

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

PRINTED: 05/22/2013  
FORM APPROVED  
OMB NO. 0938-0391

1431

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505339</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/21/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MOUNT SI TRANSITIONAL HEALTH CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>219 CEDAR AVENUE SOUTH NORTH BEND, WA 98045</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is as a result of an unannounced abbreviated survey conducted at Mount Si Transitional Care Center on 05/21/2013. A sample of two residents were selected from a census of 39.</p> <p>The survey was conducted by:</p> <p><b>[REDACTED] MSW</b> Long Term Care Surveyor Aging and Long Term Care Support Administration Division of Residential Care Services 20425 72nd. Ave S, Suite 400 Kent, WA. 98032 Phone: (253) 234-6000 Fax: (253) 395-5070</p> <p><i>Bernett [Signature]</i> Residential Care Services Date</p>	F 000	<p>This Plan of Correction is submitted as required under Federal and state regulations and statutes applicable to Long-term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility. The submission of this plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, or that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied.</p> <p>This Plan of Correction constitutes our Credible Allegation of compliance.</p> <p>RECEIVED JUN - 3 2013 DSHS/ADSA/RCS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE <b>Administrator</b>	(X8) DATE <b>5-31-13</b>
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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 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure two of two residents (Resident #1 and #2) who were permitted unrestricted and unescorted access to the community had in place care plans which ensured their safety while in the community.</p> <p>Findings Include:</p>	F 279	<p>F-279 Develop Comprehensive Care Plans</p> <ol style="list-style-type: none"> <li>1. Resident #1 and #2 will be educated regarding safety in the community and instructed how and when to use deterrent equipment. Identification with current address and phone# will be obtained for resident and instruction to carry when on independent community outings. Care plan will be updated to reflect current safety measures.</li> <li>2. All residents who have been assessed for independent community outings have had their care plans reviewed and updated with individualized safety interventions. Safety measures and educational instructions will be reviewed with these residents. Current identification will be procured.</li> <li>3. Guidelines for safety in independent community outings will be reviewed and updated. Staff will be educated. Any resident who has been assessed and has met criteria for independent community</li> </ol>		

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F 279	<p>Continued From page 2</p> <p><b>RESIDENT #1</b> Resident #1 had been a resident of the facility for almost [REDACTED] years having been admitted with multiple medical diagnoses. He was independent with the use of his electric wheelchair for mobility. It was noted the resident was permitted almost daily to leave the facility to interact with the outside community without signing the Resident Log.</p> <p>Review of the resident's medical record showed his most recent quarterly Minimum Data Set (MDS) assessment dated 04/17/13 reflected a score of 11 out of 15 on the Brief Interview for Mental Status (BIMS). This score reflected some cognitive deficits but also indicated Resident #1 usually was understood and usually could understand others. The MDS also reflected the resident had no delirium, no behaviors and no recent history of falls. (It is significant there had been a decline in the resident's BIMS score from a 12 out of 15 from the annual MDS dated 08/23/12.) It was also noted that it was very important to him to be able to get fresh air.</p> <p>Review of the facility's incident report for this resident dated 05/11/13 revealed Resident #1 reported he had been bitten by a [REDACTED] while out in the community. He received two puncture wounds to his [REDACTED] which required treatment by the facility. According to the resident's incident report, this was the third [REDACTED] he had sustained in three years.</p> <p>Observations of Resident #1 revealed an appropriately dressed elderly gentleman sitting in an electric wheelchair. A gauze bandage was observed on his [REDACTED] area.</p>	F 279	<p>outings will be educated and care plans will be initiated reflecting individual safety needs.</p> <p>4. Care plans and safety measures will be reviewed with each resident during their quarterly conferences for continued appropriateness and adaptations will be made as necessary. Medical record audit will be adapted to include review of safety measures. Any negative trends will be reviewed at the QA meeting on a quarterly basis.</p> <p>5. 6/5/2013</p> <p>6. Director of Nursing Services and/or designee.</p>	

