

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

PRINTED: 09/06/2013
FORM APPROVED
OMB NO. 0938-0391

1446

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505522	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/04/2013
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - SALMON CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 2811 NE 139TH STREET VANCOUVER, WA 98686
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Manorcare of Salmon Creek on 9/3/2013 and 9/4/2013. A sample of 7 residents was selected from a census of 100. The sample included 4 current residents and the records of 3 former and/or discharged residents.</p> <p>The following complaints were investigated:</p> <p>#2842801 #2847252 #2853203 #2853425 #2861081 #2862083 #2862121</p> <p>The survey was conducted by: [REDACTED] RN, MS</p> <p>The survey team is from: Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, District 3, Unit D 5411 East Mill Plain Blvd., Suite 203 Vancouver, WA 98661</p> <p>Telephone: 360-397-9550 Fax: 360-992-7969</p> <p><i>[Signature]</i> Residential Care Services Date 9/4/13</p>	F 000	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p style="text-align: center;">RECEIVED SEP 20 2013 DSHS/ADSA/RCS</p>	9/24/13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 9/19/13
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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 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure alleged incidents of suspected abuse and/or neglect were promptly reported and failed to protect residents from further mistreatment for 2 of 7 residents (#1 & 7) as outlined in facility policy. This failure placed the affected residents and other potential residents at risk of continuing abuse and/or neglect and delayed timely investigation.</p> <p>Findings include:</p> <p>The facility policy labeled "Patient Protection Practice Guide", dated 11/2011 stated "Centers can best support the detection and prevention of abuse by implementing a process that supports immediate reporting of suspected abuse (p.7). Abuse against patients can be initiated by various people within the center. The center supports and protects patients, family members and staff from harm during an investigation of alleged abuse. Patient protection actions include immediately removing the patient from contact with the alleged abuser during the investigation. If the incident involves a center employee, the employee is suspended pending completion of the investigation (p. 11). The center must ensure</p>	F 226	<p>F 226 or designees will be responsible for compliance.</p> <p>Res 1 interviewed and states that they feel staff treat them with respect and dignity; that they have a say in their care and the right to refuse; and they feel safe.</p> <p>Res 2 interviewed and stated that they feel staff treat them with respect and dignity; that they have a say in their care and the right to refuse; and they feel safe.</p> <p>2. All residents are at risk. No other residents during interviews identified concerns with physical or psychological harm.</p> <p>3. Current interdepartmental staff in-serviced on Patient Protection Guideline and mandatory reporting. New staff will receive education on Patient Protection Guideline and mandatory reporting</p>	9/24/13	

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F 226	<p>Continued From page 2</p> <p>that all alleged violations involving mistreatment, neglect or abuse are immediately reported to the administrator of the facility and other officials in accordance with state law (p. 12).</p> <p><Resident #1> Resident #1 was admitted to the facility on [REDACTED] 2013 with diagnoses to include [REDACTED] and [REDACTED]. According to the Minimum Data Set (MDS), an assessment instrument, dated 7/24/13, the Resident was alert with periods of confusion. Resident #1 required extensive assistance of 1 staff member for completion of activities of daily living (ADLs). The Resident was to receive several insulin injections throughout the day to manage diabetes, depending on the blood sugar readings. The Resident had a history of occasionally refusing the insulin injections.</p> <p>On 9/3 at 11:25 a.m., during interview, Nursing Assistant (NAC) A stated "On 8/13 at lunch time, I was in the dining room getting residents ready for lunch and waiting for the trays to be delivered. I saw Licensed Nurse (LN) E walk into the dining room. {LN E} asked {Resident #1} if she could give insulin in the dining room. The Resident said 'No, not in here'. Then {LN E} said 'How about if I turn you around where no one can see you'. The Resident again said 'No, I don't want the insulin to be given in here'. {LN E} then said 'No one can see you', then she just stuck the needle into the Resident's arm. The Resident {#1} gasped and acted surprised. I did not report what I had just seen. I finished lunch, did some more work, then clocked out and left for the day. I knew what I had seen wasn't right, and I thought more about it during the night. Then the next day I called the Resident Care Manager (RCM) and left a phone</p>	F 226	<p>4.</p> <p>Interdepartmental team will conduct random audits monthly concerning patient protection. Results will be tracked and trended for the next 3 months and findings reported to the QA&A committee with action plans developed and implemented if indicated.</p> <p>Date of compliance 9-26-13</p>	9/24/13	

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F 226	<p>Continued From page 3</p> <p>message for her and reported what I had seen."</p> <p>On 9/3 at 12:10 p.m., Resident #1 was unable to recall receiving insulin in the dining area.</p> <p>On 9/3 at 4:35 p.m., LN E stated "I was working day shift on 8/13. I finished my shift that day around 2:30 p.m., and did not get suspended until the next day. I didn't realize there was a problem."</p> <p>On 9/4 at 12:25 p.m., the Director of Care Delivery (DCD) H stated "We expect our staff to report any concerns, even if they are not sure what they are seeing. We frequently remind staff they are mandatory reporters. There is always someone to call if the staff are concerned. {NAC A} waited until the next day to report her concerns. I have the expectation that she would have reported her concerns on 8/13 instead of waiting until 8/14. We suspended the nurse {LN E} immediately when we heard the concerns and we completed an investigation into the matter. There was an unnecessary delay in beginning the investigation because of the delay in reporting. We did provide additional education to the NAC and in the next situation she reported more timely."</p> <p><Resident #7> Resident #7 was admitted on [REDACTED]/12 with [REDACTED]. The MDS, dated 6/17/13, showed the Resident to be alert, but confused, and dependent on 2 staff members for ADL care. The Resident also had bladder and bowel incontinence and fragile skin. The Resident was scheduled to go to the hospital on [REDACTED] in the early afternoon for [REDACTED].</p>	F 226		9/24/13

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F 226	<p>Continued From page 4</p> <p>On 9/3, Resident #7 was determined to be non-interviewable due to mental and medical conditions.</p> <p>According to facility reports, on 8/28 at about 10:00 a.m., NAC A found {Resident #7} to be very wet and she had a suspicion that no care had been provided since the 6:00 a.m. shift start. NAC A reported her concerns to the charge nurse (LN F), who then assigned care to be completed by NAC A before transportation arrived to take Resident #7 to the hospital. NAC D was responsible for the care of the Resident that shift, but no action was taken to remove her from the care area.</p> <p>On 9/4 at 12:10 p.m., DCD J stated "The Resident {#7} was to have surgery. The nursing assistant {NAC A} reported to the nurse {LN F} that the Resident had not received care for several hours. She {LN F} came to me in the early afternoon after the Resident left for the hospital to convey the concerns about the lack of care. We then went to talk to the Director of Nursing. I don't recall in the other nursing assistant {NAC D} worked the rest of the shift."</p> <p>On 9/4 at 3:50 during telephone interview. LN F stated "I did not find out about the situation until after the resident left for the hospital, a little after noon. Earlier that day, I had met with NAC D to provide a 1:1 inservice on delivery of breakfast trays because there had been a delay in her delivering the morning meal to a resident."</p> <p>According to facility payroll records, NAC D clocked out on 8/28 at 2:05 p.m., finishing her regular shift as scheduled.</p>	F 226		9/24/13
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F 226	Continued From page 5 On 9/4 at 1:10 p.m., DCD H stated "The nursing assistant {NAC D} had left for the day by the time we started our investigation. We called her back into the facility and suspended her. Upon conclusion of the investigation, we did conclude she had neglected the resident and the NAC was terminated. The NAC was not suspended when we first found out about the concerns".	F 226		9/24/13