

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

PRINTED: 04/08/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505216	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/06/2015
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NAME OF PROVIDER OR SUPPLIER FIDALGO CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1105 27TH STREET ANACORTES, WA 98221
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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 Abbreviated Survey conducted at Fidalgo Care Center on April 6, 2015. A sample of 3 residents were selected from a census of 37.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#3084083</p> <p>The survey was conducted by:</p> <p>Leslie Martin, BSHS</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Disability Services Administration Residential Care Services, District 2 A 3906 172nd Street NE, Suite 100 Arlington, WA 98223 Telephone: (360) 651-6850 Fax: (360) 651-6940</p> <p><i>Kathy Gold</i> 4-8-15 Residential Care Services Date</p>	F 000	<p>APR 20 2015 ADSARCS Region 3</p>	<p><i>[Signature]</i> 4/15/15</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Esperanza Duran</i>	(X6) DATE <i>4/15/15</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

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

1. Incident summaries and investigation were found for the incidents involving Resident 1 and Resident 2.
2. DNS will conduct thorough incident investigations and ensure that incident summaries are completed within 72 hours of occurrence of incident and kept with original incident form.
3. Three random audits of investigations will be done by Clinical Services Director (CSD) monthly.
4. April 30, 2015
5. CSD to ensure correction and Executive Director to oversee compliance.

4-30-15
& On-going

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F 225	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to conduct thorough investigations for Resident's (1 and 2). 2 of 3 incident investigations reviewed. This failure placed Resident 1 and 2 at risk of further accidents and/or potential abuse/neglect.</p> <p>Findings include:</p> <p>On 4/6/15, a review of the incident log revealed on 3/20/15, Resident 1 sustained a fall in the facility parkin lot.</p> <p>Review of the facility investigation revealed, Resident 1 left the facility with her personal care giver. A few minutes later, the facility staff where informed the resident fell in the parking lot. The resident was noted sitting on the street, next to the car door with her legs under the door, her wheelchair was behind her.</p> <p>The facility investigation failed to include witness statements, failed to notify the resident's family, failed to conclude what could have caused the fall and failed to include measures to prevent re-occurrence.</p> <p>A second incident investigation with the date of date 2/26/15 was reviewed for Resident 2. Resident 2 was sitting in the foyer, he informed the staff he had a coffee spill on his thigh. In response the facility staff applied a cold towel on the resident's thigh.</p> <p>The facility investigation failed to include witness statements, an assessment of the resident's</p>	F 225		

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F 225	Continued From page 3 ability to hold the coffee cup safely and how the facility would prevent re-occurrence. In an interview on 4/6/15 with the acting Director of Nursing Services, she verified there was no additional information to add to the investigations and agreed the investigations were incomplete.	F 225		