

1463

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505407	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/24/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW REHABILITATION AND CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5925 47TH AVENUE NE MARYSVILLE, WA 98270
--	--

(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	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Off-Hours Quality Indicator Survey conducted at Mountain View Rehabilitation and Care Center on 2/18, 2/19, 2/20, 2/21, and 2/24/14. The survey included data collection on 2/21/14 from 4:50 a.m. to 8:00 a.m. A sample of 28 residents was reviewed from a census of 70. The sample included 25 current residents and and the records of 3 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████, B.S.H.S.          ██████████, R.N., B.S.N.          ██████████, R.N., B.S.N., M.S.Ed          ██████████, R.N., B.S.N.          ██████████, R.N., B.S.N.</p> <p>The survey team is from:</p> <p>Department of Social and Health Services          Aging &amp; Long Term Care Services Administration          Residential Care Services          3906 172nd Street NE, Suite 100          Arlington, WA 98223-4740</p> <p>Telephone: 360-651-6850          Fax: 360-651-6940</p> <p><i>[Signature]</i>          Residential Care Services</p>	F 000	<p><i>This Plan of Correction is the facility's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>RECEIVED          MAR -7 2014          ADSA/RCS          Smokey Point</p>	
-------	--	-------	--	--

2/27/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE Administrator	(X6) DATE 3/7/14
---	------------------------	---------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505407</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/24/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW REHABILITATION AND CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 47TH AVENUE NE MARYSVILLE, WA 98270</b>
---	--

(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 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure monitoring, evaluation and following physician orders related to diabetic management for 1 of 4 sampled residents (33). This failure had the potential to place the resident at risk for inadequate care and treatment of his diabetes.</p> <p>Findings include:</p> <p>Resident 33 was originally admitted [redacted] 2011 with diagnosis to include [redacted]. Per the physician orders, Resident 33 had three different orders in which his blood sugars were to be monitored.</p> <p>The resident was to have his blood sugar monitored every Monday and Thursday at 7:30 a.m. The physician wanted to be notified when the morning blood sugar results were below 75 or above 150. The morning blood sugars were reviewed for the months of December 2013-February 2014. The resident's blood sugar was documented above [redacted] four times. The resident's physician was only notified once of the elevated blood sugar.</p>	F 309	<p>F 309=D Provide Care/Services for highest level of well being</p> <p>Resident #33 blood sugar monitoring and parameter orders were clarified and updated with physician on [redacted]/14.</p> <p>The Director of Nursing Services and /or designee will conduct three month review of current residents blood sugar monitoring to ensure that physicians were notified of blood sugar readings that were out of parameter and to ensure the values are clearly documented on Medical Record as ordered</p> <p>Licensed Nurses will be in-serviced by the Director of Nursing Services and or designee on the Diabetic Management Policy and Procedure with emphasis on notification when blood sugar reading is out of parameter or unavailable.</p> <p>Medical Records will conduct periodic audits of the blood sugar documentation to monitor compliance. Findings will be given to the Director of Nursing Services for review.</p> <p>The Director of Nursing Services will bring findings from the blood sugar monitoring audit to the Quality Assessment and Assurance (QA&amp;A) Committee.</p> <p>The QA&amp;A Committee will review findings and make recommendations as necessary.</p> <p>The Director of Nursing Services will ensure compliance.</p>	3/15/14
---------------	--	-------	--	---------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505407</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/24/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW REHABILITATION AND CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 47TH AVENUE NE MARYSVILLE, WA 98270</b>
---	--

(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 309	<p>Continued From page 2</p> <p>The resident was to have his blood sugar monitored every Thursday at bed time. The resident's Medication Administration Record (MAR) was reviewed for the months of September 2013 to February 21, 2014. There were only 4 out of 25 blood sugars documented in the medical record.</p> <p>The third order was to monitor the resident's blood sugars every Tuesday before supper. There were 6 missing documented blood sugars for the months of September and October 2013.</p> <p>There was no notification to the doctor of the missed blood sugar tests.</p> <p>In an interview on 2/21/14 at 9:15 a.m., Staff A verified the resident's MAR had missing documentation of the above blood sugars.</p>	F 309		
F 314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505407</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/24/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW REHABILITATION AND CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 47TH AVENUE NE MARYSVILLE, WA 98270</b>
---	--

