

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

PRINTED: 08/09/2013  
FORM APPROVED  
OMB NO. 0938-0391

1393

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505272	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/06/2013
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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF MOUNT VERNON	STREET ADDRESS, CITY, STATE, ZIP CODE 2120 EAST DIVISION STREET MOUNT VERNON, WA 98273
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F 000 INITIAL COMMENTS

F 000

This is the result of an unannounced Abbreviated Survey conducted at Life Care Center of Mount Vernon on 7/30/13, 7/31/12, 8/1/13 and 8/6/13. A sample of 12 current residents was selected from a census of 83.

The following complaints were investigated as part of this survey:

- 2833685
- 2848329
- 2846407
- 2826543
- 2841112

The survey was conducted by:

██████████ R.N., B.S.N.

The survey team was from:  
Department of Social and Health Services  
Aging and Long-Term Support 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

*Robert Crawford* 8/23/13  
Residential Care Services Date

RECEIVED  
AUG 29 2013  
ADSA/RCS  
Smokey Point

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 provision of federal and state law.

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

*Janis Wilson* Executive Director 8/23/13

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 000  F 225 SS=D	Continued From page 1  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 000  F 225	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 provision of federal and state law.  <b>F 225</b>  <b>Correction as it relates to the resident:</b> Resident 2 was interviewed by social services to assess for psychological harm; no additional concern or issues identified and no symptoms of psychological harm were observed. Staff D no longer works at the facility.  Resident 3 was interviewed by social services to determine if they feel protected and safe, no further concerns were reported. The resident is not exhibiting symptoms of psychological harm. Staff E completed a return demonstration on use of the mechanical lift and colostomy care.  <b>Action taken to protect residents in similar situations:</b> Resident allegations of abuse/neglect will be reported timely to facility abuse prevention coordinator/designee. The investigation will be thorough including plans to prevent recurrence.

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F 225	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to immediately report allegations of abuse/neglect to the facility administrator, conduct thorough investigations, and develop/implement plans to prevent further potential abuse/neglect for 2 of 4 sampled residents (2, 3) whose investigations were reviewed. This failure placed Residents 2 &amp; 3 at risk of further potential abuse/neglect.</p> <p>Findings include:</p> <p>The state "Nursing Home Guidelines" dated February 2012 define sexual abuse as "... any form of non-consensual contact, including but not limited to, unwanted or inappropriate touching ..."</p> <p><b>RESIDENT 2</b> Resident 2 was admitted to the facility in [REDACTED] 2013 with diagnoses to include [REDACTED] and [REDACTED]. Her admission Minimum Data Set assessment dated [REDACTED] 3 revealed she was without cognitive impairment.</p> <p>A review of the facility investigation indicated the resident made an allegation of sexual abuse on 7/9/13 at 00:30 a.m. The resident stated Staff D, a Nursing Assistant Certified (NAC) who was on duty, had "kissed me on my lips. It made me uncomfortable ..."</p> <p>On 7/9/13 at 5:00 p.m., the allegation was reported to Administrative staff, 16 hours later.</p>	F 225	<p><b>Measures taken or systems altered to ensure the problem does not recur:</b> Staff were re-educated by the Staff Development Coordinator (SDC) on reporting requirements for abuse/neglect allegations.</p> <p>The Executive Director and Director of Nursing were re-educated by the Regional Nurse on the policy and procedure for completing thorough investigations including plans to prevent recurrence.</p> <p><b>Plans to monitor performance to ensure solution is sustained:</b> Investigations involving allegations of abuse/neglect will reviewed by the Regional Nurse/designee for three months to ensure the allegation was reported timely, thoroughly investigated and appropriate interventions implemented.</p> <p>The results of this review will be forwarded to the Executive Director for any required follow up. The results will be presented to the facility Performance Improvement (PI) committee monthly for three months to identify further educational needs.</p> <p><b>Date Certain:</b> 9/10/13</p> <p><b>Title of Person Responsible for Compliance:</b> The Executive Director</p>	

