

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

PRINTED: 11/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505042	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 10/30/2014
NAME OF PROVIDER OR SUPPLIER  BALLARD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 820 NORTHWEST 95TH STREET SEATTLE, WA 98117		
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Complaint Survey conducted at Ballard Care Center on 10/30/14. A sample of 4 current residents from a total census of 119 residents was selected for review.</p> <p>The survey was conducted by: Katherine Ander, MN, RN, Complaint Investigator</p> <p>Complaints investigated include: 3049516; 3046964; 3049967</p> <p>The survey team is from: Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, District 2, Unit D 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388</p> <p>Telephone: (253) 234-6000 Fax: (253) 395-5071</p> <p><i>[Signature]</i> Residential Care Services      11/12/14 Date</p>	F 000		11-21-14	

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

*[Signature]*      Administrator      11-18-14

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.

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F 250 SS=G	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide medically-related social services to 1 of 4 sample residents (Resident #1) from a census of 119 by failing to adequately intervene for clear symptoms of depression (hopelessness, helplessness, suicidal thoughts, decreased appetite and significant weight loss). This resulted in harm from inadequate mental health support and attention.</p> <p>Findings include:</p> <p>Observation at 10/30/14 at 1:55 p.m. found Resident #1 lying in bed awake and alert. On interview, Resident #1 stated "I can't walk" and "I can't eat the food here." and "They just try to keep you here." According to Resident #1 he could not go home because he couldn't walk or drive his car and had no one to watch out for him at his house. Resident #1 said he did not get out of bed because "What is the point of getting up?"</p> <p>On interview 11/04/14 Resident #1's family member stated Resident #1 went from being completely independent and ambulatory in the community to completely dependent and unable to walk after surgery. The family member said</p>	F 250	<p>The Ballard Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The Plan of Correction is prepared and executed solely because it is required by federal and state law.</p> <p>F250</p> <ol style="list-style-type: none"> <li>1. Resident #1 discharged from the Center on [REDACTED] 14.</li> <li>2. Other residents at risk were identified on 11-12-14 by the Interdisciplinary Team (IDT) to include residents with signs and symptoms of depression, suicidal ideation, and/or weight loss – and, further if any of these identified residents had previously refused or had not yet been offered mental health services. Mental health services, physician involvement, and care plan</li> </ol>		

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F 250	<p>Continued From page 2</p> <p>Resident #1 developed incontinence of bowel and bladder while in the facility. According to the family member "The experience is traumatic for him, he refuses to eat and has lost significant weight." and "He is a very different person." The family member said no one at the facility talked to her about Resident #1's mental condition or emotional adjustment to change in life circumstances.</p> <p>Record review found Resident #1 was admitted to the facility [REDACTED] 14 after surgery for an [REDACTED]. The resident's admission minimum data set (MDS) assessment dated [REDACTED] 14 scored the resident's brief interview for mental status (BIMS) at 9, indicating moderate cognitive impairment. The MDS identified a baseline of no depression and no behavior problems. Resident #1 required extensive assistance of 1-2 persons for activities of daily living. According to the admission MDS, Resident #1 was always continent of bowel and bladder.</p> <p>Nutrition notes documented from admit on [REDACTED] 14 to [REDACTED] 14 Resident #1 lost 41.9 pounds in 2 months due to food refusal and not eating ([REDACTED] to [REDACTED] pounds). Facility records documented standard nutritional interventions: family bringing in food, health shakes, snacks, fortified food, meeting food preferences.</p> <p>Nutrition notes documented there could be a psychological or depressive component to the resident's condition. On 9/18/14 Resident #1 said "I don't want to live like this anymore." On 10/16/14 Resident #1 was asked to eat in the dining room. Resident #1 responded "It would be depressing, most of there (sic) people are never</p>	F 250	<p>development was initiated as needed for this identified population.</p> <p>3. Social Services Team was re-educated via Genesis University courses on 11-19-14 regarding recognition of the signs and symptoms of depression and suicidal ideation, the development of related care planning, and when to make mental health referrals for additional resident support. Further formal training has been scheduled by the Center's mental health provider for the Social Services Team as well as the remaining IDT in December 2014. Licensed Nurses were re-educated by Social Services Team and/or designee on 11-19-14 regarding recognition of the signs and symptoms of depression and suicidal ideation, the development of related care planning, and when to make mental health referrals for additional resident support.</p>	

