of facility leadership and potentially calling the State hotline were conducted for facility care team. Facility Licensed Nurses (LN) have been in-serviced on the key elements of investigating incidents that occur and completing facility monitoring form and again notifying facility leadership and/or calling State hotline if deemed necessary. Incident log and all reports will be reviewed at facility monthly Quality Assurance meeting to monitor compliance. This will be monitored by ADON and overseen by Facility Administrator.	2/03/13 ADON ongoing

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F 225	Continued From page 3 she learned another staff member used the hug technique when transferring Resident 1 and she had not investigated this allegation or determined how to resolve this situation. She had no plan in place to prevent reoccurrence of the incident for Resident 1 or any other residents in the facility. Although NA 2 was terminated, she did not know whether other NAs of the facility were following care plans or were appropriately trained to use the hug transfer technique. Additionally, the DNS had no information why staff who knew of the incident prior to 11/06/12 failed to notify the State Hotline or facility leadership per Federal regulation and State code. Review of the facility investigation revealed some facility staff witnessed and/or learned of the incident and failed to follow facility policy to notify appropriate personnel and authorities of the incident in a timely manner. There was no interview of the resident's spouse, who was in the room when the incident occurred. There was no documentation of interviews of other residents for appropriate transfer assistance or of re-enactment of what NA 2 did for the transfer. There was no plan to prevent future reoccurrence of such transfer technique by untrained/unqualified staff. There was no conclusion to rule out abuse/neglect. 2. Resident 2 was admitted in 2011 with diagnoses including diabetes, hypertension, and arthritis. Her native language was Korean. On 12/03/12 she alleged Nursing Assistant (NA) 6 spoke rudely to her on 12/02/12 and told her to wait 30 minutes before NA 6 would assist her to the toilet. On 12/04/12 Resident 2 told NA 7 she did not want to see NA 6 "ever again".	F 225		

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F 225	Continued From page 4 On 12/19/12, at 11:50 a.m., the DNS reported she was informed of the allegation, but had not yet completed the investigation. She had not yet logged the allegation or notified the State Hotline as required by State code. The named Resident had not yet been interviewed for her statement and other residents had not been interviewed for any similar concerns of rudeness. There was no plan to prevent reoccurrence for Resident 2 or any other resident. Review of the facility incident log found no evidence of documentation of the allegation of Resident 2. The State Hotline was notified on 12/14/12, 7 days beyond the 5 day limit for reporting allegations of abuse/neglect. Review of the facility investigation revealed LN 1 notified the Staff Development Coordinator (SDC) on 12/03/12 of the allegation of verbal abuse. The SDC interviewed Resident 2 and other residents on 12/20/12, 13 days beyond the timely completion allowed for investigation of such allegations. The SDC conducted the interview with Resident 2 in English and documented Resident 2 wanted NA 6 to continue to provide care services to her. On 01/09/13 at 9:16 a.m., Resident 2 was interviewed via a Korean speaking interpreter. She stated she understood only a little English. If she needed something urgently, she gestured. Some of the staff spoke too fast and she did not understand them. NA 6 was in that group. Also NA 6 was not courteous to the elderly. Resident 2 reported she did not want NA 6 to provide care services to her.	F 225		
F 241	483.15(a) DIGNITY AND RESPECT OF	F 241		

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F 241 SS=G	Continued From page 5 INDIVIDUALITY 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility staff failed to maintain verbal respect for Resident 2. Failure to acknowledge Resident 2's limited English and communicate politely during a conversation resulted in Resident 2's feeling "despised" and "looked down on" for not understanding what was said to her in English. Findings include: Resident 2 was admitted in May 2011 with diagnoses including hypertension, arthritis, and diabetes. Her native language was Korean. Her most recent minimum Data Set (MDS) assessment, dated 10/17/12, identified some memory impairment by staff. On 12/03/12 Resident 2 told NA 5 of an incident with NA 6 on the evening of 12/02/12. The resident reported NA 6 "told her several times to 'speak English' and told her to "wait 30 minutes" to use the bathroom when the resident requested toileting assistance. Resident 2 told NA 5 this behavior "hurt her heart". On 12/04/12 Resident 2 told NA 7 of the same incident with NA 6. She repeated her statement of feeling "it hurts my heart." NA 7 wrote she	F 241	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. Safety plan was put in place on 12/20/13 to include supervision of NA 6 and prevention of contact with Resident #2. This plan also included interviews with other residents to indentify any potential issues with dignity, respect or individuality. None were identified in interviews. Resident was interviewed by Social Services with daughter present and acting as interpreter. Resident feels comfortable and respected at facility. NA 6 no longer works in facility. A Korean word board has been obtained by facility and placed in resident room to assist staff with providing care and communicating with staff. Staff has also been in-serviced on speaking slowly as resident does have some understanding of care intent. Also on addressing resident by what they wish to be called. Facility has established an "Informational" book for the skilled nursing unit that will include information obtained in the facility activity/interest assessment. It will be completed upon admission to the facility complete with current resident and new admits. This will be available to all facility staff and be updated as information is learned about each resident that will assist in respecting their individuality.	2/23/13 And Ongoing

