

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

PRINTED: 12/15/2014
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505092 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 12/10/2014 |
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| NAME OF PROVIDER OR SUPPLIER ALDERWOOD PARK HEALTH AND REHABILITATION | STREET ADDRESS, CITY, STATE, ZIP CODE 2726 ALDERWOOD AVENUE BELLINGHAM, WA 98225 |
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| F 000 | <p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Alderwood Park Health and Rehabilitation on 12/09/14 and 12/10/14. A sample of 14 residents was selected from a census of 91. The sample included 11 current residents and the records of 3 former and/or discharged residents.</p> <p>The following complaints were investigated as part of this survey:</p> <p># 3055588 # 3055093 # 3055545 # 3055544 # 3056556</p> <p>The survey was conducted by:</p> <p>Michelle Scollard R.N., B.S.N. Joy Kerns, R.N., B.S.N.</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Disability Services Aging & Long-Term Support Administration Residential Care Services, District 2, Unit A 3906 172nd Street NE, Suite 100 Arlington, WA 98223</p> <p>Telephone: (360) 651-6850 Fax: (360) 651-6940</p> <p><i>[Signature]</i> 12/15/14 Residential Care Services Date</p> | F 000 | <p><u>Disclaimer Clause</u></p> <p>Preparation and/or execution of this plan of correction does not constitute the provider's admission of or agreement with 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.</p> | 1/16/15 |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>N.L. Graham</i> | TITLE Administrator | (X6) DATE 12/30/14 |
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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 | Continued From page 1 | F 000 | F226 483.13 © Develop/Implement Abuse/Neglect, Etc. Policies | | |
| F 226 SS=E | <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to implement their abuse/neglect policy and procedure for 14 of 14 residents (Residents 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13 & 14) reviewed for abuse and neglect. The failure to identify, investigate and report abuse and neglect placed 14 residents at risk, and had the potential to place all other residents at risk, for unidentified abuse and neglect.</p> <p>Findings include:</p> <p>The facility's policy regarding "Reporting and Investigation," dated February 2007, directed staff to immediately report allegations of abuse/neglect to the state survey and certification agency, resident's physician and authorized representative. Furthermore, substantiated allegations of abuse and neglect were reported to the state licensing board. The License Nurse (LN) was responsible to document in the resident's medical record the details of the event, complete a resident evaluation, check for injury, and initiate an investigation. The resident was placed on alert</p> | F 226 | <p><u>Plan of Correction</u></p> <p>Resident 1 is no longer in the facility. The incident was logged and called into the state.</p> <p>The incident regarding resident number 6 has been documented in the medical record. Staff C is no longer working in the facility. Staff C's license has been reported to the Department of Health.</p> <p>Resident 1 and resident 4 are no longer in the facility. Resident 4 was actively dying and receiving hospice care. Separate incident reports were completed on residents 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10. Each incident was thoroughly investigated, logged and reported. Staff B is no longer employed at the facility and employee B's license was reported to the Department of Health.</p> <p>Resident 14 is no longer in the facility. The incident was documented in his medical record; physician and responsible party were notified of the incident. Social services assessed and ruled out</p> | 1/10/15 | |