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F 250	<p>Continued From page 3 going to leave this place."</p> <p>Nursing notes and Social Service notes documented on 9/5/14 Resident #1 had suicidal thoughts. Nursing notes documented "Upon interview, resident stated that he had wished to be dead because he was tired of having people take care of him." Social services notes documented Resident #1 had suicidal thoughts 4 days in the last two weeks.</p> <p>Social Service interventions for Resident #1's suicidal thoughts on 9/5/14 included completing a suicide risk form, informing nursing staff so the resident could be monitored every 15 minutes. Social service staff offered Resident #1 a care conference, which was declined.</p> <p>There was no documentation or indication that social services checked back in or talked to Resident #1 about his feelings or concerns. There was no documentation the doctor was notified of Resident #1's suicidal thoughts. There was no mental health referral. There was no update to the plan of care related to Resident #1's suicidal thoughts or statements of not wanting to "live like this".</p> <p>A care conference was held on 9/26/14. Care conference notes documented Resident #1 had a decline in function, had very poor eating and wanted to discharge home. There was no reference to suicidal thoughts, depression or determination of why the resident was eating so poorly other than "Resident will not eat food at facility." The plan was "will eat cream of wheat from facility." There was no plan to talk to the resident about his loss of function or factors contributing to his food refusal.</p>	F 250	<p>Licensed Nurses additionally were re-educated on 11-17-14 and 11-18-14 by the Nurse Practice Educator and/or designee regarding physician notification of change of condition.</p> <p>4. The IDT will review residents in the Center's CARE meeting x2 monthly recognizing the MDS/OBRA schedule and including at risk residents identified via routine Center practice of review of 24-hour report, IDT Stand Up meeting, Center generated software data reports, etc.</p> <p>Audits will be conducted by the IDT in CARE meeting x1 each month by the collective IDT to identify residents with signs and symptoms of depression, suicidal ideation, and/or weight loss – and, further if any of these identified residents had previously refused or had not yet been offered mental health services.</p>		

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F 250	Continued From page 4  On interview 10/30/14 at 4:20 p.m. Staff F (social service director) stated she and Staff G shared social service duties and communicated verbally about resident care needs. According to Staff F when residents make suicidal statements, staff makes sure the resident is safe, nurses check every the resident every 15 minutes and the resident is offered mental health services. After reviewing Resident #1's record, Staff F said "I don't know what happened to the follow up."  On interview 11/05/14 at 12:10 p.m. Staff G stated she did not talk with Resident #1 after 9/5/14 about his suicidal thoughts or feelings or discuss the resident's statements of suicidal feelings at the 9/26/14 care conference because the resident's suicidal thoughts were not brought up again. Staff G stated she was not aware that Resident #1 had continuing significant weight loss.  On interview 11/05/14 at 10:25 a.m. Resident #1's doctor stated 10 - 15 pounds of the resident's 40 pound weight loss could have been related to eliminating excess bodily fluid built up during surgery. According to the doctor, overall Resident #1's weight loss was related to his medical condition (causes breakdown of body tissue), depression and lack of eating. According to the resident's doctor, no one told her about Resident #1's suicidal statements on 9/5/14. The doctor stated the first she heard of Resident #1's expression of suicidal thoughts was 10/31/14 (the day after the department investigation visit).	F 250	Audits will be completed x1 each month for 3 months and tracked/trended by the Social Services Team and presented in monthly Quality Assurance/Performance Improvement (QAPI) meetings for the next 3 months and action taken as needed.  5. Social Services Team, Resident Care Managers and Director of Nursing will ensure compliance.  6. 11-21-14.  F309 1. Resident #3 is currently receiving skilled therapy. Resident #3's pain management appears adequate based upon ongoing LN assessment, Nursing Assistant and Rehab Team observation and report, and Resident #3's self-report and non-verbal assessment by Nursing Team.		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309			

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F 309 SS=G	Continued From page 5 HIGHEST WELL BEING  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.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed recognize and provide timely intervention for signs of injury after a fall and failed to provide adequate pain monitoring and medication after return from surgery for 1 of 4 sample residents (Resident #3) from a census of 119. This resulted in a 4 day delay in care for a broken hip and inadequate pain relief.  Findings include:  Observation on 10/30/14 at 3:35 found Resident #3 lying in bed. The resident was unable to answer questions about recent history or care at the facility.  Record review found Resident #3 was admitted to the facility [REDACTED] 12 with medically disabling conditions and dementia. Resident #3's annual minimum data set (MDS) assessment dated 5/16/14 identified the resident had moderately impaired decision making. The MDS identified Resident #3 required extensive assistance of 1 person for activities of daily living including transfer, toileting and hygiene. Resident #3 was always incontinent of bowel and bladder.	F 309	2. Other residents were identified for review by the IDT based upon recent falls, other injury, and reports of increased pain. IDT review was completed on 11-18-14 and involved a review of identified resident records to include IDT progress notes, skin care records, medication administration records (MAR), treatment administration records (TAR), pain assessments, etc. Changes were made to individual residents' pain management plan as needed.  3. Licensed Staff were re-educated on 11-17-14 and 11-18-14 by the Nurse Practice Educator and/or designee regarding recognizing the signs and symptoms of and initiating timely and suitable intervention for signs of injury following a resident experiencing a fall or other injury. Licensed Staff were re-educated on 11-17-14 and 11-18-14 by the NPE and/or designee regarding proper	

