

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/28/2014
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NAME OF PROVIDER OR SUPPLIER  RIVERSIDE NURSING & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1305 ALEXANDER CENTRALIA, WA 98531
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Riverside Nursing and Rehabilitation Center on 10/28/2014. A sample of 8 residents was selected from a census of 75. The sample included 4 current residents and the records of 4 former and/or discharged residents.</p> <p>The following complaints were investigated:</p> <p>#3042974 #3044652 #3045609 #3045615 #3045831 #3047207</p> <p>The survey was conducted by:</p> <p>Rebecca Christiansen, RN, MS</p> <p>The survey team is from:</p> <p>Department of Social &amp; Health Services Aging &amp; Disability Services Administration 13600 NE 9th Street Suite 220 Vancouver, WA 98684</p> <p>Telephone: 360-397-9550 Fax: 360-992-7969</p> <p><i>[Signature]</i> Residential Care Services Date 11/6/14</p>	F 000	<p style="text-align: center;"><b>RECEIVED</b> NOV 21 2014 DSHS/ADSA/RCS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 11/14/14
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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 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 interview and record review, it was determined the facility failed to provide the necessary care and services for 1 of 8 residents (#4) when they failed to assess and monitor the resident's new colostomy and surgical abdominal wounds. This failure caused a delay in returning the resident to the hospital for necessary treatment and additional surgery.</p> <p>Findings include: According to the American Cancer Society, a colostomy, a procedure done for a variety of medical reasons, is where a portion of the colon is brought out through the abdominal wall through an artificial opening, or stoma. A wafer of adherent material is usually placed around the stoma and a plastic type of bag device is attached to the wafer. The ostomy bag collects any stools that are expelled by the colon. It is expected the stoma would be pink or red in color, which would indicate a good blood supply to the area. It is important to monitor the color, quantity and consistency of the stools in the ostomy collection bag to ensure proper function of the bowels and ostomy. It would also be important to</p>	F 309	<p><i>"This Plan of Correction constitutes this Facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of our agreement with deficiencies or conclusions contained in the Department's inspection report."</i></p> <p><b>F309</b> <b>483.25 Provide care/services for highest well being</b></p> <p><u>Individual Residents</u> Resident #4 no longer resides at the facility.</p> <p><u>Residents in similar situations</u> Newly admitted Residents at Riverside have the potential to be affected</p> <p><u>Measures to prevent reoccurrence</u></p> <p>Re-education was completed with licensed nurses on the policy and procedures related to: Complete and thorough Assessments, documentation and Physician reporting.</p> <p>Ostomy assessment and documentation will be placed on the TAR (Treatment administration record) to monitor for any potential changes in appearance or function.</p>	

