

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

PRINTED: 12/03/2014
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 09/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SNOHOMISH HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE ZIP CODE 800 10TH STREET SNOHOMISH, WA 98290
--	--

(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 INITIAL COMMENTS

F 000

This report is the result of an unannounced Abbreviated Survey conducted at Snohomish Health and Rehabilitation on September 23, 2014.

The following complaint was investigated as part of this survey:

3030136

The survey was conducted by:

Janet Thorson-Mador, RN, MN

The survey team is from:

Department of Social and Health Services
Aging and Long Term Support Administration
Residential Care Services, Region 2, Unit B
3906 172nd St. NE, Suite 100
Arlington, WA 98223

Telephone: (360) 651-6850

Fax: (360) 651-6940

RECEIVED
DEC 11 2014
ADS/RCS
Smokey Point

IDR AMENDED
by Lisa Cramer

Lisa Cramer for District
Residential Care Services Date: 12/3/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>X C. Westerman</i>	TITLE <i>X Administrator</i>	(X6) DATE 10/14/2014
--	---------------------------------	-------------------------

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.

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 09/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SNOHOMISH HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 800 10TH STREET SNOHOMISH, WA 98290
--	---

(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 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>1. Resident 2 – Incident has been thoroughly investigated and facial/jaw bruising per staff is reasonably related to resident grabs and pinches her face. Bruises the size of fingertips. Staff witnessed resident bump forehead during hooyer transfer resulting in bruise. Staff in-serviced on transfers and positioning related to incident.</p> <p>Resident 3 – Incident has been thoroughly investigated and resident and forearm skin tear is reasonably related to resident hitting forearm on bedside table while staff obtaining urine specimen via femcath. Per staff she startles easily and most likely flinched. Staff members were not restraining her Arms and fresh blood indicated recent trauma.</p> <p>Resident 4 – Allegations have been thoroughly investigated.</p> <p>Several residents interviewed regarding any caregivers being abusive or innappropriate. Residents denied any caregivers being abusive or inappropriate.</p>	<p>9/24/14</p> <p>8/25/14</p> <p>9/24/14</p> <p>9/24/14</p>
---------------	---	-------	--	---

IDR AMENDED

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 09/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SNOHOMISH HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 800 10TH STREET SNOHOMISH, WA 98290
--	---

(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 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, the facility failed to thoroughly report and/or investigate injuries sustained by Residents 2 and 3, and an abuse allegation made by Resident 4, three of four sampled residents. This placed all residents at risk for injury or unrecognized abuse, and did not meet the requirements set out under 483.13(c)(2) and 483.13(c)(4).</p> <p>Findings include:</p> <p>Resident 2</p> <p>Resident 2 had impaired cognition and memory, and required extensive assistance from staff for mobility and personal care.</p> <p>On 09/23/14 at 10:45 a.m., the resident was observed sleeping in bed. At 1:50 p.m. the resident was observed sitting in her wheelchair in her room. She was unable to answer questions, but made eye contact.</p> <p>Review of incident reports revealed that on 08/22/14, three nursing assistants(NACs)-- Staffs E, B and G-- saw bruises on the resident's left jaw and/or forehead. Bruising on the "forehead and cheek" was reported in nursing notes the same date. Staff F, a night shift NAC, completed a witness statement that he had not seen the bruises and did not know what happened. "Bruises of deep color and depth" was circled on the form, and also "Origin established." No reporting staff had witnessed the bruising occur. The report concluded "Resident's head bumped on hoyer (mechanical lift) 'T' bar during transfer."</p>	F 225		
-------	--	-------	--	--

IDR AMENDED

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

PRINTED: 12/03/2014
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 09/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SNOHOMISH HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 800 10TH STREET SNOHOMISH, WA 98290
--	---

(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 225	<p>Continued From page 3</p> <p>Review of the facility incident log revealed that this incident was not called in to the State.</p> <p>During an interview on 09/23/2014 at 3:18 p.m., Staff A was asked who was the NAC taking care of the resident on the night shift before the bruise was discovered, and she stated that it was Staff F. When asked, she said that the hoier lift would not have been used on the night shift. When asked if the State was notified of the incident, as an injury of unknown origin, Staff A said no.</p> <p>Resident 3</p> <p>Resident 3 had [REDACTED] and needed extensive assistance with personal care and transfers.</p> <p>On 09/23/2014 at 2:00 p.m., the resident was observed sitting in the hallway in a tilted-back wheelchair, a bruise on the top of her right hand, She did not respond verbally to questions.</p> <p>Review of incident reports revealed that on 08/28/2014, the resident was observed to have a skin tear 3.5 cm by 1 cm on her left forearm. Staff I, a licensed nurse, reported that two NACs had been holding the resident's legs while she (Staff I) inserted a urinary catheter, but did not explain how the arm skin tear occurred. Staff F and J both reported that they had been the NACs assisting during the procedure, but neither knew how the skin tear occurred. The report concluded that the resident had not been resistant to the procedure, and the origin of the skin tear was established as reasonably related to the resident's condition, and "not preventable."</p> <p>During an interview on 09/23/2014 at 3:20 p.m.,</p>	F 225		
-------	---	-------	--	--

