

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

PRINTED: 07/30/2013  
FORM APPROVED  
OMB NO. 0938-0391

1450

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 07/23/2013
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NAME OF PROVIDER OR SUPPLIER  PRESTIGE CARE & REHABILITATION - CAMAS	STREET ADDRESS, CITY, STATE, ZIP CODE 740 NE DALLAS STREET CAMAS, WA 98607
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Prestige Care and Rehabilitation of Camas on 07/23/2013. A sample of 6 residents was selected from a census of 60.</p> <p>The following complaints were investigated:</p> <p>#2837795 #2844143</p> <p>The survey was conducted by: [REDACTED] RN, MS</p> <p>The survey team is from: Department of Social &amp; Health Services Aging &amp; 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>	F 000	<p style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;">AUG 12 2013</p> <p style="text-align: center;"><b>DSHS/ADSA/RCS</b></p> <p>“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Camas Care &amp; Rehabilitation 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>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Janice Jones 7/30/13</i> <i>Maureen [Signature]</i>	TITLE  <i>Executive Director</i>	(X6) DATE  <i>8/8/13</i>
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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 000  F 226 SS=D	Continued From page 1 Residential Care Services Date 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to operationalize policies and procedures for the protection of residents and for the prevention, identification, investigation and reporting of abuse, neglect, mistreatment, and misappropriation of property for 1 of 6 residents (Resident #2). This failure placed Resident #2 at risk for loss of timely retrieval of crucial investigative information and at risk for ongoing abuse and neglect.  Findings include:  According to the facility policy on "Abuse" reviewed on 1/2013, "Staff with knowledge of inappropriate sexual comments or contact between staff and resident will report immediately to the facility social services director, DNS or administrator. Allegations of sexual abuse will be reported to the facility administrator, involved residents physicians and family/responsible parties, DSHS and law enforcement.  Resident #2 was admitted to the facility on [REDACTED] 07 with diagnoses to include [REDACTED]	F 000  F 226	Resident #2 was assess for injury and placed on alert. The resident's family and doctor were notified. A thorough investigation was completed.  Any allegation of abuse/neglect is investigated fully and immediately. Investigations were reviewed to assure state and federal regulation compliance.  Staff have been educated on timely Mandated Reporting, resident safety and alerting ED and DNS to allegations of abuse/neglect. The ED and DNS will investigate and review allegations of abuse/neglect. Incident/Accident review and reporting will be reviewed at the center's Quality Assurance/Performance Improvement meetings. Employee education regarding abuse/neglect will be conducted for newly hired employees and additional education regarding abuse/neglect will be conducted throughout the year.	8/6/13	

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F 226	<p>Continued From page 2</p> <p>██████████ According to the Minimum Data Set (MDS), an assessment tool, dated 07/21/13, the Resident was able to verbalize the current season, location of the room and the location of the facility within the community, but had otherwise moderately impaired decision making abilities. The Resident was very hard of hearing, but was able to speak. The Resident was completely dependent on 1-2 care givers for all personal care and activities of daily living. Resident #2 was incontinent of bladder and bowel, required staff assistance for personal care and used incontinence briefs.</p> <p>Facility records reflected on 7/15/13 at 11:00 p.m., the Resident was lying in bed. Nursing Assistant (NAC) A asked NAC B to assist with repositioning, personal care and with changing the incontinence brief. NAC A went to the sink in the room to obtain warm water for the cloths which were to be used for the care. NAC B went to the Resident's bedside, near the window, across the room from the sink, pulled the curtain and stood with back against the curtain. NAC A finished gathering supplies and went to position self at the window side of the bed. NAC A recalled the sheets and blankets were pulled down to the bottom of the bed, but could not recall whether the briefs had been loosened. As soon as NAC A arrived, the Resident told NAC B to "Get out of my room". A short time later, NAC C came into the room to inquire if NAC A needed assistance. NAC A asked NAC C to find out what was going on with the Resident, as the Resident was able to hear NAC C's voice better. Resident #2 reported "He {NAC B} rolled my brief down" like he was going to "examine me" the pulled or spread the genitals causing "pain". "I told him to stop but he continued. He never spoke and did</p>	F 226	<p>The Quality Assurance/Performance Improvement committee will review incident and accident s, including any allegations of abuse/neglect and will review for trends and any changes in facility practice.</p> <p>The Executive Director will assure ongoing compliance.</p>	

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F 226	<p>Continued From page 3</p> <p>not stop until the second aide {NAC A} came into the room." NACs A and C continued to provide care, then reported the conversation to the Nurse {Licensed Nurse, LN, E}.</p> <p>On 7/23/13 at 2:20 p.m., LN E stated "On 7/15, when the staff reported the Resident's statements to me, I checked the timecards and found that NAC B had clocked out, so I thought the Resident was safe. I did an assessment and did not find any injuries. The Director of Nursing was having a birthday celebration, so I decided to wait until the next day to notify her. I felt the Resident was safe, so I thought it could wait until the next day. The Resident has made allegations before, but it was usually related to a [REDACTED] I did not call the family, physician or Law Enforcement."</p> <p>On 7/23/13 at 10:00 a.m., the Director of Nursing stated "The first I knew of this allegation was on 7/16/13 when {LN E} came into work on the evening shift. The NAC {B} was scheduled to work the evening shift on 7/16, so I had someone intercept him when he arrived for work. I called the police and DSHS, I had the Licensed Nurse (LN E) call the family and the Doctor. We launched a full investigation as soon as I found out about the allegations. The Nurse should have started this investigation when it was reported to her on 7/15."</p> <p>On 7/23/13 at 10:40 a.m., Resident #2 was asked if anyone had been rough or touched the Resident in a way that caused discomfort. The Resident replied "Just one person. That was about a week ago. An aide put his fingers in my brief. I asked him to stop and he did not. I asked him again to stop and he did not. He did not stop</p>	F 226		

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F 226	Continued From page 4 until the other aide came in the room."	F 226			