

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

PRINTED: 06/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505338	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/30/2013
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NAME OF PROVIDER OR SUPPLIER MERRY HAVEN CARE CENTER LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 800 10TH STREET SNOHOMISH, WA 98290
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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 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Merry Haven Care Center on 5/21/13, 5/24/13, 5/28/13, 5/29/13 and 5/30/13. A sample of 16 residents was selected from a census of 78. The sample included 15 current residents and the record of 1 former and/or discharged resident.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#2812191 #2808972 #2811758</p> <p>The survey was conducted by:</p> <p>Richard L. Woodrum, BSN; RN Michelle Scollard, RN, BSN</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, Region 2, 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> 6/4/13 Residential Care Services Date</p>	F 000	<p>RECEIVED JUN 13 2013 ADS/RCS Smokey Point</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 6/10/13
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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 157
SS=D

483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on record review, and interview, the facility failed to consult with a physician regarding

F 157

F 157 483.10 (b) (11)
SS=D
NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)

The facility must notify the resident; Consult with the resident's physician; And if known, notify the residents Legal representative of family memberchange in the resident's physical, Mental or psychosocial status...need To alter treatment, or to transfer or Discharge the residentchange in room assignment or roommate assignment.

This will be evidenced by;
Resident #1
The resident did not experience A negative outcome due to delay In response from the on-call physician. Her level of pain was adequately Managed during that time and in house x-rays were obtained She is Currently receiving Skilled Therapy services

How the nursing Home will protect Residents In similar situations;
The Medical Director position assumes The responsibility for the coordination Of medical care in the facility
Licensed staff will be educated regarding His role.

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F 157 Continued From page 2

an accident with a significant injury in a timely manner. This failure delayed treatment for a resident (Resident #1) with a fractured hip when the resident was not sent to a hospital for 24 hours.

Findings include:

Resident #1 admitted to the facility in [redacted] with diagnosis that included [redacted]. The resident was dependant upon staff for activities of daily living.

A review of the facility incident report on 5/21/13 at 10:10 a.m. revealed the resident had fallen from bed on the evening of 5/19/13 at 4:00 p.m. According to nurse notes in the resident's record, the on call physician was notified. The physician ordered a mobile X-Ray at 6:55 p.m. that evening.

The X-Ray report was received at 10:00 p.m. at the facility. It indicated an undiagnosed fracture to the right hip. The on-call physician was paged, but did not return a call. Several attempts were made to page the physician to inform him of the fractured hip. A review of the nurse notes dated 5/20/13 at 5:00 a.m. indicated the physician had not returned any calls. Nurses were giving Tylenol to the resident, as this was the only medication previously ordered for any type of pain. One nurse note dated 5/20/13 at 5:00 a.m. revealed "no complaints" from the resident.

A nurse noted dated [redacted] "day" stated "continues to have discomfort right side". An order was received from another physician at

F 157

Licensed nurses have been in serviced on;

1. When to contact/consult with nurse management
2. When to contact MD related to changes in condition or urgent clinical issues that Require immediate attention.

6/10/13

Per NW Geriatrics Protocol;
Page for changes in condition requiring interventions including transfers to the Hospital or 911. May transport without an Order if no response before medics arrive

Do not page for non-injury falls or minor injuries that require topical antibiotic tx or steri strips instead please use the voicemail or fax to communicate

The facility will monitor through review of the 24 hour report at the morning meeting

DNS will be responsible for lasting compliance

Date of compliance 06/10 2013 and ongoing

On going

On going

On going

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F 157	Continued From page 3 4:40 p.m. to send the resident to the Emergency Room for treatment. The resident left the facility after 5:00 p.m., 25 hours after the fall. The Administrator was interviewed on 5/22/13 at 9:00 a.m. She stated the facility policy directed staff to contact the medical Director when the "on-call" physician did not return phone calls.		F226 483.13 (c) SS=D DEVELOP/IMPEMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement policies and procedures That prohibit mistreatment, neglect And abuse of residents and Misappropriation of resident property
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement their procedure for investigation of allegation of abuse/neglect related to a thorough investigation and reporting of incidents of potential abuse/neglect for 2 of 7 sampled residents (#4 and 5). Findings include: A review of the facility's policy on "Abuse & abuse prevention" states: - ... all allegation or abuse, neglect and including injuries of unknown source are thoroughly investigated	F 226	... including injuries of unknown source Are thoroughly investigated This will be evidence by; Resident #4 On 03/29/13 The LN Completed a Skin Condition Report Which included; 1. Date Observed 2. Location of skin issue-possible Bruise 3. Size of skin issue/possible bruise 4. Probable cause of skin issue/possible Bruise which included laying on the Zipper of her sweater 5. Documented the skin issue/possible Bruise on the MAR for LN's to Monitor On 04/03/2013 a late entry was made by the LN For skin issues/possible bruise.The resident was Placed on alert charting for documentation q shift X72hours

