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

1454

PRINTED: 12/17/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	505226		C 12/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTIGE CARE & REHABILITATION - SUNNYSIDE	721 OTIS AVENUE SUNNYSIDE, WA 98944

(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	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Survey conducted at Prestige Care & Rehabilitation - Sunnyside on December 12, 2013. A sample of 6 residents was selected from a census of 71 residents. The sample included 3 current residents and the records of 3 former and/or discharged residents. The following were complaints investigated as part of this survey: #2918566 #2903565 The survey was conducted by: [redacted] R.N. The survey team is from: Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services, District 1, Unit C 3611 River Road, Suite 200 Yakima, Washington 98902 Telephone (509) 225-2800 Fax: (509) 574-5597 [redacted] 12/17/13 Residential Care Services Date	F 000	**F000 Initial Comments** "This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Prestige Care - Sunnyside 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."	
F 201 SS=D	483.12(a)(2) REASONS FOR TRANSFER/DISCHARGE OF RESIDENT The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the	F 201	**F 201** 1. Res #1 has been readmitted to this facility. [redacted] is satisfied with this. 2. RCM/designee review of Resident for appropriate needs for services provided by this facility. Transfer/discharge managed individually by interdisciplinary team with **F 201 continued**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [redacted] TITLE (X6) DATE 1-7-14

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 201 Continued From page 1

facility;

The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

The safety of individuals in the facility is endangered;

The health of individuals in the facility would otherwise be endangered;

The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or

The facility ceases to operate.

This REQUIREMENT is not met as evidenced by:
Based on record review and interviews the facility failed to permit the resident to remain in the facility by discharging the resident without appropriate justification for 1 of 3 sampled residents (#1) reviewed for discharge.
Findings include:

Resident #1: Admitted to the facility on [redacted]/13 with diagnoses which included [redacted] Review of the resident's plan of care revealed she had [redacted] impairments with [redacted] and [redacted] term [redacted] loss. In addition, she was at risk for wandering out of the facility, thus she had an

F 201 **F 201 continued**

resident and/or [redacted] involvement. Ombudsman and government agencies informed as required.

3. Administrator in-serviced by Regional Directing Officer and Corporate Nurse Consultant on 12/17/13 regarding policy for resident transfer or discharge, including where discharge is necessary for resident's welfare and/or the resident's needs cannot be met.

4. Social Services Director to communicate resident discharge plan to Interdisciplinary team, resident and or responsible party as they arise. Social Services Director will report on Resident Discharges at QAPI monthly meeting for three months. Director of Nursing responsible for compliance.

1/9/14

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F 201	Continued From page 2 electronic elopement monitor (a device that alarmed when the resident crossed the threshold of exit doors equipped with the elopement monitoring system - staff would have to manually reset the alarm) that she wore on her wrist. Nursing approaches were for staff to frequently monitor the resident's whereabouts and to engage her in activities. Review of Progress Notes dated 12/3/13 revealed the resident was alert and oriented to self and surrounding, "occasionally chronically confused and forgetful but pleasantly compliant with care and making needs known." Progress Notes dated 12/4, 5/13 stated the resident was redirected numerous times to whereabouts and activities. There was no further nursing documentation until [redacted]/13 [redacted] which stated the resident was discharged to another skilled nursing facility (within corporation). An interview on [redacted]/13 at 2:55 p.m. with Staff A (Administrator) revealed the resident was discharged from the facility as she was concerned about her getting out of the facility endangering her life due to the cold temperatures outdoors. She stated the electronic elopement monitoring system was only present on four of the nine exit doors in the facility. Staff B (Director of Nursing) revealed on [redacted]/13 at 3:00 p.m. that the resident had only gotten approximately two steps out of the facility at which time the electronic elopement monitoring system alerted staff to respond and bring her back into the building. She stated she had no knowledge of the resident attempting to exit from any of the five doors that were not equipped with the elopement monitoring system.	F 201	F. 201 see prior page	