(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 314	<p>Continued From page 3</p> <p>by: Based on observation, interview, and record review, the facility failed to ensure necessary care and services were provided to prevent pressure ulcers for 1 of 2 sampled residents (67). Failure to ensure the resident's plan of care was implemented may have contributed to a pressure ulcer. Additionally, failure to follow the plan of care placed the resident at risk for compromised healing and/or complications of the left heel pressure ulcer.</p> <p>Findings include:</p> <p>Resident 67 was admitted to the facility [REDACTED] 2013 with diagnoses to include [REDACTED] disease and severe [REDACTED] disease.</p> <p>A Podiatrist note, dated 2/12/14, revealed no skin concern of the [REDACTED] foot.</p> <p>On 2/14/14 a Braden scale, a skin at risk assessment tool, identified the resident at a "low risk" for pressure ulcer development.</p> <p>A review of the residents current plan of care, dated 11/6/13, identified the resident had potential for pressure ulcer development related to decreased [REDACTED] and weeping [REDACTED] extremity [REDACTED]. The interventions included: ". . . bridge [REDACTED] heel with pillows, position so no pressure on [REDACTED] heel" and "protective foam boot to [REDACTED] foot."</p> <p>A fax to the physician on 2/16/14 stated a 3 x 3 centimeter (cm) necrotic wound on the [REDACTED] heel "was found." The nursing staff suggested a "pressure relieving boot and skin prep (a treatment) to be done BID (twice daily)." On</p>	F 314	<p>F314=D Treatment/SVCS to prevent/heal pressure sores</p> <p>Resident #67 plan of care was reviewed for appropriate intervention to ensure that resident receives necessary treatment and services to promote wound healing, prevent infection, and prevent new sores from developing.</p> <p>The Resident Care Manager's will monitor compliance through routine rounds, record review, and direct observation of residents to ensure that necessary care and services are implemented as directed in residents' care plan. These findings will be given to the Director of Nursing Services for review.</p> <p>Nursing will be in-serviced by the Director of Nursing Services and or designee on the Policy and Procedure on Pressure Ulcer Prevention with emphasis on the importance of consistently implementing interventions as directed in residents' plan of care for prevention and/or to promote healing of existing wound.</p> <p>Findings from routine rounds and direct observation will be reported to the Quality Assessment and Assurance (QA&amp;A) Committee.</p> <p>The QA&amp;A Committee will review findings and make recommendations as necessary.</p> <p>The Director of Nursing Services will ensure compliance.</p>	3/15/14
-------	--	-------	---	---------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505407</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/24/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>MOUNTAIN VIEW REHABILITATION AND CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5925 47TH AVENUE NE MARYSVILLE, WA 98270</b>
---	--

(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 314	<p>Continued From page 4</p> <p>2/18/14 the physician faxed back indicating it was "ok" to proceed with the request.</p> <p>On 2/18/14, a "wound assessment summary" was done by the Director of Nursing Services. The resident had a 3 x 5 cm blood filled blister located on her heel. The resident's risk factors for skin breakdown included impaired mobility, lower extremity swelling, and severe peripheral vascular disease.</p> <p>On 2/18/14, several observations were made of the resident lying flat in bed, with a foam boot on the lower half of the leg, and no other support to elevate her heel off the bed.</p> <p>On 2/20/14 at 9:20 a.m., the resident was observed lying flat in bed, with a foam boot on her lower extremity, and the heel was not floated. The heels were resting on the surface of the bed.</p> <p>At 10:15 a.m., the resident was observed in the same position. Staff B, a Licensed Nurse, removed the foam boot from her lower extremity. The straps from the foam boot came across the front of her shin to hold the device in place. When the foam boot was removed, there were two indentations on the front of her shin indicating the boot was on too tight. There was an intact fluid-filled blister, approximately 5 cm in length across the bottom of the resident's heel and slightly up the inner part of the heel. The surrounding skin on the resident's inner ankle was red. The resident stated she was in pain.</p> <p>On 2/21/14 at 7:00 am, the resident was observed with her foot resting directly on the footrest of her wheelchair. A sock was in place and there was no foam boot present.</p>	F 314		
-------	---	-------	--	--

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

PRINTED: 02/26/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505407	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  02/24/2014
NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW REHABILITATION AND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5925 47TH AVENUE NE MARYSVILLE, WA 98270		
(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 314	Continued From page 5  At 7:30 a.m., the resident's [redacted] foot was observed in the same position in the dining room.  At 9:00 a.m., the resident was observed during a dressing change. Staff A, Resident Care Manager, was changing the [redacted] heel dressing. The blister had drained, the skin surrounding the inner ankle was red and there was swelling from the shin down. Staff A stated a new treatment was being implemented because the blister had been "draining." Staff A placed a foam dressing over the area and wrapped the foot to secure the dressing. Staff A placed a different type of foam bootie on the resident [redacted] heel. Staff A acknowledged the resident did not have the heel protector in place that morning and the prior boot was leaving indentations on her shin related to the swelling present in her [redacted] leg.  Resident 67 had care plan interventions in place directing staff to "float" her heels and a protective boot applied to her [redacted] heel. Observations of the resident revealed these interventions were not consistently implemented placing the resident at risk for impaired healing and complications of the pressure ulcer.	F 314			