

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

PRINTED: 07/12/2013  
FORM APPROVED  
OMB NO. 0938-0391

1371

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505216</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/12/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>FIDALGO CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1105 27TH STREET ANACORTES, WA 98221</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Fidalgo Care Center on 07/03/13 and 07/12/13. A sample of 5 residents was selected from a census of 33. The sample included 3 current residents and the records of 2 former and/or discharged residents.</p> <p>The following complainants were investigated as part of this survey:</p> <p>2832072 2832481</p> <p>The survey was conducted by:</p> <p>██████████ R.N., M.S.</p> <p>The survey team was from: Department of Social and Health Services Aging and Disability Services Administration Residential Care Services, Region 3, Unit B 3906 172nd Street NE, Suite 100 Arlington, WA 98223 Telephone: (360) 651-6850 FAX: (360) 651-6940</p> <p><i>[Signature]</i> Residential Care Services      Date</p>	F 000	<p>RECEIVED <b>AUG -1 2013</b> ADSA/RCS Smokey Point</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>7/29/13</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 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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.</p> <p>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).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>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.</p>	F 225	<p>Resident 2 and Resident 5 were interviewed about the bruising during the investigation process. Resident 2 and 5 deny any improper or rough handling from staff. Resident # 4 has expired.</p> <p>There has been no further injuries in areas not vulnerable to trauma. Residents were interviewed on 6-18-13 and 7-22-13 with no concerns about staff or treatment.</p> <p>Injuries occurring in areas that are not vulnerable to trauma necessitate timely interviews of other residents to rule out rough handling. Skin related injuries occurring during transfers will be re-enacted with involved staff if etiology is not clear.</p> <p>Injuries of unknown origin will be promptly reported by care staff to the DNS upon discovery of the injury. The Licensed nurse will initiate a complete investigation of the occurrence at the time of discovery. The facility will comply with timely and complete investigations so that appropriate reporting requirements are met.</p>	8/16/13

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F 225	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct complete investigations of four of four allegations of abuse/neglect reviewed in the facility. Failure to interview other residents in a timely manner, have staff re-enact what happened and/or notify the State Hotline in a timely manner placed residents at risk of possible abuse/neglect.</p> <p>Findings include:</p> <p>1. Resident 2 was originally admitted in [REDACTED] 2012 with diagnoses including [REDACTED] and [REDACTED] and [REDACTED]. She had a history of multiple discharges and readmission since that time. Her most recent Minimum Data Set (DMS) assessment, dated 03/08/13, identified her recall and memory as severely impaired (5/15 points on the memory assessment tool). She needed a one person assist for positioning in bed, dressing and toileting.</p> <p>On 06/12/13 staff discovered multiple light purple and yellow-brown bruises on both inner thighs of Resident 2. The bruises were "consistent with finger" or "handprint like" marks. Resident 2 did not know how the bruises occurred.</p> <p>Review of the facility investigation revealed no re-enactment of staff assisting the resident with positioning, toileting or dressing. No other residents were interviewed to determine whether they experienced any rough handling by staff with assisting them with activities of daily living. The</p>	F 225	<p>The DNS will monitor completeness of investigations and will report to the Administrator daily on compliance. The DNS will track and trend all injuries of unknown origin, and subsequent investigations, to ensure completion and appropriateness of actions taken. Results will be reported to the Quality Assurance Committee monthly to determine progress and identify any additional educational needs.</p> <p>DON will monitor compliance and Administrator will oversee.</p>	8/16/13

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F 225	<p>Continued From page 3</p> <p>facility did in-service nursing staff on gentle handling for residents on 06/12/13.</p> <p>2. Resident 5 was admitted in [REDACTED] 2011 with diagnoses including [REDACTED] and [REDACTED]. She had [REDACTED] and very [REDACTED]. Her most recent MDS assessment, dated 04/16/13, identified her recall and memory as fairly intact (12/15 points on the memory assessment tool). She was a two person assist for dressing, positioning in bed and toileting.</p> <p>On 06/16/13 staff discovered yellow and brown bruises on both inner thighs. Staff statements noted the bruises were "possibly from fingermarks" or from "use of fingers when rolling of resident." Another staff wrote the bruises "could have been from the Hoyer (mechanical) lift."</p> <p>3. Resident 4 was admitted in [REDACTED] 2012 with diagnoses including [REDACTED] and [REDACTED]. His MDS assessment, dated 04/11/13, identified he had memory and recall problems (8/15 points on the memory and recall assessment tool). He was a two-person assist for transfer and positioning. On 06/09/13 two staff were transferring Resident 4 from the chair to the bed using a mechanical lift. They noted a skin tear on his arm. Review of the facility investigation revealed there was no re-enactment of the transfer technique used by the staff for the transfer. There was no clarification of how or when the skin tear occurred.</p> <p>4. On 07/03/13 at 2:10 p.m., the Director of Nursing Services (DNS) reported she did not</p>	F 225			

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F 225	Continued From page 4 include interviews with residents when the fingerprint bruises were found on Resident 2. She included resident interviews when similar "fingerprint" bruises were discovered on Resident 3 within a week.  The DNS stated an in-service was conducted on 06/12/13 for staff to be extra gentle with care for residents with [REDACTED], like Residents 2 and 3. She did not assess or re-evaluate whether the in-service training for gentle care with [REDACTED] of 06/12/13 was successful when the second set of "fingerprint" bruises was discovered on 06/18/13.  The DNS reported she did not have the staff re-enact the transfer technique used with the mechanical lift for Resident 4. She stated it might help clarify what happened during the transfer. She had no additional information of how the staff performed the transfer or whether they followed the facility process for the transfer.	F 225	In citation F-225, Resident #5 should be listed instead of Resident #3.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES  The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to consistently meet resident individual	F 242		

