

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

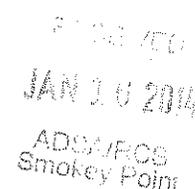
143

PRINTED: 01/07/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505465	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/27/2013
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NAME OF PROVIDER OR SUPPLIER JOSEPHINE SUNSET HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 9901 272ND PLACE NORTHWEST STANWOOD, WA 98292
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced abbreviated complaint survey conducted at Josephine Sunset Home on December 16 and December 27, 2013. A sample of 6 residents was selected from a census of 154. The sample included 5 current residents and the record of 1 former and/or discharged resident.</p> <p>The following complaints was investigated as part of the survey: 2921106 2917355 2919889</p> <p>The survey was conducted by: [REDACTED], RN, MSN</p> <p>The survey team is from: Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, Region 3, Unit B 3906 172nd Street NE, Suite 100 Arlington, WA 98223</p> <p>Telephone: (360) 651-6850 Fax: (360) 651-6940</p> <p><i>[Signature]</i> Residential Care Services Date: 1/7/14</p>	F 000	<p>The submission of this plan of correction does not constitute admission by the provider of any fact or conclusion set forth in the statement of deficiency. This plan of correction is being submitted because it is required by law.</p> <p style="text-align: right;">  </p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 1-16-2014
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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 226	<p>Continued From page 2</p> <p>was suspected abuse ...the mandated reporter, any witnesses and licensed nurse(LN) would contact police, state hotline, and Director of Nursing Services (DNS), Assistant DNS or Administrator immediately.</p> <p>Resident 3 lived in the facility for several years. She was assessed as being cognitively intact, and required 2 person extensive assist for most activities of daily living.</p> <p>A progress note dated 11/29/13 at 21:42 documented Resident 3 had asked to have an 8 p.m. antidepressant medication brought to her at 9:30 p.m. Per the note, Staff 1 advised the resident the medication could only be given between 7 p.m. and 9 p.m. (One hour before or after the designated time). The note indicated Resident 3 became verbally upset. There was indication of further discussion between Staff 1 and Resident 3, and the medication was not administered.</p> <p>An interview with a resident nurse manager (RCM) on 12/27/13 at approximately 10:45 a.m. revealed Staff 1 phoned the RCM on the evening of 11/29/13 and their discussion was mainly about timing of medication administration related to facility policy and professional license.</p> <p>A written allegation dated Friday 11/29/13 by Staff 2 indicated Staff 1 was heard arguing with and yelling at Resident 3 about medication time during evening shift 11/29/13.</p> <p>Review of the nursing schedules/assignments revealed both Staff 1 and Staff 2 worked the Friday 11/29/13 evening shift, and were both assigned to Resident 3. Staff 2 did not work</p>	F 226	<p>The facility will in-service direct care and ancillary staff on the policy and procedure regarding allegations and the abuse/neglect policy.</p> <p>The DNS or designee will conduct a random audit of 5 residents weekly for four consecutive weeks. These residents will be interviewed and assessed to ensure that any allegations have been identified, properly investigated and reported per facility policy and procedure. Audit results will be reviewed at the Quality Assurance Performance Improvement Committee monthly meeting until consistent, substantial compliance is met. Compliance will then be monitored and reported to the Committee through five random resident interviews on a quarterly basis.</p>	<p>2-3-14</p> <p>2-3-14</p> <p>Ongoing</p>

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F 226	Continued From page 3 Saturday 11/30/13 or Sunday 12/1/13. Staff 1 worked and was assigned to Resident 3 on both of those evenings. Review of documentation revealed a facility investigation of the 11/29/13 allegation, report to police and state hotline, and resident protection from further potential abuse was initiated on Monday 12/2/13. During an interview with the DNS on 12/27/13 at 3:15 p.m. the DNS indicated Staff 2 had left the 11/29/13 allegation note on the DNS's desk, and therefore the DNS did not become aware of the allegation until 12/2/13. Staff 2 did not report to the state reporting hotline or act to protect Resident 3 from further potential verbal abuse.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to consistently promote care for 1 of 6 residents(3) in a manner that maintained dignity and respect in full recognition of her individuality. Failure to accomodate Resident 3's request for a medication to be given at a specific time placed the resident at risk for frustration and/or lack of self worth.	F 241	F 241 Staff #1 was in-serviced 12/05/13 regarding communication and attempting to honor resident wishes and maintaining resident dignity. There no other residents at this time in a similar situation.	12-5-13