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F 226	<p>Continued From page 4</p> <p>Resident # 4 Resident was admitted [REDACTED] with diagnoses of [REDACTED]</p> <p>A review of a progress note dated 4/3/13 revealed a 9.5 x 1.5 centimeter "bruise" to the left side of the neck found during morning care on 3/29/13. The "bruise" was described as dark purple at the top and lighter purple going towards the bottom.</p> <p>The bruise was not documented on the facility's incident tracking log.</p> <p>Resident # 3 Resident was admitted [REDACTED] with diagnoses of [REDACTED]</p> <p>A review of a progress note dated 4/13/13 revealed the resident's wheelchair was bumped by another resident. Resident #3 "hit the other res on her left arm 1-2 times."</p> <p>The resident to resident altercation was not documented on the facility's incident tracking log.</p> <p>In an interview on 5/29/13 at 2:45 p.m. with Staff A, administrative staff, and Staff B, Director of Nursing, identified the resident to resident altercation and bruises of unknown origin were to be investigated to determine the cause and/or establish a pattern. Staff A and B confirmed both incidents were not logged and not investigated.</p>	F 226	<p>An investigation of the incident was conducted and the incident was called to the State hotline. The injury was logged in the tracking log as a late entry 05/30/2013</p> <p>Resident#3 An investigation of the incident was conducted and the incident was called to the State hotline. The incident was logged in the tracking log as a late entry 5/31/13</p> <p>How the nursing home will protect Resident's in similar situations; Staff have been educated to the policy for Abuse/neglect prohibition and incident Reports for resident to resident altercations At a general staff meeting held June 10, 2013 5/10/13</p> <p>Incident reports will be discussed at the morning meeting Staff will notify the Administrator and DNS of any incidents that require notification to the hotline. On going</p> <p>All incident will be thoroughly investigated And logged within the 5 day requirement On going</p> <p>The facility will monitor through review of all completed incident reports by the DNS and Administrator On going</p> <p>DNS will be responsible for lasting compliance</p> <p>Date of compliance 06/10/2013 & ongoing</p>
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280	

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F 280 SS=D	<p>Continued From page 5</p> <p>PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure the resident's plan of care was revised as the resident's status changed for 1 of 7 residents (#2) reviewed for care plan revisions. The failure to revise the resident's plan of care directing care staff on dealing with mood and behavioral concerns exhibited by Resident #2 and protecting other residents at risk for potential physical and psychological harm due to resident to resident altercations.</p> <p>Findings include:</p>	F 280		

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F 280	<p>Continued From page 6</p> <p>The facility's policy on "abuse & abuse prevention" stated:</p> <ul style="list-style-type: none"> - Intervention strategies are developed to prevent and/or reduce occurrences and changes that would trigger abusive behaviors are monitored, and interventions are reassessed on a regular basis <p>Resident #2 Resident #2 was admitted to the facility in [REDACTED] with diagnoses of [REDACTED] the resident exhibited mild short term and long term memory loss. The resident was able to express self and understand what is stated. The resident required one person extensive assist for most of her activities of daily living needs, and was able to move her own wheelchair throughout the facility.</p> <p>Resident #2 had been involved in four resident to resident altercations since January 2013.</p> <p>Upon review of the conclusion for each investigation, there was no evidence on the plan of care for the resident to direct staff on specific interventions and/or actions the facility had concluded to prevent reoccurrence. These included:</p> <p>A. After a resident to resident altercation on 4/01/13, both residents were kept in separate dining rooms and common areas as much as possible</p> <p>B. After a resident to resident altercation on 5/09/13, the resident's care plan was to have mood and situational behaviors identified that placed others at risk for injury.</p> <p>C. After a resident to resident altercation on</p>	F 280	<p>F280 Participate Planning Care-Revise Care</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of State, to participate in planning of care and treatment or changes in care and treatment.</p> <p>Resident #2 and IDT met to discuss/ Implement appropriate care plan revisions and a behavioral contract which reflects mood and situational behaviors along with interventions for the resident and staff members.</p> <p>IDT reviewed all residents with situational behaviors and moods to revise plan of care with appropriate interventions.</p> <p>Social Service to monitor residents with situational behaviors and moods to ensure care plan and interventions are appropriate upon admission, quarterly via the MDS schedule and PRN.</p> <p>Will monitor for residents with a change in mood and behaviors at morning IDT meeting.</p> <p>Administrator and DNS will monitor for compliance at quarterly Q.A. meeting.</p>	<p>5/31/13</p> <p>6/10/13</p> <p>On going</p> <p>On going</p> <p>On going</p>

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F 280	Continued From page 7 5/19/13, the resident was to have a behavioral contract. In an interview on 5/29/13 at 2:45 p.m. with Staff A, administrative staff, and Staff B, Director of Nursing, confirmed the residents care plan did not reflect the updates.	F 280		