

1381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505080	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/13/2013
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF KENNEWICK	STREET ADDRESS, CITY, STATE, ZIP CODE 1508 WEST SEVENTH AVENUE KENNEWICK, WA 99336
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Kennewick Life Care Center on August 5, 2013, August 6, 2013, and August 13, 2013. A sample of 7 residents was selected from a census of 88 residents. The sample included 7 current residents.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#2845393 #2850483 #2849666</p> <p>The survey was conducted by: ██████████ R.N.</p> <p>The survey team is from: Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services, District 1, Unit C 3611 River Road, Suite 200 Yakima, Washington 98902</p> <p>Telephone (509) 225-2800 Fax: (509) 574-5597</p> <p><i>Spulstrey 8/22/13</i> Residential Care Services Date</p> <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>	F 000	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p>	
F 241 SS=D		F 241	<p>Resident has been provided clean clothes, assistance with bathing and grooming and dressings have been changed.</p> <p>Residents are at risk for poor hygiene, and audits have been completed to ensure appropriate grooming and hygiene needs have been met.</p> <p>Staff has been educated on promotion of care for residents in a manner that maintains dignity and respect for a resident's individuality. Education will also be provided at hire orientation for new staff and as needed.</p> <p>Staff Development Coordinator or designee to audit a sample of 10 residents weekly for four weeks, then monthly for 3 months for clean, appropriate attire and hygiene.</p>	09/13/13

Received
Yakima RCS
SEP 4 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE EXECUTIVE DIRECTOR	(X6) DATE 8-30-13
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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.

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

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OMB NO. 0938-0391

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F 241

Continued From page 1

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interviews the facility failed to ensure the dignity of 1 of 7 residents (#1) regarding grooming and personal hygiene. Resident #1 was transferred to the Emergency Room in soiled clothing, poor personal hygiene, and offensive body odor. This placed the resident at risk for a diminished quality of life and potential for infection. Findings include:

Resident #1: Readmitted to the facility on [REDACTED] 13 following surgery to his [REDACTED] for [REDACTED] [REDACTED]s. In addition, he had multiple bruises and scabbed areas with pressure ulcers to his [REDACTED] area and [REDACTED] of [REDACTED]

Review of the resident's plan of care dated 7/21/13 revealed he required extensive staff assistance with dressing, toileting, showers, and personal hygiene. In addition, the plan of care stated the resident was frequently incontinent of urine and stool.

Review of hospital records dated 7/29/13 noted the resident was transferred to the Emergency Room (ER) that day following a change of condition and was noted to be alert and oriented. Documentation in the record by an ER Licensed Nurse (LN) stated the resident's disposable brief was "soaked and heavy with urine." The resident stated his brief had not been changed for approximately two days. There were several foreign metallic objects stuck to the tip of his [REDACTED] and [REDACTED] with pennies found at his [REDACTED] area. There were at least 20 pieces of hard, dried, partially eaten licorice scattered

F 241

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F 241 Continued

Results of audits to be reviewed by Performance Improvement committee.

Director of Nursing to ensure compliance.

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F 241	<p>Continued From page 2</p> <p>under the resident along with several pennies. The resident's pajama bottoms had significant dried blood on them. In addition, he had blood stained long stockings on both arms and dried blood to his right hand. The resident smelled strongly of urine.</p> <p>A telephone interview on 8/6/13 at 11:45 a.m. with the above ER LN revealed the resident was "filthy...and smelled awful." She stated his pajama pants, which were soiled with dried blood, were the same pants the resident wore when he was seen in the ER on 7/24/13 (5 days prior). She stated the resident had stated during her assessment, "they don't do anything with me."</p> <p>Upon questioning the resident on 8/5/13 at 11:15 a.m. relative to his ER transfer on 7/29/13 he stated, "they (staff) seem to ignore me." The resident was observed to be wearing disposable briefs. He had fragile skin with multiple areas of bruising to both arms. The resident had just returned from a shower and was wearing clean clothing.</p> <p>A telephone interview on 8/13/13 at 12:40 p.m. with a paramedic, involved in the transfer of the resident to the ER on 7/29/13, stated staff had expressed to him they were unable to care for the resident due to his refusals. He stated the resident smelled like he had not had a bath in over a week and was wearing soiled clothing.</p> <p>An interview on 8/13/13 at 11:15 a.m. with Staff A (Shower Aide) noted the resident had rarely refused to take a shower which was scheduled twice weekly. She stated upon review of the shower records the resident had not had a shower since 7/23/13. He was scheduled for a</p>	F 241	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provide of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p>	
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F 241	Continued From page 3 shower on 7/25/13; however, he was sleepy and requested her to leave items so he could give himself a bed bath that evening. Staff A stated she was unaware if he actually gave himself a bed bath or not, and no other attempts had been made to give him a shower (prior to his ER transfer 7/29/13). Telephone interviews conducted on 8/13/13 with Staff B (LN) at 12:25 p.m. and Staff C (Nursing Assistant) at 1:50 p.m. (assigned to care for resident at the time of his ER transfer on 7/29/13) revealed the resident was confused prior to the transfer and was refusing to allow staff to change his soiled clothing. Staff C stated he only asked the resident one time (approximately 6:00 p.m.) during his shift to change his clothing at which time the resident had refused. The resident was transferred to the ER at 6:30 p.m. (30 minutes later).	F 241	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provide of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews the facility failed to provide medically-related social services to 1 of 3 residents (#1) who exhibited behaviors. Failure to ensure staff identified reasons for frequent refusals and considered alternatives to ensure	F 250	F 250 An appropriate comprehensive behavioral management plan, which establishes a plan for staff to utilize when approaching and caring for the resident, has been developed and implemented. Residents with frequent refusals of care have had care plans reviewed to ensure appropriate behavioral management plans are in place. Staff has been educated on ensuring residents with refusals of care are implementing the interventions from the appropriate behavioral care plan. Care plan audits to be completed weekly by Social Services for four weeks, then monthly for three months. Results will be forwarded to Performance Improvement committee. Director of Nursing to ensure compliance.	09/13/13