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F 242	<p>Continued From page 5</p> <p>preference for care services. Affected was Resident 3 who expressed a preference not of have certain staff as her care giver. This failure resulted in Resident 3 receiving some care services from staff she did not want in her room.</p> <p>Findings include:</p> <p>Resident 3 was admitted in [REDACTED] 2009 with multiple diagnoses including history of a [REDACTED] that resulted in her [REDACTED]. Her most recent Minimum Data Set (MDS) assessment, dated 05/05/13, identified she could understand sufficiently for simple and direct communication only. Her MDS assessment, dated 08/02/12, identified she expressed her wants and ideas [REDACTED] with adequate understanding when she used simple, direct communication only. The resident often used hand gestures to communicate her wants and needs. She was unable to participate/respond for the memory recall assessment.</p> <p>On 06/18/13 Staff 1 entered Resident 3's room to provide care services per the care plan. She required assistance from a second care giver and asked Staff 2 to assist her. Staff 2 noted there was no other staff person visible in the area and agreed to assist Staff 1. Staff 2 entered the room of Resident 3. Resident 3 gestured for Staff 2 to leave her room. Staff 2 did not exit the room; she remained and assisted Staff 1 with the care services. After completion of the care services, Staff 2 exited the room of Resident 3.</p> <p>On 07/03/13 at 2:10 p.m., the Director of Nursing Services (DNS) reported less than a week after Staff 2 started employment with the facility; it was</p>	F 242	<p>Resident #3 no longer receives care from staff #2. The care plan for Resident #3 reflects this choice. Staff has been in-serviced on this care plan.</p> <p>Facility staff conducted interviews with residents on preferences of staff who care for them. There has been no other unmet staff preferences noted through concern and comments, Resident Council, care conferences, resident review, observation or record review.</p> <p>The DNS or designee will in-service facility personnel on the resident's right to refuse care from specific staff. The Staff Development Coordinator (SDC) will include information upon hiring of new staff that will include the resident's right to choose aspects of their care with an emphasis on honoring preference of staff. This will also be included in annual resident rights in-services.</p> <p>The DNS or designee will monitor through observation, resident interview and record review at least monthly for three months, then at least quarterly, to assure the resident's right to have staff preferences honored.</p> <p>DON will monitor compliance and Administrator will oversee.</p>	8/13/13

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F 242	Continued From page 6 observed that Resident 3 consistently gestured for Staff 2 not to enter her room. The DNS investigated and was unable to identify any specific reason(s) Resident 3 did not want Staff 2 in her room. The DNS decided to not assign Staff 2 to care for Resident 3 as protection for both Resident 3 and Staff 2. At that time, in early or mid-May 2013, the DNS verbally notified all facility staff nurses and Staff 2 that she was not to enter Resident 3's room or provide any care services to Resident 3.  Review of the facility investigation, dated 06/18/13 revealed Staff 2 knew she should not enter the room of Resident 3. Staff 2 noted in her written statement that she "provided care ...at times" for Resident 3 on 06/18/13. She entered the room in the morning to assist with toileting care and again in the afternoon to assist with toileting care. Staff 2 wrote Resident 3 "did not want me in the room." Additionally, Staff 2 noted she thought Resident 3 was "upset" with her presence in the room. Staff 2 thought she was "one of her (Resident 3's) triggers" and Resident 3 did "not like her or something about her." Staff 3, a facility nurse, wrote she was unaware Staff 2 was not to provide care services to Resident 3. She asked Staff 2 to help Staff 1 as she was available, and no other staff were present in that area at that time in the afternoon.	F 242			
F 494 SS=D	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY  A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has	F 494			

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F 494	<p>Continued From page 7</p> <p>completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b).</p> <p>A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section.</p> <p>Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to validate staff license status for Staff 1. Failure to complete licensing of Staff 1 in a timely manner placed residents at risk of care from unlicensed staff.</p> <p>On 07/03/13 at 2:10 p.m., the Director of Nursing Services reported she was uncertain whether Staff 1 had full licensure when working at the facility in mid and late June 2013 as required for full compliance with Federal regulation and State code.</p> <p>Review of the facility documentation, dated 07/10/13, revealed the facility failed to verify Staff</p>	F 494	<p>Staff #1 is no longer employed here.</p> <p>Nursing licenses were reviewed to verify there no further concerns with licensure. There were no issues noted.</p> <p>The SDC will monitor NAR dates of hire and ensure that the certification takes place within the 4 month period. NAR staff will not be permitted to work in the skilled facility after 120 days. An agreement will be signed upon hire by NAR, Administrator and SDC that states termination will occur if they fail to become certified within 4 months.</p> <p>The SDC will provide DNS with monthly tracking forms of any NAR's. The Director of Nursing, or designee will monitor through audit and observation with report to the Quality Assurance Committee, at least monthly for three months, then at least quarterly, to assure full compliance.</p> <p>SDC will monitor compliance and Administrator will oversee process.</p>	8/13/13	

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F 494	Continued From page 8 1 completed full State licensure within 4 months. The facility Administrator wrote Staff 1 failed to complete her certification in 120 days. She worked 9 days beyond the allowed 120 days before the facility identified her lack of current licensure.	F 494		