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F 201	Continued From page 3	F 201	F. 201 see prior page	
	A telephone interview on [redacted]/13 at 12:54 p.m. with the resident's legal representative revealed the resident's [redacted] had never been contacted by the facility relative to the resident attempting to exit from the facility. The legal representative stated the resident's [redacted] was called on [redacted]/13 by the facility and informed they needed to discharge the resident that day to another facility and if they did not do so they would have to have a [redacted] member be with her at all times during her waking hours. The legal representative stated the resident's [redacted] was unable to be with her during those times due to their work schedules. He stated following the telephone call he cme to the facility and met with several administrative staff on [redacted]13. The Administator stated the resident "has to move as she gets out of the building." The legal representative then asked the Administrator, "If the alarm goes off isn't someone supposed to run and bring back (the resident)?" The Administrator replied, "Not possible at all times." The legal representative stated he returned to the facility the following day on [redacted]/13 to "plead his case" again with the Administrator to no avail.			
	Review of Progress Notes from the time of admission to discharge [redacted]/13) did not evidence the resident exiting out of the facility. In addition, there was no evidence of documentation regarding any incidents of exiting the facility necessitating a discharge to another facility.			
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE	F 203		
	Before a facility transfers or discharges a resident, the facility must notify the resident and,			

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F 203	Continued From page 4 if known, a [redacted] member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the	F 203	**F 203** 1. Resident #1 has been readmitted to this facility. [redacted] is satisfied with this. 2. RCM/designee review resident for appropriate needs for services provided by this facility. Transfer/discharge managed individually by interdisciplinary team with resident and/or [redacted] involvement. Ombudsman and government agencies informed as required. 30 day discharge notice will be utilized as appropriate. 3. Administrator in-serviced by Regional Directing Officer and Corporate Nurse Consultant on 12/17/13 regarding policy for resident transfer or discharge, including where discharge necessary	

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F 203	Continued From page 5 protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to provide written notice of discharge to 1 of 3 sampled residents (#1) reviewed for discharge. Iin addition, the facility failed to document the reasons for the discharge in the resident's medical record. This failure resulted in Resident #1's discharge without appropriate and timely written notice given to the resident and legal representative informing them in writing regarding the reasons for discharge, effective date of discharge, location to which the resident was being discharged, appeal rights, and advocacy contact information. Findings include: Resident #1: Review of the resident's medical record noted she was discharged from the facility to another skilled nursing facility on [redacted]/13. There was no documentation regarding the reason(s) for the resident's discharge. A telephone interview on [redacted]13 at 12:54 p.m. with the resident's legal representative revealed the facility had called another [redacted] member on [redacted]/13 stating the resident needed to be discharged that day as she kept getting out of the facility and it was 15 degrees outside. He stated the facility had not provided him or the resident with any written notification of the resident's	F 203	**F 203 continued** for welfare and/or the resident's needs cannot be met. 5. Social Services Director to communicate resident discharge plan to Interdisciplinary team, resident and or responsible party as they arise. . Social Services Director will report on Resident Discharges at QAPI monthly meeting for three months. Director of Nursing responsible for compliance.	1/9/14

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F 203 Continued From page 6

discharge.

An interview on [redacted]13 at 2:55 p.m. with Staff A (Administrator) revealed no written notice of discharge was given to the resident and legal representative.

F 204 SS=D 483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG

A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r).

This REQUIREMENT is not met as evidenced by:
Based on record review and interviews the facility failed to provide sufficent preparation to ensure a safe and orderly transfer for 1 of 3 sampled residents (#1) reviewed for discharge. This failed practice potentially resulted in psychological harm to the resident relative to increased confusion and anxiety. Findings include:

Resident #1: Admitted to the facility on [redacted]/13 with diagnoses which included [redacted]. Review of Progress Notes dated 12/4, 5/13 noted the resident had to be frequently redirected to her

F 203

F204

1. Resident has been readmitted to this facility. [redacted] satisfied with this outcome.

F 204

2. Discharge assessment at admit, quarterly with MDS schedule and as residents needs change. Resident and/or responsible party, Interdisciplinary Team and Ombudsman as necessary, will be involved in discharge process.

3. Administrator was in-serviced on 12/17/13 by Regional Directing Officer and Corporate Nurse Consultant on discharge/transfer policy including care planning and notifications.

4. Social Services Director to communicate resident discharge plan to Interdisciplinary team,

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F 204	Continued From page 7	F 204		

whereabouts and activities. There was no further nursing documentation until [redacted]/13 ([redacted] later) which stated the resident was discharged that day to another skilled nursing facility.

