

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

PRINTED: 09/16/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/02/2014
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NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - PINWOOD TERRACE	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 EAST ELEP STREET COLVILLE, WA 99114
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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 & Rehabilitation - Pinewood Terrace on 9/2/14. A sample of 7 residents was selected from a census of 72. The sample included 6 current residents and the records of 1 former and/or discharged resident.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#3034230 #3034494 #3038727</p> <p>The survey was conducted by:</p> <p>Linda Loffredo R.N., B.S.N.</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Long-Term Support Administration Division of Residential Care Services, District 1, Unit A 316 West Boone Avenue, Suite 170 Spokane, Washington 99201</p> <p>Telephone: (509)323-7302 Fax: (509) 329-3993</p> <p><i>Cathy C. [Signature]</i> <i>Acting FM</i> 9/16/14 Residential Care Services Date</p>	F 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Prestige Care & Rehabilitation-Pinewood Terrace 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> <p style="text-align: center;">RECEIVED SEP 24 2014 DSHS ADSA RCS SPOKANE WA</p>	09/22/2014
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kaplan R. [Signature]</i>	TITLE <i>Interim Administrator</i>	(X6) DATE 09/23/2014
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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 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F 225	<p>F225 Corrective Action/s for residents identified to have been affected:</p> <p>The identified NAC's Employer (Staffing Agency) was notified of the results of the investigation and the WA State Board of Licensing notified.</p> <p>Resident #1 was assessed for injury by the DNS on 09/02/2014 and an x-ray was obtained 09/03/2014. A comprehensive pain assessment was performed on 09/05/2014. There was no indication of physical or emotional injury. The progress notes of Resident #5 were reviewed for any evidence of emotional distress since the occurrence (October, 2013), and there was no evidence of emotional distress or psychological harm. Care plan was updated regarding potential for pain with repositioning, and interventions to reduce this.</p>	09/22/2014
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F 225	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, it was determined the facility failed to ensure that allegations of physical and verbal abuse regarding 2 of 7 sample residents (#1, 5) were reported and thoroughly investigated as required by 42 CFR 483.13(c)(2)(3)(4). The identified residents, and potentially all residents, were placed at risk for mistreatment.</p> <p>1. Per record review, Resident #1 had memory problems, no behavior problems, and required extensive assistance for most activities of daily living.</p> <p>On 9/2/14 at 11:10 a.m., the resident was observed actively participating in exercise group in the main dining room.</p> <p>In an interview with Staff #B and #C (administrative staff) on 9/2/14 at 12:45 p.m., Staff #C stated a few weeks ago she was asked by Staff #D (a licensed nurse) to assume care of the resident for the remainder of a day shift. The resident indicated she did not want Staff #I to care for her anymore. Staff #C said she told Staff #D that Staff #I could be a "little rough" sometimes.</p> <p>On the following day, Staff #C said she was providing care to the resident before breakfast. When turning in bed, the resident complained of pain in the left rib area. Staff #C inspected the area, and saw no bruising or obvious injury. When Staff #C was getting clothes out of the resident's closet, Resident #6, a room-mate, said the previous day she overheard the resident screaming and saying "wait,wait, stop" while Staff #I was providing care. Staff #C indicated she asked Resident #1's roommate to tell Staff #D (a licensed nurse) her concerns. After finishing</p>	F 225	<p>Identification of residents with the potential to be affected:</p> <p>Residents that require assistance with bed mobility are at risk related to this citation.</p> <p>All residents and staff were interviewed starting 9/2/2014 by the Social Services Director and DNS to identify any other potential abuse/ neglect incidents.</p> <p>All reported issues from either resident or staff were investigated to determine if abuse/ neglect existed.</p> <p>Measures to prevent recurrence:</p> <p>Staff were re-educated on identification and reporting of abuse and neglect on 9/2/2014; 9/05/2014; and 9/08/2014 by the DNS.</p>		

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F 225	<p>Continued From page 3</p> <p>resident care, Staff #C said she told Staff #D about both Resident #1's pain and her roommates concerns.</p> <p>In an interview on 9/2/14 at 3:30 p.m., Staff #A said he had been the acting Administrator during the past month, and staff did not report the allegations to him. Staff #B said she had been the acting Director of Nursing Services since 8/18/14, and staff had not reported the allegations to her.</p> <p>The facility investigation of 9/5/14 documented that Resident #1 reported on the day of the incident that she was having pain when turning. She asked Staff #I to stop and he did not stop. She confirmed she told staff she did not want Staff #I to care for her anymore.</p> <p>Additional interviews conducted during the investigation confirmed the resident's roommate had reported concerns about Staff #I's treatment of Resident #1 to both Staff #C and #D.</p> <p>During a telephone interview on 9/10/14, Staff #B stated the facility investigation determined Resident #1 did not sustain any injury during care. The investigation confirmed the resident's allegation that Staff #I did not stop providing care when she asked him to, the facility should have suspended Staff #I, reported the incident to the state agency, and conducted a thorough investigation at the time the incident occurred.</p> <p>2. Resident #5 had diagnoses including [REDACTED] and resided in the specialized care unit in the facility. Per record review, the resident made repetitive verbalizations but could not communicate his needs, and required total assistance for all care.</p> <p>In an interview with Staff #B and #C (administrative staff) on 9/2/14 at 12:45 p.m., Staff #C said she and Staff #I were providing care to the resident some time last fall. The resident</p>	F 225	<p>Monitor for Corrective Action:</p> <p>Grievances will be reviewed at daily stand-up meeting by the administrator and investigations for potential abuse/ neglect completed, with appropriate agency notification ongoing.</p> <p>Facility managers will each randomly interview 1 staff member and 2 residents per week for 4 weeks for potential allegations of abuse/ neglect using a standardized questionnaire.</p> <p>Any positive responses will be immediately referred to the Administrator/ DNS for investigation and appropriate agency notification.</p> <p>Results of the resident/ staff interviews will be reviewed during monthly Quality Assurance Performance Improvement Meeting for 2 months or until resolved to ensure continued compliance.</p>		

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F 225	<p>Continued From page 4</p> <p>was making repetitive verbalizations and Staff #I made a potentially intimidating/verbally abusive statement to the resident. Staff #C stated she did not know if the resident understood what Staff #I said. Staff #C stated she reported the allegation to Staff #G (administrative staff) the next day and Staff #G advised her to tell another administrative staff. Staff #C stated she did not know if the facility followed up but she stopped talking about it.</p> <p>Review of the facility incident log during that time revealed the facility did not conduct any investigations related to the allegations involving Resident #5 and Staff #I.</p> <p>Review of the facility investigation dated 9/5/14 (many months after the incident) revealed Staff #I did not recall making the potentially intimidating/verbally abusive statement to the resident, but said he did make what he considered as humorous statements to the resident.</p> <p>Additional interviews conducted during the investigation revealed Staff #G did not remember hearing about the allegation, but if she heard an allegation of abuse, she would have reported it to the Director of Nursing, the Administrator, and would have called the State Hotline.</p> <p>During a telephone interview on 9/10/14, Staff #B said the facility investigation confirmed Staff #I's statement to the resident was verbally abusive, the facility should have suspended Staff #I, reported the incident to the state agency, and conducted a thorough investigation at the time the incident occurred.</p>	F 225			