

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

PRINTED: 05/01/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505092</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/22/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALDERWOOD PARK CONV CTR LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2726 ALDERWOOD AVENUE BELLINGHAM, WA 98225</b>	
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Alderwood Park Convalescent Center on 4/15/14 and 4/22/14. A sample of 11 current residents was selected from a census of 85.</p> <p>The following complaint was investigated as part of the survey:</p> <p>2987162</p> <p>The survey was conducted by:</p> <p>Nadyne Krienke, R.N., M.S.N.</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, Region 3, Unit B 3906 172nd Street NE, Suite 100 Arlington, WA 98223</p> <p>Telephone: (360) 651-6850 Fax: (360) 651-6940</p> <p><i>[Signature]</i> 5/1/14 Residential Care Services Date</p>	F 000		

MAY 14 2014  
ADSA/RCS  
Region 3

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

*[Signature]* Administrator 5/8/2014

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 309 SS=D	<p><b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b></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 observation, interview, and record review, the facility failed to provide appropriate, timely care and services for 1 of 3 residents (Resident 2) who had an unwitnessed fall with changes in mental and functional status. The lack of consistent monitoring, timely recognition and reporting of a change status to the physician, resulted in delayed medical evaluation and treatment for the resident.</p> <p>Findings include:</p> <p>The facility defined a significant change as "a decline in a resident's status that would not normally resolve itself without intervention by staff, impact more than one area of the resident's health status, and required review and/or revision of the care plan".</p> <p>The facility policy/procedure for alert charting, dated 1997, directed staff to include neuro checks (a neurologic assessment that includes level of consciousness, strength of grips and size/response of eye pupils to light) for 72 hours</p>	F 309	<p>Provide Care/Services</p> <p>The resident of this deficiency can't have anything changed at this time.</p> <p>Future residents whom have the same or similar incidents, will be put on alert and have assessments completed as needed due to increase or decrease of symptoms.</p> <p>When communicating with resident's physician, nursing staff will take notice for timely response. If no timely response, facility will contact primary physician per phone and if unable to get immediate response facility Medical Director will be contacted.</p> <p>Changes will be made to present policies, procedures, and forms reflecting the above practices and in service staff.</p> <p>Director of Nursing will make certain new practices are being followed.</p>	5/26/2014 mg...	

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F 309	<p>Continued From page 2 after non-witnessed falls.</p> <p><b>RESIDENT 2:</b> Resident 2 was admitted to the facility on [REDACTED] due to [REDACTED]. The minimum data set (MDS) assessment, dated 2/6/14, indicated he required supervision with bed mobility, was a one person assist for transfers and was continent of urine and bowel. The Medication Administration Record for March 2014 revealed he received daily [REDACTED] (blood thinner) for clot prevention.</p> <p>Review of the nursing notes from 2/22/14 to 3/28/14, revealed he was able to make his own decisions, and was independent with activities of daily living. Resident 2 ambulated with a walker and used a wheelchair (W/C) for distances. The clinical record, dated 3/27/14, indicated he was ready for discharge.</p> <p>Review of the facility's investigative report, revealed Resident 2 had an unwitnessed fall on 4/1/14 at 01:00 a.m. The occurrence report read: "pt (patient) laying on floor next to bed on his back .. stated unable to get self up, was confused and denied pain". The LN documented there were no signs or symptoms of any injuries and indicated (by a check mark) that neurologic checks were not initiated. The physician was notified by fax, dated 4/1/14 regarding the non-injury fall (NIF).</p> <p>Nursing notes for the evening shift dated 4/1/14 at 11:20 p.m., (over 10 hours after the fall), documented Resident 2 was using his wheelchair (WC) "most of the shift" and "frequently falling asleep in chair." He also reported "feeling weak". In addition, the LN documented the resident now</p>	F 309		

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F 309	<p>Continued From page 3</p> <p>required 3 people to transfer him from his WC to his bed instead of his usual one person assistance. This represented a possible decline in the resident's condition.</p> <p>On 4/2/14 at 03:00 a.m., nursing documented the resident's pupils were equal and reactive to light. Day shift nursing notes written on 4/2/14 (time not indicated), documented Resident 2 was "not himself, thought process slower, difficulty to express self, mumbles" and did not touch his lunch. He required "much encouragement to get up". The LN documented he required use of his W/C "more" instead of his walker.</p> <p>A fax, dated 4/2/14, was sent to the resident's physician at 11:58 a.m., by the LN. This fax read: current problems: "past 24 (hours) change condition", increased "sleeping, thought process slow, difficult to express self, urine concentrated" The LN requested blood work and a urinalysis. There was no documented evidence thorough and ongoing neurologic assessments had been completed. The following day, 4/3/14, this fax was sent back to the facility at 8:31 a.m. The physician agreed regarding the nurse's request for lab tests.</p> <p>The evening nurse's note entry for 4/2/14 at 10:45 p.m., documented Resident 2 was now incontinent of urine, "more sleepy most of the times" and required 2 person assistance for transfers.</p> <p>There was no documented evidence additional attempts were made by nursing to communicate with the resident's physician, even though the resident's mental and functional status continued to decline with confusion, somnolence, decreased</p>	F 309			