A telephone interview on [redacted]13 at 12:54 p.m. with the resident's legal representative revealed the [redacted] received a telephone call from the facility on [redacted]13 stating they needed to move the resident to another facility that day as she kept getting outdoors and it was 15 degrees outside. He stated neither he or other [redacted] members had ever been contacted by facility staff regarding attempts by the resident to exit the facility. The legal representative stated he was "very unhappy" with the change in the facility as it increased the resident's confusion. He stated there were many differences in the two facilities relative to the environment. He stated when he visited the resident following her discharge from the facility all she could talk about was the high number of residents in the new facility in wheelchairs that could not carry on a conversation.

Review of the resident's medical record did not evidence any discharge planning prior to her discharge.

A telephone interview on [redacted]/13 at 4:45 p.m. with Staff C (Social Service Director) revealed there was no discharge planning prior to the discharge of the resident. She stated the resident's [redacted] did not want her to be discharged due to her level of confusion.

F 279 SS=E 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

F204 continued

resident and or responsible party as they arise.
Social Services Director will report on Resident Discharges at QAPI monthly for three months.
Director of Nursing responsible for compliance.

1/9/14

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F 279	Continued From page 8 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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). This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews the facility failed to develop comprehensive plans of care for 3 of 6 sampled residents (#'s 2,3,4) reviewed for care plans. This failure placed residents at risk for receiving inadequate care and services to meet individualized needs. Findings include: Resident #2: Review of the resident's medical record noted she was readmitted to the facility on [redacted]/13 following surgery for a [redacted] which was sustained when she [redacted] at the facility on [redacted]/13. Other diagnoses included [redacted], [redacted], and [redacted]	F 279	**F 279** 1. Resident # 2 & #3 care plans reviewed and updated Resident #4 no longer in the facility. 2. Care plans reviewed for comprehensive plan and revised as warranted. 3. DNS in-serviced Interdisciplinary Team on Care plan policy, including time frames for completion, updating, and revising as necessary when resident needs change. 4. DNS/designee will monitor for care plan compliance. Results will be reported to QAPI committee monthly X 3 months. DNS responsible for overall compliance. 1/29/14	

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F 279	Continued From page 9 The resident was observed on 12/12/13 at 11:45 a.m. being pushed by staff in a reclining type wheelchair down the hallway. She had [redacted] therapy via [redacted] and a [redacted] retention [redacted] in place. Despite the resident's multiple problems: [redacted], [redacted], [redacted] with [redacted] problems, at risk for [redacted] and [redacted] problems, [redacted] activities of daily living, and recent [redacted] for a [redacted], review of the comprehensive care plan only addressed the problems of discharge planning and activities. Staff B (Director of Nursing) acknowleged on 12/12/13 at 3:00 p.m. that the resident's care plan was not completed at the time it was reviewed by the state investigator. Resident #3: Review of a facility investigation report dated 11/28/13 revealed the resident had exited the facility and was found two blocks away. She had cut her electronic elopement monitoring device off (a device that alarmed when the resident crossed the threshold of exit doors equipped with the system - the alarm would alert staff to respond), which had been attached to her walker. As a preventative measure the investigation report noted the elopement monitoring device was placed on her right ankle rather than the walker. The report stated the resident's plan of care was updated to identify to staff the resident had a history of removing her elopement monitoring device. Observation of the resident on 12/12/13 at 12:00 noon noted she had an electronic elopement monitoring bracelet on her right wrist.	F 279	F. 279 see prior page	

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F 279	Continued From page 10 Review of the resident's comprehensive plan of care noted it had not been updated to reflect the change in the location of the elopement monitoring device (from walker to right wrist), and her history of cutting the device off. Resident #4: Review of the resident's medical record noted on [redacted]/13 an electronic elopement monitoring bracelet was placed on the resident as he attempted to exit the facility through the front door. On 11/12/13 the resident was found on the sidewalk in his wheelchair and stated he was looking for the parking lot. On 11/13/13 he attempted to exit from the facility four times. Observation of the resident on 12/12/13 at 2:15 p.m. noted he had an elopement monitoring bracelet on his left wrist. Despite the use of the elopement monitoring device review of the comprehensive assessment did not evidence that it was utilized by the resident.	F 279	F. 279 see prior page	