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| F 226 | <p>Continued From page 2</p> <p>charting for 72 hours and monitored for any changes in the resident's mental or functional status.</p> <p>The Nursing Home Guidelines a.k.a., "The Purple Book," fifth edition, stated facilities were to report to the Department (the state hotline), the Coroner, and the State Department of Health (DOH) any alleged abuse or neglect.</p> <p>RESIDENT 1 Resident 1 was a former resident admitted to the facility [REDACTED] with diagnoses to include heart disease, dementia and depression. According to the most recent Minimum Data Set (MDS), an assessment tool, dated [REDACTED] indicated the resident was severely cognitively impaired and required supervision with transfers and ambulation.</p> <p>The resident's care plan was reviewed. On 11/17/14 the resident had a pressure alarm placed on the bed and wheelchair to alert staff of when the resident transferred without assistance.</p> <p>Documentation on the "Event Investigation Report Completion Guide," dated 11/23/14, stated the resident had an unwitnessed fall at 4:30 a.m. The resident was heard calling for help. A Nursing Assistant Certified (NAC) responded to the resident and then alerted the LN. The LN assessed the resident and noted her left knee was bruised, swollen and was experiencing severe pain. An x-ray was obtained on 11/23/14 at 10:10 a.m., the resident had a "subacute proximal fibular fracture", (Resident 1 had a broken leg).</p> <p>There was no conclusion to the investigation. The</p> | F 226 | <p>psychological harm. Staff D is no longer working for the facility and his license was reported to the Department of Health.</p> <p>Resident 11 incident was reinvestigated, logged and reported. Resident 11's transfer status has been reviewed and updated the plan of care. Staff A is no longer employed in the facility and reported to the Department of Health.</p> <p>Resident 12 medical record has been updated to document incident, physician and responsible party notified. Social service assessed to rule out psychological harm. Staff member A no longer employed and has been reported to the Department of Health.</p> <p>A separate incident report was created for resident 13 and investigated thoroughly. The medical record has been updated to document the incident, physician and responsible party has been notified. Social service assessed to rule out psychological harm.</p> <p>Current interviewable facility residents were interviewed utilizing</p> | 11/21/15 |

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| F 226 | <p>Continued From page 3</p> <p>facility failed to implement their policy regarding investigation of an event. There was no information on what the resident was doing prior to the fall, when the resident was last seen or taken to the bathroom. There was no evidence of the care plan being followed including if there was a bed alarm on the bed prior to the fall. Abuse and neglect was not ruled out. The facility logged the incident on the state log as a fall with no injury.</p> <p>On 12/10/14 at 1:15 p.m. the facility administrator was made aware the investigation was incomplete and the incident was not logged into the state log accurately.</p> <p>RESIDENT 6 Resident 6 was admitted to the facility [REDACTED] with diagnoses to include stroke and dementia. According to a quarterly MDS assessment, dated [REDACTED], the resident had short and long term memory deficit and was moderately impaired in decision making skills. The resident was dependent on staff for dressing and toileting needs.</p> <p>On 12/9/14 and 12/10/14 the resident was observed in her room sitting in her wheelchair. Resident 6 was not interviewable.</p> <p>Documentation on the "Event Investigation Report Completion Guide," dated 11/20/14, stated on 11/19/14 (no documented time) Staff F, NAC, directed Staff C, an agency NAC, to provide morning care for resident 6. Staff F found unused washcloths and towels lying on the resident's bed. Staff F checked the resident and found her "soaking wet." Staff F notified the LN on duty immediately. The LN documented the "agency</p> | F 226 | <p>an abuse and neglect questionnaire. Non-interviewable residents' responsible parties were contacted utilizing the family abuse/neglect questionnaire. Allegations of abuse or neglect were followed up per facility policy and state/federal regulations. A head to toe skin assessment was conducted on current facility residents to assure no injuries of unknown origin or other signs and symptoms of abuse or neglect were present. An audit was completed for current facility staff and agency staff to assure OBRA, Washington state background checks and licenses were current and on file. An audit of the facility incident log was completed back to 11/01/14 to assure incidents were thoroughly investigated and appropriately reported. An in-service was conducted for facility staff on abuse and neglect reporting and investigation. Weekly audits of the incident reporting log will be completed by the ED or designee to assure incidents with abuse or neglect have been thoroughly investigated and reported. The DNS or designee will audit the skin checks weekly to assure injuries of</p> | 11/6/15 |

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person was sent home."

The conclusion of the investigation identified Resident 6 was neglected. The resident was placed on alert to monitor for emotional distress, and the agency was notified of the incident and Staff C, NAC, was not allowed back into the facility. There was no evidence the facility investigated to ensure other residents were not affected/neglected and if DOH was notified of the neglect.