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F 309	<p>Continued From page 2</p> <p>notice the condition of the skin surrounding the stoma and how the ostomy bag is adhering to the skin.</p> <p>Resident #4 was admitted on [REDACTED] with diagnoses to include a new ostomy secondary to colon obstruction and diabetes. According to chart notes, the resident was alert and oriented and able to express care needs. The resident required assistance for activities of daily living. Progress notes from the hospital accompanying the resident upon admission stated "Stoma is non-viable (dead tissue) to the outer layers. There is stool exiting from the center of the stoma, but there is also drainage leaking (from outside the bag) Stoma will continue to slough (have dead tissue) and at some point will probably need (removal) of the dead tissue."</p> <p>On [REDACTED] a nursing admission assessment records "Colostomy noted. Intact and draining appropriately. Incision midline abdomen intact 17 staples noted with 2 open areas noted in incision."</p> <p>No information was found regarding the condition of the stoma or the nature of the drainage. It was not known in the open areas of the incision were present before admission.</p> <p>On 9/23/14 at 12:40 p.m., nursing notes report "Has about 17" (inch) incision on abd (abdomen) 1" x 1" area of dehiscence (separation of the edges of the surgical wound) slightly above belly button and 2 cm (centimeters) x 4 cm spot below belly button. Applied new colostomy bag."</p> <p>No information was located regarding the condition of the stoma or the nature of colostomy</p>	F 309	<p><u>On-going monitoring</u></p> <p>All residents admitting to the facility with ostomies, will be placed on the clinical follow up tool and brought to the clinical meeting to ensure all assessment components are completed.</p> <p>DON or designee will monitor TARs twice a week for 1 month, then weekly for 2 months to identify current residents with ostomies, for any documented changes in appearance or functionality.</p> <p>Trends of audits and reviews will be forwarded to the Quality Assurance Performance Improvement Committee Monthly x 3 months or as determined by the committee for opportunities of continued quality improvement.</p> <p><u>Individual to Ensure Compliance</u> Director of Nursing or designee</p> <p><u>Date of Compliance</u> 12-2-2014</p>	
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F 309	<p>Continued From page 3 drainage.</p> <p>On 9/25/14, a "Nursing Comprehensive Assessment" reflected the resident had a "large open" ostomy in "mediocre" condition but gave no additional information.</p> <p>On 9/25/14, a "Bowel Data Collection and Assessment" tool indicated "Has ostomy in poor condition, being monitored and MD (physician) updated with changes"</p> <p>The Treatment Administration Record (TAR) indicated the resident should have ostomy care as needed. It was done on 9/23, 9/24 and 9/25.</p> <p>On 9/26/14, nursing notes indicated "Res (resident) sent to the emergency department secondary to inability to maintain patency of ostomy and concern with upper portion of incision opening. Stoma black in entirety and unable to place wafer due to necrotic tissue with malodorous (smells bad) drainage."</p> <p>On 10/28/14 at 2:35 p.m., the Director of Nursing (DNS) stated "We already knew the resident's stoma was necrotic (dead) with slough (peeling off tissue). Traditionally we would monitor the stoma on the TAR, The resident had fragile tissue around the stoma and we could not make the ostomy bag stay on."</p> <p>At 3:45 p.m., Licensed Nurse (LN) A stated "I expect the nurses to monitor the ostomy every shift and report changes. We would use the initial assessment for the reference point."</p> <p>When asked if the nurses would have been able to determine the findings of the initial assessment</p>	F 309			

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F 309	Continued From page 4 based on information in the record, LNA replied "I see what you mean. We didn't note anything about the stoma condition, color or size or about the surrounding skin or bowels until the day the resident discharged back to the hospital. We should have been monitoring that information. The ostomy was never fully sealed and it was leaking. I didn't think the resident was medically stable when she came to us and her admission was delayed several times."	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary care and services to maintain personal hygiene for 4 of 8 residents (#3, 5, 7, & 8). This failure caused the residents to not have assistance for bathing.  Findings include:  <Resident #3> Resident #3 was admitted to the facility on [REDACTED] with diagnoses to include congestive heart failure,	F 312	<p><b>F312</b> <b>483.25(a)(3) Adl Care provided for Dependent Residents</b></p> <p><u>Individual Residents</u> Resident #7 no longer resides at the facility. Residents #3, 5 and 8 were offered showers and had shower preferences reviewed. Care plans were updated as needed.</p> <p><u>Residents in similar situations</u> Resident bathing records were reviewed for the last 30 days. Residents who had not received a shower within the last 7 days were reapproached and preferences were updated.</p> <p><u>Measures to prevent reoccurrence</u> LNs and NACs were educated by the Education and Training Director (or designee) on bathing practices and how to communicate refusals.</p> <p>Bathing records will be reviewed through the clinical process for completion. Refusals and preferences will be addressed through daily clinical review (M-f) for necessary updates and interventions.</p>	