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F 241	Continued From page 6 knew Resident 2 was "sincerely upset". Resident 2 told NA 7 she never wanted to see NA 6 again. On 12/19/12 at 2:14 p.m., Resident 2 reported she did not speak much English. She reiterated she did not speak English, she spoke Korean. On 01/09/13 at 9:16 a.m., Resident 2 was interviewed with a Korean speaking interpreter. She reported NA 6 and another NA entered her room and she could not understand what they said to her. NA 6 said "speak English". Her tone of voice was "despising" and "looking down on" Resident 2. Resident 2 did not feel good. She felt NA 6 was ordering and commanding her. She stated NA 6 told other staff, and they were laughing at her. She did not want NA 6 to provide care services to her any more. See F225 for additional details.	F 241	Facility has conducted in-services on dignity, respect and individuality with items listed in survey document. Bi-monthly interviews will be conducted with both resident 2 and other residents in facility and reported and content reviewed at facility monthly Quality Assurance meeting. ADON and Administrator will monitor and oversee compliance.	2/23/13 ADON ongoing
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility staff failed to provide care services with adequate personnel and consistent with Resident 1 ' s care plan for a safe transfer. Failure to use a	F 323		

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F 323	Continued From page 7 two-person assist technique for transfer contributed to harm of a fractured rib for Resident 1. Findings include: Resident 1 was admitted in January 2011 with multiple diagnoses including lymphoma cancer and osteoporosis. Her most recent Minimum Data Set (MDS) assessment, dated 10/17/12, identified her memory and recall as intact (15/15/ points on the memory assessment tool). On 12/19/12 at 9:38 a.m., Resident 1 reported she recalled one nursing assistant (NA) who "grabbed" her one night. The NA had "hands like steel"; she "hurt me". Later, Resident 1 told other staff about the incident. Review of the facility investigation revealed during the night of 11/06/12 Resident 1 complained of right sided chest pain to NA 1. The resident told NA 1 that during a transfer by NA 2 a couple of nights previously she heard a "pop" in her right chest. She had pain off and on since then. Written statement from NA 2 read on 11/03/12 she transferred Resident 1 alone using a transfer technique she had "seen other co-workers do". As she lifted Resident 1, she heard a "pop". NA 2 lowered Resident 1 back to a sitting position on the edge of the bed. She did not notify the licensed nurse (LN) of the incident at that time. Instead she obtained a gait belt and placed it on Resident 1. A second staff, NA 3, was present when the incident occurred. In her written statement, she wrote NA 2 asked her to help with the transfer of	F 323	Resident 1 and all other resident POCs were reviewed for accuracy. Staff was in-serviced on importance of following the POC and utilizing the appropriate equipment and required number of staff to provide resident care, especially with resident transfer techniques. This included one to one demonstration of competence. As mentioned previously, facility staff was in-serviced on abuse and neglect by Social Services and SDC. LN's were in-serviced on key elements of investigation and timeliness of data gathering and evaluating the need to notify facility leadership for further investigation and logging on facility incident log. "Purple Book" investigative process discussed with special emphasis on protecting the resident(s) throughout the investigative process. Resident care, to include observation of resident transfers, will be spot checked during "unannounced" facility rounds at varying times of the day to monitor that proper technique is used by facility staff. These rounds will be conducted at least twice weekly. ADON to monitor and Administrator to oversee compliance	2/23/13 And Ongoing

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F 323	Continued From page 8 Resident 1. When she entered to assist NA 2, she was told by NA 2 she would move Resident 1 alone. NA 2 asked NA 3 to hold the wheelchair rather than participate in a two-person assist transfer. After the incident, NA 2 and NA 3 used a two-person assist technique to move Resident 1. Neither NA 2 nor NA 3 notified the LN of the incident that shift. On 11/04/12 Resident 1 told NA 4 how NA 2 gave her "a hug to transfer" and it caused pain to her right rib. NA 4 asked NA 2 about the transfer incident and told NA 2 to follow the "IP" for Resident 1, which instructed staff to use 2 assist for bed mobility and transfer. NA 4 told LN 1 of the incident. The facility notified the resident ' s physician who ordered a chest x-ray. The chest x-ray revealed a fractured rib on the right side. The facility substantiated abuse by NA 2 for failure to follow the "IP" and use a two-person transfer technique and terminated her employment. On 12/19/12 at 11:50 a.m., the Director of Nursing Services reported Resident 1 was a two-person assist for transfer at the time NA 2 chose to assist Resident 1 by herself. The DNS stated NA 2 had no explanation for not following the care plan. See F225 for additional details.	F 323		