In an interview on 12/9/14 at 1:18 p.m., Staff F confirmed she had found Resident 6 soaked with urine and immediately reported it to the LN on duty. Staff F stated this occurred before noon.

Staff C's time card was reviewed. Staff C worked full morning shifts on 11/19/14 and 11/20/14 (the time card was signed by facility staff both days). There was no evidence Staff C was removed from the floor after the allegation of neglect was reported on 11/19/14.

The facility failed to document the incident in the resident's medical record.

In an interview on 12/10/14 at 1:15 p.m., the facility administrator verified the facility did not notify DOH of the substantiated neglect. The facility was not able to provide a current background check from the department. When asked if the facility investigated other residents on the hall to ensure neglect did not occur, the administrator stated no.

ALLEGATION OF NEGLECT ON THE WEST HALL
On 11/25/14 at 7:00 a.m., there was an allegation

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unknown origin are reported and investigated.
The ED or designee will audit the employee records weekly to assure new employees are screened via OBRA, Washington state background and licensure. These are done yearly.

Trends identified will be reported to the QAPI committee monthly and as needed until a lesser frequency is deemed appropriate.

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| F 226 | <p>Continued From page 5</p> <p>of neglect regarding 10 residents (1, 2, 3, 4, 5, 6, 7, 8, 9 and 10). The allegation was brought to the LN on duty by Staff E and F, the morning shift NAC's.</p> <p>Witness statements dated 11/25/14, were reviewed and revealed the following:</p> <ol style="list-style-type: none"> 1. Resident 1 was left soaked with urine and her bed in a high position. 2. Resident 2 was a resident who received nutrition through a feeding tube. Resident 2's bed was found in a high position and she was flat on her back. 3. Resident 3 was found positioned half way down her bed, with her feet hitting the bottom of the bed. 4. Resident 4, 6, 8, 9 and 10 were found "wet" and had "dirty pads on the bed." 5. Resident 5 was found "soaked." 6. Resident 7 was found "soaked all the way through" with urine. <p>Documentation on the "Event Investigation Report Completion Guide," indicated on 11/25/14 at 7:00 a.m., the LN initiated an allegation of neglect regarding Resident 1, 2, 3, 4, 5 and 7.</p> <p>Documentation on the "Investigator's Interview/Statement of Event" form identified residents 1, 2, 3, 4, 5, 6, 7 and 8 were not changed frequently, head of bed not properly positioned at 30 degrees or more for a resident with a feeding tube and beds left up in the air when the residents had a low bed. Multiple residents were identified and placed in one investigation.</p> <p>Documentation on the final summary identified Staff B, NAC, neglected multiple residents by not</p> | F 226 | | |

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| F 226 | <p>Continued From page 6</p> <p>providing care and not following the resident's care plan. Staff B had prior incidents of neglect and her employment was terminated on 11/26/14.</p> <p>A review of the facility state reporting log identified the facility documented neglect for resident's 2, 3, 4, 5 and 7. The other five resident's involved (1, 6, 8, 9 and 10) were not logged on the state reporting log.</p> <p>On 12/10/14, the involved resident's charts were reviewed. The incident was not documented in any of the resident's charts. The residents were not placed on alert or monitored for any possible signs of psychosocial harm. The resident's physician and/or responsible party were not notified of the neglect. There was no documentation regarding a skin assessment done for Resident's 1, 3, 5, 6, 7, 8, 9, and 10 until 11/26/14. Resident 2's respiratory status was assessed on 11/26/14 to rule out possible aspiration related to being found lying flat in bed. Resident 2's care plan directed staff to keep her head of bed elevated at 30 degrees or more to decrease the risk of aspiration.</p> <p>On 12/10/14 at 9:20 a.m., Resident 3 was interviewed regarding the substantiated neglect. Resident 3 was not able to recall the event.</p> <p>At 9:50 a.m., Resident 5 was interviewed regarding the substantiated neglect. Resident 5 was not able to recall the event.</p> <p>Resident's 2, 6, 8, 9 and 10 had short and long term memory deficit and were moderately to severely impaired in decision making skills and were not interviewable.</p> | F 226 | | |