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F 279	<p>Continued From page 3</p> <p>Interviews were conducted with Resident #1 on 05/21/13 at 12:30 p.m. and 2:35 p.m. concerning his trips outside the facility. He stated most recently, he had been bitten by a leashed [redacted] on the [redacted]. He stated there were two people who appeared to be walking the [redacted] and that the two people didn't say anything to him about the [redacted]; simply leaving the area. When asked if he had provoked the [redacted] or done anything to agitate the [redacted], he stated no "I was just trying to pet him." When asked if he had been able to defend himself, he said he just pushed the [redacted] away.</p> <p>Resident #1 was asked if he had any identification on him which reflected his current residence. He produced a business card from his bank but which had no information concerning the resident. When asked if he was unable to tell someone where he lived, how would they know who to call, Resident #1 stated "They could call the bank. They all know me."</p> <p>Resident #1 was asked if he had any method to protect himself from attacks from [redacted]. He stated "No. I've thought about carrying a cane or stick with me but I've never asked for anything. My legs don't work so I sure can't run from them."</p> <p>Review of Resident #1's medical record revealed a physician's order dated 06/09/09 which stated "May go out unescorted." A review of the resident's Care Plan revealed two care plan problems related to the resident's frequent leave out of the facility. The care plan intervention for "Minimal Activity Involvement" had an intervention which stated "Resident egresses independently into surrounding community."</p>	F 279		
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F 279	Continued From page 4  The care plan interventions for "Fall Risk" had the Goal of "Prevent falls and/or minimize falls with injury" with five interventions directed toward use of the resident's wheelchair in the community." One intervention stated "(Resident #1) needs to be reminded to sign out in 'sign out' book before he goes OOF (out of the facility)."  There was no care plan problem which directly concerned maintenance of Resident #1's safety while out of the facility including use of information concerning his residence, ongoing assessment of his ability to be independent and how to protect himself from dog attacks related to his three time history of being bit.  <b>RESIDENT #2</b> Resident #2 was a long term resident of the facility having been admitted with multiple medical diagnoses including immobility. She was independent in use of her electric wheelchair and had unrestricted and unescorted access to the community according to administrative nursing Staff A.  Review of Resident #2's most recent annual MDS dated 03/11/13 reflected a BIMS of 14/15 indicating few issues with cognitive functioning. The MDS indicated it was very important to the resident to be able to get fresh air.  An interview was conducted with Resident #2 on 05/21/13 at 1:30 p.m. Observation during the interview revealed a well dressed woman with multiple craft type objects in the process of being worked on.	F 279			

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F 279	<p>Continued From page 5</p> <p>When asked about her experiences going out of the facility, she stated she always felt safe and she had not had any issues with falls or accidents. When asked if she had any identification reflecting her residence, she produced a Washington State Identification card with an expiration date of July, 2013.</p> <p>Review of the resident medical record showed a physician's order dated 06/09/09 stating the resident was permitted to go out of the facility without escort. Review of Resident #2's care plan showed only one Problem of "Decreased Activity" with an intervention of "(Resident #2) is able to go into the community independently. Resident visits the library, grocery store, hardware store and the Farmer's Market." There was no care plan problem which directly concerned maintenance of Resident #2's safety while out of the facility including ongoing assessment of her ability to continue accessing the community safely or ensuring current information concerning her residence.</p> <p>An interview was conducted with administrative nursing Staff A on 05/21/13 at 11:00 a.m. She stated residents were generally required to sign the Resident Leave Log prior to exiting and when returning to the facility. She stated Resident #1, along with Resident #2, had been "grandfathered in" in relationship to the facility's leave policy because of how long they had been independent in community access. She stated Resident #1 never utilized the sign out log but indicated nursing staff were aware when both residents left the facility since the height of the security access code panel was inaccessible by a person in a wheelchair.</p>	F 279		

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F 279	Continued From page 6  When shown both resident's care plan, Staff A stated she believed these were the only documents which reflected the facility's planning for ensuring the safety of both residents in the community.	F 279			

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