DEPARTMENT OF HEALTH AND H. AN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505362		C 08/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST VIEW TRANSITIONAL HEALTH CENTER	5129 HILLTOP ROAD EVERETT, WA 98203

(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
F 000	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Survey conducted at Forest View Transitional Health Center August 29 and 30, 2013. A sample of 4 current residents and 5 former or discharged residents was selected from a census of 64. The following were complaints investigated as part of this survey: 2862464 2867541 The survey was conducted by: Nedra Vranish, R.N., B.S.N., MSEd The survey team is from: 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 Residential Care Services 9/4/13 Date	F 000	This plan of correction is prepared and submitted as required by law. By submitting this plan of correction does not admit that the deficiency listed on this form exist nor does the facility admit to any statements, findings, facts or conclusions that form the basis for the alleged deficiency. The facility reserves the right to challenge in legal and/or regulatory or a administrative proceedings the deficiency, statements, facts and conclusions that form the basis for the deficiency Resident 1, 2, 3 have been discharged. The facility will insure that a post discharge plan of care be initiated for all applicable discharging residents to address their continuing care needs. Discharge care Planning has been updated to reflect the current plan. All staff involved in the discharge process have been in-serviced on the post discharge process. Post discharge care planning documentation is maintained in the resident's clinical record. RECEIVED SEP 19 2013 ADSA/RCS Smokey Point	9/23/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: RD/DNS — (X6) DATE: 9/19/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505362		C 08/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST VIEW TRANSITIONAL HEALTH CENTER	5129 HILLTOP ROAD EVERETT, WA 98203

(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
F 284 SS=D	483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to plan for and ensure an orderly discharge for 3 of 5 sample residents (1, 2, 3) reviewed for discharge plans. Failure to plan for and ensure necessary services, medications and supplies are in place for discharged residents placed them at risk for medical complications, poor adjustment in the lesser-care setting and readmission to hospital or nursing facility. Findings include: 1. Resident 1 was admitted to the facility [redacted]11 as a result of subarachnoid hemmorhage (bleeding into the brain). He required extensive total assistance with his activities of daily living and had swallowing problems requiring tube feeding to maintain nutritional status. Review of the clinical record revealed social service (SS) documentation, dated 5/9/13, that family desired to take the resident home with a family member as the primary caregiver. SS documentation, 5/15/13, indicated family desired Resident 1 to discharge home the first or second week of June. The documentation stated, "SS will assist arranging equipment, HH (home	F 284	Post discharge care planning will be audited by DNS/RCM/SDC staff on a daily basis as applicable. Date when corrective action will be completed; September 23, 2013 DNS is responsible to assure correction Further audits will be conducted by members of the facilities QA committee. Responsible persons: DNS, RCM and SSD Completion by 9/23/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505362		C 08/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST VIEW TRANSITIONAL HEALTH CENTER	5129 HILLTOP ROAD EVERETT, WA 98203

(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
F 284	Continued From page 2 health) services and identifying a new PCP (primary care provider)." A Physician Order was obtained 5/27/13 for a home care referral. There was no SS documentation from 5/27/13 until 8/8/13 when documentation stated faxes had been sent to Bellevue Health Care (for equipment) and Providence Home Health. It indicated confirmation of both had been received. Family had requested Home Health through Providence, oxygen, and epi-pen (medication to counteract an allergan, as Resident 1 had allergy to bees), a pump & formula for tube feeding and medication prescriptions. The resident discharged home with family on [redacted]13. When the family and resident arrived home there was no contact from a Home Health care agency, no oxygen supply company, no tube feeding pump or supplies, no medication prescription and no epi-pen. Family contacted the facility and had to return to obtain his house supply of tube feeding formula and pump as well as his house supply of medications. Review of the "Interdisciplinary Summary of Stay" which was a summary of the resident's stay and included information regarding care needs and the post discharge plan of care. It indicated the resident was to have nothing by mouth and had a J-tube (feeding tube) in place. Home Care Referral was indicated with a check by "Yes" but no agency was designated and no home care instructions. Future Appointments stated "follow up with your primary care provider." No names, dates, times or phone numbers were listed.	F 284		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505362		C 08/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST VIEW TRANSITIONAL HEALTH CENTER	5129 HILLTOP ROAD EVERETT, WA 98203

(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
F 284	Continued From page 3 The family of Resident 1 made an appointment with his PCP 8/15/13 and obtained the necessary orders for home health, medications, oxygen and ongoing tube feeding supplies. On 8/30/13 the Social Services director was interviewed regarding the coordination of discharge services for Resident 1. He stated he had home health services set up and does not know what happened. He did confirm family had returned to the facility the day of discharge to obtain a tube feeding pump and his supply of formula. On the same date a Licensed Nurse was interviewed and stated there had been ogoing hands-on teaching with family for the administration of medications and formula per tube. 2. Resident 2 was admitted to the facility [redacted]13 with diagnoses including dementia and [redacted] He required supervision and assistance with all activities of daily living. Review of the clinical record revealed SS documentation, dated 7/8/13, related to a planned discharge to an Adult Family Home (AFH). A discharge assessment was conducted 7/11/13 by a Home and Community, Department of Social and Health Services case manager (DSHS CM) in preparation for the discharge. It was determined the resident would benefit by an on-going program of exercise and a Home Health referral would be made by the Facility prior to discharge to the AFH. Resident 2 discharged to the AFH on [redacted]13. On [redacted]13 the AFH reported to the DSHS CM there had been no contact from a Home Health Agency. The facility was contacted and Physician	F 284		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505362		C 08/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST VIEW TRANSITIONAL HEALTH CENTER	5129 HILLTOP ROAD EVERETT, WA 98203

(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
F 284	Continued From page 4 orders were obtained on 8/13/13 for the requested Home Health referral. Review of the "Interdisciplinary Summary of Stay" included a "No" checked by Home Care Referral. On 8/30/13 the Social Services director was interviewe regarding the failure to obtain physician orders and make a Home Health referral prior to discharge. He stated, "I may have missed the boat on that one." 3. Resident 3 was admitted to the facility [redacted]13 and had diagnoses including dementia, weakness, heart disease, high blood pressure and chronic back pain. She required supervision and assistance with all activities of daily living. Resident 3's nine prescription medications included ones for control of blood pressure, to be taken twice daily, a blood thinner and heart medication, as well as other prescribed medications. Review of the clinical record revealed SS documentation, dated 6/27/13, which revealed discharge options were being researched. The resident expressed interest in returning home. On [redacted]13 an assessment was conducted by the DSHS CM in preparation for the discharge. Resident 3 discharged home with family [redacted]13. Per the family, Resident 3 was discharged with a 1-day supply of her medications. The pharmacy, requested by the family, was allegedly faxed a list of the resident's medications. When Resident 3's family went to pick up the medications on [redacted]13 the pharmacy said they had not received the faxed list of medications.	F 284		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505362		C 08/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST VIEW TRANSITIONAL HEALTH CENTER	5129 HILLTOP ROAD EVERETT, WA 98203

(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
F 284	Continued From page 5 On 8/30/13 at 10:10 a.m. a Licensed Nurse and Director of Nursing Service were interviewed regarding coordination of discharge for Resident 3. It is the responsibility of the Licensed Nurses to initiate the discharge summary, review the discharge plan with the resident/family and dispense the resident's house supply of medications. They did not know why Resident 3 would have only been discharged with a 1-day supply of mediation. No further information was provided.	F 284		