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F 250 Continued From page 4
the resident's needs were met placed him at risk for untreated medical problems. Failure to develop an interdisciplinary comprehensive behavior management plan placed him at risk for worsening behaviors and distracted from his psychosocial well-being. Findings include:

Resident #1: Admitted to the facility with multiple diagnoses which included [REDACTED], [REDACTED], [REDACTED] and [REDACTED]. In addition, he had a history of [REDACTED] with [REDACTED] at times.

On 8/5/13 at 11:08 a.m. the resident was observed lying in his bed. He had an [REDACTED] to his [REDACTED] and pressure ulcers to [REDACTED]. The floor next to his bed was littered and soiled with multiple coins, papers, dried food, and fluid stains. There were several food items located throughout the resident's room which included candy, fruit, and snack type items.

Review of the resident's Progress Notes revealed the following documentation:

7/23 - refused vital signs
7/27 - not always cooperative with care - refused assistance with personal care, refused vital signs
7/28 - food all over the room - smells like some of the food is going bad - unable to check as resident refusing, assisted with hygiene as resident allows

Refer to F241 relative to observations made of the resident's hygiene/grooming by hospital staff on 7/29/13 when he was transferred to the Emergency Room.

A telephone interview on 8/13/13 at 12:25 p.m.

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F 250 Continued From page 5
with Staff B (Licensed Nurse) revealed the resident often refused care by staff and could become "very aggressive with his refusals, was unclean, and did not like to be bothered.

Staff D (Resident Care Manager) stated on 8/13/13 at 2:00 p.m. that the resident had several outdated food items as he would not allow staff to dispose of them, many refusals of care, did not like to change his clothes, and liked to be left alone.

An interview on 8/13/13 at 12:05 p.m. with Staff E (Social Services) revealed she was not made aware of the resident's frequent refusals relative to care, food items, and room cleanliness until the state investigation was initiated on 8/5/13.

Review of the resident's plan of care dated 6/25/13 and/or 7/21/13 revealed a problem relative to refusal of cares, negative statements, refusing hygiene, and "kicks aides out of room." Despite the above problems there was no behavior management plan established for staff to utilize when approaching and caring for the resident.

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.

This REQUIREMENT is not met as evidenced by:

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F 312 **09/13/13**

Resident was provided incontinent care and repositioned.

Residents residing on the unit interviewed to ensure care given.

Staff has been educated on incontinent care and repositioning.

Staff Development Coordinator or designee will ensure care completed by interviewing residents and rounding each shift to ensure repositioning and incontinent care is provided per policy. Audits and rounds will occur weekly for four weeks, then monthly for three months. Results will be forwarded to Performance Improvement Committee.

Director of Nursing to ensure compliance.

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F 312	<p>Continued From page 6</p> <p>Based on record review and interviews the facility failed to ensure 1 of 4 residents (#2), who were dependent on staff for care, received appropriate care and services relative to repositioning and incontinent care. Resident #2 was left sitting in her wheelchair throughout the night shift with no care being provided by staff. This failed practice potentially resulted in skin breakdown. Findings include:</p> <p>Resident #2: Admitted with multiple diagnoses which included [REDACTED]. Review of the resident's plan of care revealed she was alert and oriented, and was at risk for skin breakdown due to incontinence problems, impaired mobility, and history of pressure ulcers. Nursing interventions were for staff to reposition the resident every two hours while in her bed or wheelchair, and to provide incontinent care following each incontinency episode.</p> <p>Review of a facility investigation report dated 7/16/13 revealed the resident had been left sitting up in her wheelchair in her room throughout the night shift. Nursing staff had not checked on her or provided her any care. The door to her room was closed during the shift.</p> <p>An interview with the resident on 8/5/13 at 3:45 p.m. relative to the above incident revealed she was watching television in her wheelchair in her room. She stated she usually puts her call light on to go to bed. "I forgot to tell the Nursing Assistant to put me to bed." She stated she did not see or hear any staff throughout the night.</p> <p>A telephone interview on 8/14/13 at 10:15 p.m. with Staff F (Licensed Nurse) noted that when she went to administer medication to the resident</p>	F 312	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p>	
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F 312	Continued From page 7 at 5:30 a.m. on 7/16/13 she noticed the resident was still in the same clothing as the evening before and was in her wheelchair. She stated the door to the resident's room had been closed during the night. The resident informed her she had fallen asleep in her wheelchair. She stated nursing assistant staff had changed assignments and in doing so they had forgotten to check on the resident and provide care to her. Staff was to reposition the resident and check to see if she needed incontinent care.	F 312	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
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