

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

PRINTED: 09/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505362	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/17/2013
NAME OF PROVIDER OR SUPPLIER FOREST VIEW TRANSITIONAL HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Forest View Transitional Health Center on 9/7/13 and 9/12/13. A sample of 10 residents was selected from a census of 61. The sample included 10 current residents and one discharged resident.</p> <p>The following complainants were investigated as part of this survey:</p> <p>2848499 2870414 2870494 2869491 2866739 2870862</p> <p>The survey was conducted by:</p> <p>Nadyne Krienke, R.N., M.S.</p> <p>The surveyor was from:</p> <p>Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, District 2, Unit A 3906 172nd Street NE, Suite 100 Arlington, WA 98223</p> <p>Telephone: (360) 651-6850 FAX: (360) 651-6940</p> <p><i>Donna D. Doherty</i> 9/25/13 Residential Care Services Date</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Forest View Transitional Health Center, does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>RECEIVED OCT -3 2013 ADSA/RCS Smokey Point</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *May Ursatt RN* TITLE *DNS* (X6) DATE *10/3/13*

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 242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, and record review, the facility failed to respect the right for 1 of 3 residents(1) to make choices about significant aspects of his life at the facility. Failure to allow access to a requested visitor or to assist the resident with telephone calls related to a significant visitor of his choice, as requested by the resident, resulted in Resident 1 being denied his rights and a diminished quality of life.</p> <p>Findings include:</p> <p>Resident 1 was admitted to the facility on [REDACTED] 13. The Minimum Data Set (MDS) assessment, dated 8/29/13, indicated he had no cognitive impairment. Nursing notes documented the resident was alert and able to make his own decisions.</p> <p>Review of the clinical record on 9/12/13 revealed Resident 1 had signed his own admission agreement/paperwork. His record also contained a photograph of an alleged restricted visitor with instructions for staff not to allow the person to see/visit Resident 1.</p>	F 242	<p>F242-Self-determination- right to make choices</p> <p>Plan to correct identified findings:</p> <p>Resident 1 has been seeing the family member per his request.</p> <p>Staff Member A is no longer employed</p> <p>Staff Member B will receive an education class on power attorney rights, proper legal documentation to show supporting evidence of information given, and Resident Rights.</p> <p>Staff C will receive an education on Resident Right to make choices.</p> <p>Identification similar situation:</p> <p>Licensed staff will be trained on Resident right to make choices about the aspects of residents life in the facility that are significant to the resident, use of a private phone, a proper legal documentation to show supporting evidence of information given by state officials, and</p>	10/5/13

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F 242	<p>Continued From page 2</p> <p>The nursing notes, dated 8/24/13, documented a family member had called the facility informing staff not to allow the alleged restricted visitor to see Resident 1 as a " Restraint order is pending." The facility then posted signs on the resident's door and at the nurse's station regarding the alleged restricted visitor. On 8/25/13, when the alleged restricted visitor came to visit the resident, the facility denied visitation and the visitor was escorted out of the facility.</p> <p>A Social Service (SS) note dated 8/26/13 indicated the resident was asked if he would like to have visits from the alleged restricted visitor. The resident responded he would like to have visits with that person.</p> <p>Per a SS late entry note for 8/29/13, the resident was advised of a temporary no-contact order regarding the alleged restricted visitor (five days after the facility was notified by family of a " pending " no contact order).</p> <p>A nursing note dated 9/6/13, documented "res (resident) asked if (staff) could dial a # (number) for him ". The staff person reviewed the cell phone call log which showed numerous calls to the alleged restricted visitor. The staff person did not dial the requested number and gave the cell phone back to the resident.</p> <p>On 9/17/13 at 10:45 a.m. the Resident Care Manager (RCM) was asked about the 9/6/13 nursing note. The RCM stated she did not dial the telephone number or provide assistance as the resident requested. She said she " should not have done that. "</p>	F 242	<p>involving the resident in the plan of care.</p> <p>Measures to prevent recurrence:</p> <p>Licensed staff will be audited on Resident right to make choices about the aspects of residents life in the facility that are significant to the resident. Results of weekly audits will be forwarded to Quality Assurance Committee for thirty days.</p> <p>Monitor to sustain compliance:</p> <p>Licensed staff will be audited on Resident right to make choices about the aspects of Residents life in the facility that are significant to the resident. Results of audits will be forwarded to Quality Assurance Committee for thirty days.</p>		

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F 242	<p>Continued From page 3</p> <p>A SS note dated 9/10/13, documented the alleged restricted visitor had notified the facility to provide assistance for Resident 1 so he could receive a call from a court in order to testify by telephone regarding legal matters. SS documented the facility did not have the means to provide assistance as the resident " did not have cell phone."</p> <p>SS was interviewed on 9/12/13 at 3:50 p.m. He stated the facility administrator told him that staff "could not sit for 2 hours" waiting to assist with a phone call from the court, as the resident did not have a personal cell phone and the facility's portable phone was not working. SS indicated a family member "took phone from the pt (patient)." SS said a family member had a restraining order against the alleged restricted visitor. When asked for a copy of the restraining order, the SS stated "I think we have it ", but was unable to produce the legal document at that time. When asked whether the resident was able to make his own decisions, SS said Resident 1 was able to make his own decisions.</p> <p>During an interview on 9/12/13 with the RCM, the RCM stated the facility's second floor portable phone was broken. Currently both floors were sharing the 1st floor portable phone whenever a resident needed to use a phone or received a call.</p> <p>On 9/12/13, at 10:25 a.m., Resident 1 was observed in his room. The resident did not have a phone in his room. At 2:40 p.m., the resident informed the surveyor that he was "getting a cell phone."</p> <p>During an interview with Resident 1 on 9/17/13,</p>	F 242		

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F 242	<p>Continued From page 4</p> <p>he stated he told the facility staff that he wanted to see the alleged restricted visitor, "I want to see her, and I love her very much."</p> <p>During an interview on 9/17/13 at 1:45 p.m., the Director of Nursing stated the posted signs regarding the alleged restricted visitor had "looked like the 10 most wanted " and she had staff remove the posted information.</p> <p>On 9/17/13 at 1:45 p.m., the Director of Nursing stated Resident 1's rights were violated and the pictures and signage regarding the alleged restricted visitor should not have been posted.</p>	F 242		
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