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F 312	<p>Continued From page 5 lung disease and anxiety.</p> <p>According to the Minimum Data Set (MDS), an assessment instrument, dated [REDACTED], the resident required extensive assistance for activities of daily living (ADL) care, including bathing. The resident was severely cognitively impaired and unable to express needs.</p> <p>A review of the bathing records for the previous 30 days showed a total of 1 shower was administered (on 10/07) with "resident refused bath" recorded 8 times (on 9/30, 10/3, 10/10, 10/13, 10/17, 10/21, 10/24 &amp; 10/25). A review of the nursing notes and care plan did not reveal any information about the baths not being given or what to do if the resident refused care.</p> <p>On 10/28 at 4:20 p.m., resident #3 was observed to be recently bathed, groomed, shaved and was wearing clean clothing with no odors noted. The resident was not interviewable.</p> <p>Licensed Nurse C stated He (resident #3) took a shower for us this evening. He sometimes refuses care, but he is usually re-directable if you approach him correctly.</p> <p>&lt;Resident #5&gt; Resident #5 was admitted on [REDACTED] with diagnoses to include diabetes, obesity, [REDACTED] arthritis and a stroke.</p> <p>According to the MDS dated [REDACTED] the resident required extensive assistance for bathing. The resident was alert and oriented and able to state his needs.</p> <p>A review of the resident's bathing records for the</p>	F 312	<p><u>On-going monitoring</u> The nursing management will review bathing records daily (M-f). Findings will be reviewed through the QAPI process monthly for three months for identification of additional education and training needs.</p> <p><u>Individual to Ensure Compliance</u> Director of Nursing or designee</p> <p><u>Date of Compliance</u> 12-2-2014</p>	

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F 312	<p>Continued From page 6</p> <p>previous 30 days showed 4 showers and 1 bed bath were administered. "Resident refused bath" was recorded on 10/6 and 10/13. No additional explanation was found in the record.</p> <p>On 10/28, resident #5 was out of the facility and not available for observation or interview.</p> <p>&lt;Resident #7&gt; Resident #7 was admitted on [REDACTED] with diagnoses to include diabetes, depression and lung disease.</p> <p>According to the MDS dated 9/27/14, the resident required assistance for ADLs and was moderately cognitively impaired.</p> <p>A review of the resident's bathing records for the previous 30 days showed 5 showers were administered. "Resident refused bath" was recorded on 10/7 and 10/10. No additional explanation was found in the record.</p> <p>On 10/28 at 4:40 p.m., the resident was observed to be in his room, sitting on the edge of the bed. There was a strong body odor and urine odor pervasive in the room. The resident did not recall when he last received a shower.</p> <p>&lt;Resident #8&gt; Resident #8 was admitted to the facility on [REDACTED] with diagnoses to include pneumonia, [REDACTED] and [REDACTED].</p> <p>According to the MDS dated [REDACTED] the resident required extensive assistance for bathing and was severely cognitively impaired.</p> <p>A review of the resident's bathing records for the</p>	F 312		
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F 312	<p>Continued From page 7</p> <p>previous 30 days showed 3 showers were administered. "Resident refused bath" was recorded on 10/16. No additional explanation was found in the record.</p> <p>On 10/28 at 3:55 p.m., the resident was observed in the dining room in a power chair. The resident was noted to have a body odor and a urine odor. The resident was not interviewable.</p> <p>On 10/28/14 at 4:10 p.m., Licensed Nurse (LN) B stated "When the resident refuses a shower, we document that and try to find out why. It may be a resident preference and we try to accomodate preferences. The nursing assistant should reported to the LN and the LN should try to find out why the resident refused and document that in the nursing notes. If it is a resident preference the care plan should be updated. If it was a pattern, we would also have a care conference or get social services involved."</p> <p>At 4:25 p.m., LN C was unable to locate any documentation regarding why the above listed residents had refused bathing or if they had been re-approached.</p> <p>At 4:40 p.m., the Social Services Director stated. I have not been involved if a resident is resistant to care. No one has asked be to me involved."</p> <p>At 4:50 p.m., the Director of Nursing stated "I expect the nursing assistants to let their charge nurse know if a resident refuses a bath. I expect the charge nurse to re-approach the resident. If the resident has a pattern of refusing, the nurse manager should be updating the plan of care or getting social services involved."</p>	F 312			

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F 312	Continued From page 8	F 312		