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| F 226 | <p>Continued From page 7</p> <p>Resident 4 was a former resident admitted to the facility [REDACTED] with diagnoses to include dementia, heart disease and diabetes. The resident was on hospice. According to a MDS assessment, dated [REDACTED] the resident had severe cognitive impairment and required extensive assist of two people for bed mobility, transfers and toileting. On 11/25/14, after the allegation of neglect, the Nurse Practitioner documented a stage 1 decubitus on the resident's sacrum. In a progress note dated 11/26/14 at 1:30 p.m., the LN documented the resident had a "superficial opening on the right buttock." In a progress noted dated 11/27/14 at 3:00 p.m., the LN documented a 0.5 centimeter (cm) by 1 cm stage II on her right buttock. There was no documentation identifying the cause of the stage II pressure ulcer.</p> <p>Staff B's personnel file was reviewed. Staff B was hired 10/12/12. The facility was not able to provide proof of OBRA registry or a recent background check. Staff B had two prior incidents of resident neglect. On 12/14/12, Staff B left several residents soaked in urine or feces. On 4/22/14, Staff B did not change any residents all shift.</p> <p>On 12/10/14 at 1:15 p.m., the administrator and acting Director of Nursing Services (DNS) were interviewed regarding the multiple allegations of neglect. When asked why there was a discrepancy in what was investigated and what was reported to the state agency, the administrator stated there were multiple residents involved and the facility did not investigate them individually. The administrator stated Staff B's license was in the process of being reported to DOH, 16 days after the substantiated neglect.</p> | F 226 | | |

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The facility failed to implement their policy regarding investigating an allegation of neglect. The facility failed to thoroughly investigate each resident separately. All ten residents did not have evidence of the neglect documented in their medical record and were not monitored for any possible psychosocial harm. The facility failed to report Staff B's license to DOH, failed to have a current background check and OBRA registry verification.

RESIDENT 14

Resident 14 was admitted to the facility [REDACTED] with diagnoses to include a stroke and depression. According to a quarterly MDS assessment, dated [REDACTED] indicated the resident cognitive status was severely impaired.

Documentation on the "Event Investigation Report Completion Guide," indicated on 11/24/14 at 3 p.m. an allegation of verbal abuse was made regarding resident 14 and Staff D, a LN. The investigation stated Staff D was suspended during the investigation.

Upon review of Staff D's time card, on 11/24/14 Staff D worked until 6:18 p.m., 3 hours after the allegation of verbal abuse was reported to the facility administrator.

The incident was not documented in the resident's medical record. Resident 14 was not placed on alert or monitored for any potential psychosocial harm. There was no evidence the resident's physician or responsible party was notified of the event.

In an interview on 12/10/14 at 9:13 a.m., Resident

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14 stated he remembered the incident and "boys will be boys." The resident then changed subject.

The conclusion of the investigation was verbal abuse did not occur. Staff D received a verbal warning regarding communicating with residents.

In an interview on 12/10/14 at 1:15 p.m., the administrator was asked why Staff D remained in the facility after he was suspended pending an allegation of verbal abuse. The administrator stated Staff D was "charting" and not "working on the floor." The administrator was not able to state if Staff D had any un-supervised contact with residents.

RESIDENT 11
Resident 11 was admitted on [REDACTED] with diagnoses to include brain cancer, chronic pain, and obesity. The quarterly MDS dated [REDACTED] reported the resident had severe cognitive deficits. The resident was unable to be interviewed.

The care plan noted the resident needed a mechanical lift and two staff members to assist with all care. The resident was unable to ambulate and had been in bed for several months related to her condition.

On 11/22/14, on evening shift, Staff H, NAC, witnessed the resident sitting in a chair while in the room with Staff A, an agency NAC. When Staff A left the room the resident was back in bed. The resident later complained of right ankle pain, which required pain medication and later developed into a bruise. An x-ray was negative for a fracture.