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F 225	<p>Continued From page 3</p> <p>The facility investigation included the conclusion that the allegation of sexual abuse was not substantiated as Staff D did not "work with" the resident during the night shift of 7/8 - 7/9/13.</p> <p>The resident was interviewed in her room on 7/30/13 at 9:05 a.m. The resident was asked about her care at the facility, the resident stated Staff D "kissed me and pushed me down on the bed." The resident was able to recall the event that occurred prior. When asked if she had seen Staff D recently, she replied she did not want to see or have Staff D care for her.</p> <p>The NAC documentation was reviewed on 7/31/13. The documentation identified Staff D provided toileting assistance for the resident on the night shift from 7/8 - 7/9/13.</p> <p>In an interview on 7/31/13 at 9:08 a.m., the DNS verified Staff D was not removed from the resident's environment immediately after the allegation of sexual abuse was made and continued to work in the same area where resident 2 lived. Furthermore, the NAC documentation had not been reviewed as part of the investigation to verify if Staff D provided care to the resident.</p> <p><b>RESIDENT 3</b> On 7/17/13 an allegation of abuse was investigated by the facility. Resident 3 stated Staff E "banged my head" while using the Hoyer lift (a mechanical transfer device) and was rough when providing colostomy care. Staff E did not did not stop when the resident was verbalizing discomfort.</p>	F 225	

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F 225 Continued From page 4  
Upon review of the investigation provided on 7/31/13, the facility verbally in-serviced Staff E on providing good care and being gentle when providing colostomy care. There was no skills check performed verifying Staff E's ability to perform personal/colostomy care.

In an interview on 7/31/13 at 4:15 p.m., Resident 3 stated she had no current concerns with her care.

In an interview on 8/1/13 at 12:35 p.m., the Administrator and DNS verified there was no skills check done with Staff E regarding personal/colostomy care.

F 225

F 325 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  
SS=D

Based on a resident's comprehensive assessment, the facility must ensure that a resident -  
(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and  
(2) Receives a therapeutic diet when there is a nutritional problem.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview and record

F 325

F 325

**Correction as it relates to the resident:**  
Resident 1 was assessed for weight changes, physician was notified, and the care plan was updated. His physician ordered weight loss interventions were added to the medication administration record to monitor intake (MAR). A care conference was held with resident's POA to discuss artificial nutrition. POA is considering this intervention

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F 325 Continued From page 5  
review the facility failed to ensure 1 of 12 sampled residents (1) received identified interventions regarding significant weight loss. Failure to monitor and consistently implement individualized interventions placed Resident 1 at risk for poor nutrition and continued weight loss.

Findings include:  
Resident 1 was admitted [REDACTED] 2013 with diagnoses to include [REDACTED] [REDACTED] and [REDACTED]. The Minimum Data Set dated 6/6/13 identified the resident requiring set up assist with supervision/oversight/cueing from the staff with meals.

Resident 1's Health Care Directive and POLST (Physician Orders for Life-Sustaining Treatment) indicated he wished for artificial tube feedings.

The resident weighed 202 pounds on 5/30/13 and 170 pounds on 7/23/13. The resident had a significant weight loss of 32 pounds in approximately two months.

The initial Registered Dietitians report dated 6/3/13, identified the resident's usual body weight was 200-205 pounds.

The current care plan identified the resident as a nutritional risk with weight loss present. The interventions included to provide "cueing and feeding assist," restorative feeding program every lunch, and to provide a specific physician prescribed snack at 10:00 a.m. and 2:00 p.m.

On 7/10/13 the physician was notified of the resident's "continued weight loss." The physician prescribed one can (240 cc) of Ensure (a high

F 325 **Action taken to protect residents in similar situations:**  
Residents with significant weight change have the potential to be affected by this practice and will have individualized interventions implemented and monitored.

**Measures taken or systems altered to ensure the problem does not recur:**  
The licensed nurses were educated on documenting intake of physician ordered weight loss interventions.

The nursing assistants were re-educated by the Staff Development Coordinator on following the care plan interventions for dining assistance as indicated.

**Plans to monitor performance to ensure solution is sustained:**  
The Resident Care Managers/designee will audit documentation of physician ordered interventions for completion daily for two weeks then weekly for three months. Follow up will be completed as required.

Dining room observations to monitor for appropriate assistance will be completed by the dining room supervisors weekly for three months, immediate follow up will be completed.

The results of the audits will be reviewed by the facility Performance Improvement committee for 3 months to identify trends and the need for system revision and/or further education needs.

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F 325 Continued From page 6  
calorie nutritional supplement) twice daily. This was changed to the house health shake (118 cc) twice daily per the facility's request. The resident was already receiving the house health shake twice daily since 7/04/13.