(ISR AMENDED)

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 09/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SNOHOMISH HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 800 10TH STREET SNOHOMISH, WA 98290
--	---

(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 225	<p>Continued From page 4</p> <p>when asked about this incident, Staff A said that the resident "refuses most everything." She did not explain how the skin tear on the arm could have occurred during the catheterization.</p> <p>Resident 4</p> <p>Resident 4 had cognitive impairment and a psychiatric disorder for which she received daily medication. She was independent with mobility in the facility, according to her most recent MDS (Minimum Data Set) assessment, dated 09/02/2014, and suffered from delusions and hallucinations.</p> <p>On 09/23/2014, the resident was observed to be sleeping in bed at 10:00 a.m., 11:00 a.m., and 12:15 p.m. At 1:55 p.m., the resident was awake and sitting in bed. When asked, she said she was "OK." She was chewing on something, and said it was her nicotine.</p> <p>Review of incident reports revealed that on 07/22/2014, the resident alleged that a nursing assistant was "putting his fingers where they don't belong" on other female residents. The facility interviewed Staff K, the nurse on duty at the time, who concluded the resident was making up the allegation to gain additional nicotine patches. The report included the resident's own statement that "maybe" she had made up the allegation. The facility obtained witness statements from Residents 5, 6, 7 and 8. All these residents were asked if "any caregiver" had touched them in a sexually inappropriate way, and they all said no. All these residents had delirium and dementia, according to their most recent MDS Care Area Assessments. Residents 6, 7 and 8 had communication deficits.</p>	F 225		
-------	---	-------	--	--

IDR AMENDED

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 09/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SNOHOMISH HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 800 10TH STREET SNOHOMISH, WA 98290
--	---

(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 225	Continued From page 5 The facility did not interview the nursing assistant against whom the allegation was made. During an interview on 09/23/2014 at 3:25 p.m., Staff A was asked why the nursing assistant had not been interviewed about the allegation. She said that because the facility determined the allegation was false, and Resident 4 said she made up the allegation, they did not interview the nursing assistant.	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide care to promote the dignity of Resident 1, 1 of 4 residents sampled. This placed the resident at risk for experiencing a diminished quality of life. Findings include: Resident 1 had a history of a traumatic brain injury, and was completely dependent upon staff for all care and mobility, including communication and toileting. Staff used a mechanical Hoyer lift to get him out of bed into a wheelchair. On 09/23/2014 at 10:00 a.m., lying in his bed in a gown, his legs uncovered, and his incontinence brief visible. The blue line on the brief indicated it	F 241		

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 09/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SNOHOMISH HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 800 10TH STREET SNOHOMISH, WA 98290
--	---

(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 241	<p>Continued From page 6</p> <p>had urine in it. A sign on the wall by the resident's bed said it was "September 18th." The resident gestured for a white board, lying on a dresser across the room. The board had to be held for him, and it took him five minutes to write "My glasses are in the top drawer." When the resident's call light was pushed, Staff C came into the room at 10:30 a.m., asked the resident what he wanted, the resident pointed the pen toward her and she said "Don't write on me." He had turned the white board over so it was not readable. The resident told her to "Get out" and shook the pen at her. Staff C covered up the resident's legs and left the room.</p> <p>In an interview on 09/23/2014 at 10:32, Staff D, the assigned nurse, said the resident could not hear, but could point and say "I'm wet." When asked about the resident getting his brief changed, Staff said that the assigned aid was on break, but she would find someone to do it. Two NACs assisted the resident at 10:38.</p> <p>Review of the resident's care guide revealed that the resident was to be offered the bedpan "per schedule." His MDS assessment dated 08/20/14 included "always incontinent."</p> <p>At 12:00 p.m., Resident 1 was observed sitting in a hallway, away from other residents, tipped back in a wheelchair, with an overhead light on above him. Review of the care plan included "Resident likes to wear sunglasses when up in the wheelchair. Sensitive to light." When asked about this, an unidentified nursing assistant stated that she did not know he had sensitivity to light, and put a baseball cap on the resident.</p> <p>At 3:00 p.m., Resident 4 was observed being</p>	F 241	<ol style="list-style-type: none"> 1. Resident 1 care plan has been updated to allow for choices of glasses or Hat/Cap to shade eyes as well as specifying bed pan usage. Night Shift staff has been instructed to update white board with current date. Staff members involved in care have been in-serviced on changing resident's brief if => 75% of Blue indicator line is visible (per product guidelines), checked every 2 hours during the day and every 4 hours at night. Staff members involved were also in-serviced on the communicators role in communication (body language, tone of voice, etc.) 2. Charge nurse or designee to monitor provision of resident care to ensure care plan/guide is being followed. 3. Certified Nursing Assistants (CNAs) and Licensed Nurses (LNs) will be in-serviced on following the care plan/guide to ensure resident choices are addressed. The CNAs and LNs will also be in-serviced on communication roles and approaches to resident. 4. Director of Nursing (or designee) will perform random audits of 10 resident charts to ensure care plan interventions are being individualized and followed for 3 months. Results of these audits will be presented at the monthly Quality Assurance meeting. 	<p>9/25/14</p> <p>9/25/14</p> <p>9/25/14</p> <p>9/25/14</p> <p>ongoing</p> <p>10/23/14</p> <p>ongoing</p>
-------	--	-------	---	---