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F 309	<p>Continued From page 4 appetite, and incontinence.</p> <p>On 4/3/14, (time/shift not indicated), three days after the "noninjury" fall, nursing notes documented a call was placed to the resident's physician to report a change in the resident's status. The note revealed the LN was "awaiting call back".</p> <p>In additional notes dated 4/3/14 from the day shift, an LN revealed the resident continued to be confused, "staring, not knowing what to do, thought process slow, difficult to express self" and required maximum assistance with transfers. The LN continued to wait for a call back from the resident's physician. Nursing did not recognize the emergent situation, resulting in continued delay of medical evaluation and treatment for Resident 2.</p> <p>On [REDACTED] at 12:15 p.m., after another call was made by nursing to the resident's physician, the facility received an order to transfer the resident to the hospital for medical evaluation.</p> <p>A nursing note dated [REDACTED] at 2:30 p.m., documented the assessment of Resident 2 prior to his transfer to the hospital found he was not oriented, had a decreased grip in his right hand, difficulty moving in his bed, was slow to follow directions and had difficulty answering questions. His pupils were equal and reactive to light. Resident 2 "agreed to go" to the hospital.</p> <p>The hospital notes, dated [REDACTED] documented Resident 2 was brought to the ER (emergency room) for an altered level of consciousness. The "patient became more confused with waking today and several episodes of incontinence. The</p>	F 309			

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F 309	Continued From page 5 patient has been falling, several days ago striking his head. The patient has been somnolent as well as decreased appetite".  A CT scan was obtained at the hospital and revealed Resident 2 two subdural hematomas (bleeding in the head). The hospital recommended surgery due to his symptoms. The resident underwent [REDACTED] for evacuation of one hematoma and a drill evacuation of the other subdural hematoma.  When interviewed on 4/22/14 at 12:10 p.m., the DNS stated regarding the resident's change in condition and notification of the physician, that the physician's "preference" was to communicate with nursing by fax, not phone calls. When the physician was not timely in returning their calls, the DNS verified the LNs had not then attempted to notify their medical director of the resident's decline or to send Resident 2 to the hospital for further medical evaluation and treatment.  Despite the resident's decline in level of consciousness, functional abilities and the facility's knowledge he was taking anticoagulants (which placed him at increased risk for bleeding), the LNs did not recognize the need to communicate these change to the physician immediately or to contact the medical director to ensure prompt medical evaluation and treatment was provided to Resident 2.	F 309			
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION  The facility must post the following information on a daily basis: o Facility name.	F 356	Posted Nurse Staffing The posting has the required information (facility name, number of staff per category, hours, date and census). This posting is in a prominent place in the facility.	5/17/2014 X organizer	

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F 356	<p>Continued From page 6</p> <ul style="list-style-type: none"> <li>o The current date.</li> <li>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> <li>- Registered nurses.</li> <li>- Licensed practical nurses or licensed vocational nurses (as defined under State law).</li> <li>- Certified nurse aides.</li> </ul> </li> <li>o Resident census.</li> </ul> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> <li>o Clear and readable format.</li> <li>o In a prominent place readily accessible to residents and visitors.</li> </ul> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to properly maintain all required components for a daily posting of staff working in the facility. This failure placed residents and visitors at risk of not being informed of actual hours worked by Licensed Nurses (LNs) and Nursing Assistants (NACs) who were directly responsible for resident care per shift.</p>	F 356	<p>The Director of Nursing will review on the days present in facility will monitor and make certain posting is completed. Her designee will make certain posting is done when in charge for building.</p>		

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F 356	<p>Continued From page 7</p> <p>Findings include:</p> <p>During initial rounds on 4/15/14, the facility's Daily Staffing form was not observed posted prominently in the building's entry, on the west or east wing of the building.</p> <p>The daily staffing form, which was posted for 4/15/14, was only posted on the central hall. The form included the facility's name, date, current census and the number of Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Nursing Assistants (NACs). There was no breakdown of the total number scheduled hours of the licensed nursing staff.</p> <p>Review of the Daily Staffing forms from 3/1/14 to 4/15/14 found the forms did not include the breakdown of total number and/or actual hours worked by the RNs, LPNs, or NACs who were directly responsible for resident care per shift.</p> <p>During an interview with the Director of Nursing Services (DNS) on 4/15/14, she verified the posting of staff was only posted across from the central nurses' station.</p> <p>On 4/22/14, the DNS stated she was not aware of what needed to be included on the daily posted staffing form.</p>	F 356			

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