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F 309	Continued From page 6  Resident #3's care plan identified Resident #3 was to have physical assistance of 1 person getting in and out of bed. Resident #3 used a wheelchair for mobility. Alarms were used to alert staff when the Resident tried to get up without staff assistance.  Progress notes document at 1:00 p.m. 10/11/14 Resident #3 was found on the floor in his room, holding onto his bed. The alarm was sounding. On assessment, staff documented there was a small scratch on the right knee on the lateral side down to the shin. A pain assessment done after the fall noted the Resident ' s pain level was 3/10 (on a scale of 1-10 with ten being the worst pain possible). The pain assessment identified soreness was worse with activity. The pain was better (0/10) with rest. The doctor was notified of the fall.  Review of progress notes, staff statements and pain monitor found staff did not identify any physical signs of fracture (swelling, internal rotation or obvious dislocation). Staff did document Resident #3 had pain (especially with movement or repositioning) and change in mobility status over the next 4 days: -10/12/14 (day shift) complained of mild pain. (There was less pain on his right thigh after Tylenol was given) -10/12/14 (11:30 p.m. to 10/13/14 12:00 a.m.) suddenly shouted when an aid tried to change his position. -10/13/14 (day shift) had difficulty transferring from wheelchair to bed. Complained of "Pain all over". Bruising was noted on right knee. Complained of pain when being turned to side during peri-care with 2 person assist.	F 309	pain monitoring and ensuring adequate pain medication administration for residents following surgical procedures.  4. The IDT will review residents in the Center's CARE meeting x2 monthly recognizing the MDS/OBRA schedule and including at risk residents identified via routine Center practice of review of 24-hour report, IDT Stand Up meeting, and Center generated report 'Resident Responses Analyzer' in regards to MDS Section J for current residents.  Audits will be conducted by the IDT in CARE meeting x1 each month by the collective IDT to identify residents with signs and symptoms of post injury and pain following surgical procedures – as well as to review the timeliness and suitability of the Center's pain management interventions to include proper pain monitoring and ensuring adequate pain medication	

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F 309	<p>Continued From page 7</p> <p>Complained of pain when in bed and head of bed was being raised to 90 degrees. On assisting with peri-care Staff H noted Resident #3 grimace and say "ouch" on turning to his side.</p> <p>-10/14/14 (day shift) needed increased assistance when transferring out of bed to the wheelchair and back. Resident now needed two people to assist from sit to stand and pull up his pants. Had decreased mobility compared to baseline.</p> <p>-10/14/14 (evening shift) complained of pain with movement of the body and repositioning.</p> <p>Medication record review identified staff treated Resident #3's pain with a standing order for Tylenol 325 mg (2 tabs) every 6 hours as needed for pain. No Tylenol was given from October 1-11 but was given once daily October 12, 13, 14, 15.</p> <p>Progress notes document 10/14/14 at the request of the POA (power-of-attorney) day shift staff Faxed the doctor and requested an X-ray order. X-ray done on 10/15/14 showed "impacted (pieces of bone break into multiple fragments which push into each other) right femoral neck fracture." According to &lt;<a href="http://www.wisegeekhealth.com/what-is-an-impacted-fracture.htm">http://www.wisegeekhealth.com/what-is-an-impacted-fracture.htm</a>&gt; " Impacted fractures are usually very painful and also very noticeable; the fracture will not be confused with a lesser sprain. " Resident #3 was transported to the hospital for surgical repair of the fracture on [REDACTED] 14 - [REDACTED] days after the fall.</p> <p>On interview 11/05/14 at 4:30 p.m. Resident #3 's POA stated the resident fell on Saturday 10/11/14 after she left from her daily visit. The POA stated when she came for her daily visit on Sunday 10/12/14 she found Resident #3 " Sitting in a</p>	F 309	<p>administration for residents following surgical procedures. Audits will be completed x1 each month for 3 months and tracked/trended by the Director of Nursing and/or designee and presented in monthly Quality Assurance/Performance Improvement (QAPI) meetings for the next 3 months and action taken as needed.</p> <p>5. Resident Care Managers and Director of Nursing will ensure compliance.</p> <p>6. 11-21-14.</p>		

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F 309	<p>Continued From page 8</p> <p>wheelchair bent over like in misery. Something was wrong. He was just different ...just pitiful! " The POA stated she talked to staff to try to figure out what happened but there was not good documentation.</p> <p>The POA stated when she came in Monday 10/13/14 she could see Resident #3 was still in pain by the way he looked " His face was screwed up, he was tense. I said he needs and X-ray. " The POA said she talked to the director of nursing who said an X-ray would be ordered. (This was ordered 10/14, done 10/15/14).</p> <p>The POA stated that a few days after return from the hospital [REDACTED] 14 after surgery, staff told her they were starting pain medication because they heard Resident #3 cry out in pain. Review of medication records showed Resident #3's pre-hospital medication regimen was reinstated, including Tylenol "as needed" for pain,. Pain monitoring flow sheet documented on 10/21/14 at 12:00 Resident #3 had pain level of 6/10. On 10/22/14 the resident ' s pain level was 5/10. The resident was given Tylenol 650 mg on both days. Records show Resident #3 did not receive any other pain evaluation or medication until a new order was written 10/23/14 for [REDACTED] 5 mg four times daily for 30 days.</p>	F 309			

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