IDR AMENDED

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 09/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SNOHOMISH HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 800 10TH STREET SNOHOMISH, WA 98290
--	---

(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 241 Continued From page 7
assisted back to bed by two nursing assistants, Staff L and M. They used a Hoyer lift, and when the resident was in bed, they covered him up and left the room. Staff L was asked if he knew how long the resident had been up in the chair, and he did not. When asked when he was going to check the resident for incontinence, he said he would do it after he had finished transferring other residents. When told the resident had been up in the wheelchair since 12:00 p.m., Staff L said he and staff M should have checked the resident's brief when they assisted him back to bed.

F 241

During an interview on 09/23/2014 at 3:15 p.m., Staff A said dependent residents were checked for incontinence every 2 hours during the day, and every 4 hours at night.

F 250 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE
SS=D

F 250

The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure mental health services for Resident 4, 1 of 4 sampled residents. This failure placed her and other residents in the environment at risk for diminished quality of life.

Findings include:

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 09/23/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SNOHOMISH HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 800 10TH STREET SNOHOMISH, WA 98290
--	---

(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 250	<p>Continued From page 8</p> <p>Resident 4 had cognitive impairment and a psychiatric diagnosis. Her daily medication regimen included an anti-anxiety medication, a mood stabilizer, and two anti-psychotic medications. The resident moved about the facility independently, and resided in a unit with residents who were dependent upon staff for mobility and personal care.</p> <p>The Minimum Data Set assessment, dated 03/2014, included hallucinations and delusions; the previous assessments for the prior year did not note any hallucinations and delusions. The care plan, dated 09/02/2014, noted that Resident 4 "Refuses to be treated by the mental health provider," so regular facility staff would meet her psychosocial and behavioral needs. There was no specification on which staff, or how they would meet her mental health needs. Record review revealed that in 2013 the resident had been receiving mental health services.</p> <p>On 09/23/2014, the resident was observed to be sleeping in bed at 10:00 a.m., 11:00 a.m., and 12:15 p.m. At 1:55 p.m., the resident was awake and sitting in bed. When asked, she said she was "OK." She was chewing on something, and said it was her nicotine.</p> <p>On 07/22/2014, the resident had made an allegation a staff person was "attacking" female residents and touching them in a sexual manner. This caused the resident anxiety so she requested additional nicotine patches, which she sometimes put in her mouth and chewed. The allegation was determined to be unfounded, due to the resident's hallucinations and delusions.</p> <p>During an interview on 09/23/2014 at 3:22 p.m.,</p>	F 250	<p>F250 Provision of Medically related Social Service</p> <p>Resident 4's plan of care updated to include specific staff members and interventions to meet her mental health needs.</p> <p>All resident's plan of care and clinical record reviewed by Social Service Department to ensure individual specific interventions were in place to meet the mental health needs.</p> <p>Social Service to review resident's clinical record and implement plan of care with specific interventions to meet resident needs upon admission, quarterly via MDS schedule and PRN.</p> <p>Residents reviewed by IDT at monthly psychotropic meeting to ensure plan of care and interventions appropriate to meet mental health needs.</p> <p>Administrator/DNS to review at QAPI meeting.</p>	<p>10/8/14</p> <p>10/15/14</p> <p>On going</p> <p>On going</p> <p>On going</p>
-------	---	-------	---	--

INR AMENDED

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

PRINTED: 12/03/2014
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 09/23/2014
NAME OF PROVIDER OR SUPPLIER SNOHOMISH HEALTH AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 800 10TH STREET SNOHOMISH, WA 98290		
(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)	
F 250	<p>Continued From page 9</p> <p>Staff A said that she was aware the resident was declining mental health services. When asked when mental health services had stopped for the resident, why she refused them now, and what alternatives had been offered, Staff A did not know, but was going to check the medical record.</p> <p>Documentation submitted to the state agency on 09/25/2014 included a progress note by a mental health provider and social services, dated 09/24/2014, that the resident refused to talk to the clinician or have mental health services: "I don't like talking to those quacks." The resident was told she could talk to social services any time if she changed her mind.</p>	F 250		

IDR AMENDED