The resident was observed during breakfast on 7/31/13 and 8/1/13. On both occasions the resident was not offered cueing or assistance from the staff during the meal. The resident had eaten 50% of each meal when the plate was removed from the table.

The resident was observed in a restorative feeding program for lunch on 7/30/13 and 7/31/13. The resident received one on one consistent supervision and cueing.

In an interview on 8/1/13 at 8:00 a.m., Staff B stated the resident required supervision with setup assist and cueing for meals.

In an interview on 8/1/13 at 9:36 a.m., Staff A, a Residential Care Manager (RCM), was asked where the physician prescribed snacks were documented. Staff A replied they were documented in "RITA (the facility's documentation program). Upon review of the "RITA" documentation, it could not be determined what type of snack the resident received at "AM and PM."

In an interview on 8/1/13 at 10:42 a.m., the Director of Nursing Services (DNS), the facility administrator and Staff H were interviewed regarding the resident's weight loss. The plan was to have the Power of Attorney (POA) bring in food 2-3 times a week to increase his nutritional intake and the resident was started on [REDACTED]

F 325  
**Date Certain:**  
**9/10/13**

**Title of Person Responsible for Compliance:**  
The Director of Nursing

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F 325 Continued From page 7  
(a medication used to stimulate appetite). The DNS reported the POA was not currently able to consistently bring in food from home and requested the [REDACTED] to be discontinued. The DNS stated prescribed physician snacks should be documented on the Medication Administration Record (MAR). The DNS was asked if artificial tube feedings had been discussed with the resident or POA per his health care directive. This had not been done.

F 325

Upon further review of the physician visit dated 7/18/13, the [REDACTED] was discontinued related to causing "...excessive sedation and did not in fact help with the appetite increase as expected.."

There is no evidence of the prescribed physician snack on Resident 1's MAR.

F 333 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  
SS=D

F 333 F 333

The facility must ensure that residents are free of any significant medication errors.

**Correction as it relates to the resident:**

The medication was discontinued for resident 1. The adverse side effect rash resolved without complication

This REQUIREMENT is not met as evidenced by:  
Based on record review and interview the facility failed to ensure 1 of 12 sampled resident (1) was free from significant medication errors. This placed the resident at risk for discomfort and/or health complications.

**Action taken to protect residents in similar situations:**

Residents with medication allergies have the potential to be affected. An audit of resident allergies was completed to verify allergy sticker matches physician orders and medication administration records (MAR) and no other issues were found.

Findings include:  
Resident 1 was admitted to the facility [REDACTED] 2013.

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F 333	<p>Continued From page 8</p> <p>A review of the allergy sticker placed on the inside of the resident's chart included the medication "Cipro."</p> <p>A record review revealed the resident developed a "rash" on 6/12/13 to [REDACTED] (an [REDACTED]). In a note dated 6/13/13 from the Advanced Registered Nurse Practitioner (ARNP), the resident "developed an itchy rash and [REDACTED] was discontinued ..." The resident was treated with [REDACTED] cream to the "allergic rash."</p> <p>The resident was prescribed [REDACTED] on 7/8/13 for a [REDACTED]. The resident received two doses of [REDACTED] (on 7/8/13 and 7/9/13). Per the telephone order from the physician the [REDACTED] was discontinued on 7/9/13 related to an "ASE (adverse side effect) rash."</p> <p>In an interview on 8/1/13 at 11:45 a.m., the Director of Nursing Services verified the resident had Cipro listed as an allergy on his medical record and was given the above two doses per the MAR. The Licensed Nurse was responsible to verify allergies prior to medications being given. This was listed on the allergy sticker located on the medical record and on the Medication Administration Record.</p>	F 333	<p><b>Measures taken or systems altered to ensure the problem does not recur:</b> The licensed nurses were re-educated by the Staff Development Coordinator to verify residents do not have an allergy to a medication prior to administering.</p> <p><b>Plans to monitor performance to ensure solution is sustained:</b> New orders will be reviewed daily, for three months, by the Resident Care Manager/designee to verify an allergy does not exist. Any discrepancies noted will be corrected immediately.</p> <p>Results of this review will be reported to the Director of Nursing and any trends will be presented to the facility Performance Improvement committee for recommendations.</p> <p><b>Date Certain:</b> 9/10/13</p> <p><b>Title of Person Responsible for Compliance:</b> The Director of Nursing</p>	9/10/13