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F 241	<p>Continued From page 4</p> <p>Findings include:</p> <p>Resident 3 lived in the facility for several years. She assessed as cognitively intact and required 2 person extensive assist for most activities of daily living.</p> <p>During an interview with Resident 3 on 12/16/13 at 10 a.m., the resident was asked about her care & treatment, and politeness of staff. The resident said she had been feeling ill over the weekend, "It's okay, but I was feeling so bad that I probably said some things I shouldn't." The resident did not elaborate.</p> <p>Review of the record revealed a 11/29/13 nurse alert note written at 21:42 that indicated the resident asked to receive an (8 p.m.) antidepressant medication (redacted) at 9:30 p.m. The LN advised the resident the medication must be given by 9 p.m. The resident became verbally "upset." The resident told the LN the medication made her sleepy and she did not want to go to sleep at 10 p.m.; she wanted to go to sleep later. The resident asked to speak to the evening supervisor. The LN documented she called the supervisor, but there was no answer. The LN could not physically locate the supervisor, and then informed the resident she was unsuccessful in contacting the supervisor. The note also indicated the LN asked the resident if she would take the medication, "now-or they would be destroyed." The resident's response was documented as, "No, it will be all your fault that I will not sleep tonight!" The LN later called a supervisor regarding the medication episode, and marked the medication as "refused." There was no documented evidence as to whether the</p>	F 241	<p>Licensed nurses will be in-serviced regarding proper procedure for assisting residents with medication administration while ensuring dignity is maintained.</p> <p>The DNS or designee will conduct 5 random observations monthly of medication administration for the next three months to ensure staff are promoting and maintaining resident dignity in accordance with facility practice, guidelines and regulatory requirements. Observation results will be reviewed at the Quality Assurance Performance Improvement Committee monthly meeting until consistent, substantial compliance is met. Compliance will then be monitored and reported to the Committee through 5 random medication administration observations on a quarterly basis.</p>	<p>2-3-14</p> <p>2-3-14 ongoing</p>
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F 241	<p>Continued From page 5</p> <p>supervisor talked to the resident on the evening of 11/29/13.</p> <p>Review of the November 2013 medication administration record (MAR) revealed an order for [REDACTED] delayed release by mouth one time a day with the administration time marked as 8 p.m. (Order start date 8/16/13, DC date 11/30/13). The written MAR order also indicated, "May give [REDACTED] dose @ "HS" (bedtime).</p> <p>An interview with a resident nurse manager (RCM) on 12/27/13 at 10:45 a.m. disclosed the LN had called the RCM on the evening of 11/29/13. They had discussed the timing of medication administration for an 8 p.m. medication time as having 1 hour leeway before and after (between 7pm - 9 p.m.). During the interview, it was brought to the RCM's attention that the [REDACTED] order in place on 11/29/13 on the MAR also directed the medication could be given at HS. The RCM then reviewed the facility's medication administration times policy/procedure (P/P). The P/P indicated an acceptable "HS" administration time frame was 1800 - 2200 (6 pm-10 pm).</p> <p>An interview with the Director of Nursing Services on 12/27/13 at 3:15 p.m., the DNS indicated she understood they had received a new order to change the [REDACTED] administration time from 8 p.m. to 'HS' after the alleged 11/29/13 occurrence. The DNS was not aware the MAR order in place for 11/29/13 had already indicated, "May give [REDACTED] dose at "HS" (bedtime).</p>	F 241			