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505092 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 12/10/2014 |
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| NAME OF PROVIDER OR SUPPLIER ALDERWOOD PARK HEALTH AND REHABILITATION | STREET ADDRESS, CITY, STATE, ZIP CODE 2726 ALDERWOOD AVENUE BELLINGHAM, WA 98225 |
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| (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 |
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F 226

The incident was logged on the Event Investigation Log as a rule out neglect and the type of injury was self-inflicted. The findings found the incident was from an unknown source and staff training was the action.

The final summary stated it was likely Staff A had moved the resident and not followed the plan of care. The form also stated there was abuse or suspected abuse. The final summary gave no indication the suspected abuse was identified, addressed, or interventions to prevent re-occurrence of abuse were initiated. The facility did not call DOH with the finding of abuse.

RESIDENT 12

Resident 12 was admitted [REDACTED] with diagnoses to include dementia, bipolar, and degenerative joint disease. The MDS dated [REDACTED] reported the resident had severe cognitive deficits. The resident was unable to be interviewed.

The care plan noted the resident was a mechanical lift with two person assist for care. The resident was frequently incontinent of bowel and bladder and required extensive assist of 1 person to toilet.

On 11/23/14 Staff A, NAC, provided care to the resident on the day shift. The resident was found at the beginning of the evening shift with dried bowel movement on her bottom.

The finding of neglect was substantiated by the facility. The resident's record did not reflect the incident occurred. The resident was not monitored for psychosocial harm. The physician

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| F 226 | <p>Continued From page 11</p> <p>and the family were not notified of the finding. The facility did not report Staff A to the appropriate agency, DOH. The facility was unable to present an OBRA registry or a criminal background check for Staff A.</p> <p>RESIDENT 13 Resident 13 was admitted on [REDACTED] with diagnoses to include stroke, depression and dementia. The Annual MDS dated [REDACTED] revealed the resident had moderately impaired cognitive function. The resident was not able to be interviewed regarding the incident.</p> <p>The care plan noted the resident was a mechanical lift with two person assist for care. The resident was incontinent of bladder and bowel.</p> <p>On 11/23/14 Staff A, NAC, provided care to the resident on the day shift. The resident was found at the beginning of the evening shift to have been left soaked in urine.</p> <p>The incident was logged with Resident 12's incident. The incidents were investigated together. The findings were neglect and the action taken was staff counseling. Suspected abuse was also checked yes. Adult Protective Services (APS) was called for this incident. The plan to prevent reoccurrence was to not have the NAC return to work.</p> <p>The finding of neglect was substantiated by the facility. The resident's record did not reflect the incident occurred. The resident was not monitored for psychosocial harm, the physician nor the family were notified of the incident. The facility did not report Staff A to the appropriate</p> | F 226 | | |

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| F 226 | <p>Continued From page 12</p> <p>agency (DOH). The facility was unable to present an OBRA registry or a criminal background check for Staff A. Staff A's timecard showed hours worked for 11/22 and 11/23/14 to be complete shifts and were signed by facility staff.</p> <p>An interview with the acting DNS and the Administrator on 12/10/14 at 1:15 p.m., both verified the investigation process. When an incident occurs the expectation is the staff would place a resident on alert for 72 hours which includes; documenting the incident, monitoring the resident for psychosocial harm, and any contact made with the physician and the family, all should be in the resident's record. The Administrator admitted to a lack of understanding of the appropriate agencies to call for specific incidents and performing individual investigations for residents. All 16 investigations were reviewed for additional clarification and information during the interview. No additional information was obtained.</p> <p>On 12/10/14, the administrator provided a safety plan for any further possible abuse and/or neglect, including resident interview, resident assessment and a resident protection plan.</p> <p>The facility failed to implement policies and procedures that included the seven components: screening, training, prevention, identification, investigation, protection and reporting/response. This failure led to numerous incomplete investigations and left residents vulnerable to abuse and neglect.</p> | F 226 | |