

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505185	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/14/2015
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NAME OF PROVIDER OR SUPPLIER CRESTWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1116 E LAURIDSEN BOULEVARD PORT ANGELES, WA 98362
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F-000

INITIAL COMMENTS

F 000

This report is the result of an unannounced Abbreviated Survey conducted at Crestwood Health & Rehabilitation Center on July 14, 2015. The sample included 7 current residents from a census of 80 and the records of 3 discharged residents.

The following complaints were investigated:
 3117912 3118274 3118899
 3110642 3121007 3121001
 3121349 3122428 3108525

The survey was conducted by:
 Candice Mohar, PhD, RN, MSN

The survey team is from:
 Department of Social & Health Services
 Aging & Long Term Support Administration
 Residential Care Services, District 3, Unit C & D
 P.O. Box 45819
 Tumwater, Washington 98504-5819

Telephone: 360-664.8429
 Fax: 360.664.8451

[Signature] 7/21/15
 Residential Care Services Date

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 or agreement with the deficiencies or conclusions contained in the Department's inspection report.

RECEIVED
 AUG 04 2015
 DSHS/ADSA/RCS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Michael Litzman</i>	TITLE Executive Director	(X6) DATE 7/30/15
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A 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	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>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).</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to consult known legal representatives and/or consult with the</p>	F 157	<p>How the nursing home will correct The deficiency as it relates to the resident:</p> <p>Resident # 1 no longer resides at the Facility. Other residents with changes in condition have the potential to be affected.</p> <p>How the nursing home will act to protect residents in similar situation:</p> <p>License staff and Social Service personnel Were in serviced on the Notification of Resident Change in Condition policy.</p> <p>The measures the nursing home will take or the systems it will alter to ensure That the problem does not recur:</p> <p>Residents with change of condition in Last 15 days have been reviewed and Assessed with proper family and physician notifications. RCM or DNS will audit to ensure notification has occurred on change of condition.</p> <p>How the nursing home plans to monitor Its performance to make sure that s solutions are sustained:</p> <p>Notification Audits will be completed Weekly X 3 months with results Reported to QAPI for verification of Compliance.</p> <p>Dates when corrective action will be completed and title of person responsible to ensure correction:</p> <p>August 5, 2015</p> <p>Director of Nursing or designee will be Responsible for compliance.</p>	8/5/15

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F 157 Continued From page 2
 physician when changes in care and treatment and/or when significant changes in condition occurred for 1 of 1 sampled Residents (#1) reviewed for notification/consultation. This failure prevented representatives/guardians from being aware of changes in condition and treatment plans or having input related to care and placed residents at risk of not receiving the most optimal care and treatments during their recovery process.

Findings include:

Discharged Resident #1 was admitted to the facility on [REDACTED] 2014 with multiple medical diagnoses including [REDACTED] and difficulty [REDACTED]. He required extensive assistance with all daily living tasks. The resident was alert and oriented, could make his needs known and responded to yes and no questions. He had a legal representative designated as his durable power of attorney (DPOA).

The record indicated the resident had a [REDACTED] in [REDACTED] 2014 that showed [REDACTED] in [REDACTED]. On 1/14/15, the [REDACTED] showed [REDACTED]. No specific documentation was found to indicate the stage of the [REDACTED] or prognosis or that the DPOA was involved in discussions about the proposed treatments and/or options.

Physician Assistant (PA) progress notes dated 1/27/15 indicated: "male seen today at request of daughter ...called our clinic, left message regarding concerns her father is acting strange, not eating or able to sign his name anymore." The PA note continued: "Discussed patient today with facility nurses who agree that the patient has not been acting himself since returning from the

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F 157	<p>Continued From page 3</p> <p>hospital (█████ 5), used to carry on a conversation and banter with the nurses, now he doesn't converse and often stares into space. He doesn't respond to questions or follow commands very well." The documentation failed to indicate the facility had a discussion with the DPOA related to proposed treatment and/or options or why the DPOA had to contact the physician's office to report the noted change in condition.</p> <p><Weight loss> On 2/6/15, the record indicated the resident weighed █████ pounds. On █████ 15 on admission to the hospital, his weight was █████ pounds. On March 5, 2015 the facility documented a weight of █████ pounds. Documentation was not found to indicate the DPOA was informed during the weight loss process and of the proposed treatment and/or options.</p> <p>During interview on 7/13/15 at 9:00 a.m., the DPOA said she suspected weight loss because the resident's clothes were becoming more and more loose-fitting. The facility had not informed her of the specific amount of weight loss. There was no documentation to indicate the facility kept the DPOA updated regarding significant unplanned weight loss.</p> <p><Pressure Ulcers> On 1/30/15 the facility identified 2 Stage II pressure ulcers to the resident's █████ that resolved in three weeks. Documentation was not found to show the DPOA was informed.</p> <p>On 2/9/15 the resident experienced skin breakdown identified by the facility as 2 large unstageable pressure ulcers measuring 8 x 5 centimeters (cm) long and 5 cm wide on █████</p>	F 157		
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 [redacted] and 12 cm x 6 cm on the [redacted]
 The areas had increased by 2/16/15 to 12 cm x 5 cm on the [redacted] and 15.5 cm x 9.5 cm on the [redacted]

On 2/13/15, the PA documented the resident had "developed an abscess with cellulitis the last couple of days to the [redacted] that measures 7 cm in diameter."

On 2/20/15, the PA documented the resident's pressure ulcers were unstageable and loose eschar (dead skin on sore or ulcer, usually thick/hard consistency and black or brown in color) was debrided (medical removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue).

On 2/20/15, another PA identified the [redacted] Pressure Ulcers as Stage IV." Documentation was not found to indicate a discussion occurred with the DPOA related to the serious wounds and proposed and/or implemented treatments.

On 7/13/15 at 9:00 a.m., during interview with the DPOA, it was learned she was not informed of the ulcer deterioration.

On 7/13/15 at 9:00 a.m., during interview with the resident's DPOA, it was learned she was notified of the pressure ulcer on [redacted] only "Around 2/6/15 is when they (facility) told us about it (the pressure sore). The first phone call was to tell me it (pressure ulcer to buttocks) was a superficial sore and we (facility) are taking care of it. He had fallen out of bed and I would ask about the sore and they said it was better. They said they were treating it and it was getting better is what we were consistently told. When I finally

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F 157	Continued From page 5 saw the sore at the medical center (15) it was appalling! I am calling it a horrific wound and I know it did not happen overnight! I had no idea about all the other areas until the hospital shared the information and the recommendations for treatment. How did this happen?" On 7/14/15 at 5:00 p.m., the Director of Nursing Services (DNS), Social Services Director (SSD) and administrator were informed about the lack of notification and documentation to show the DPOA was informed about the multiple pressures ulcers, medication changes, treatments and weight loss so she could be included in the care and treatment decisions throughout the resident's stay and not learning of decisions after-the-fact. The staff members said there was room for improvement and communication with the DPOA could have been better. The DNS said many of the issues were addressed with the DPOA as she visited almost daily but they could have done a better job of documenting the communications.	F 157		
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 interview and record review, it was determined the facility failed to provide care in a respectful manner to promote, maintain and/or	F 241		

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F 241	<p>Continued From page 6</p> <p>enhance dignity for 1 of 1 sampled Residents (#1) when the facility transferred the resident to an appointment without being fully dressed. This failure resulted in an event in which a reasonable person would have felt embarrassment and diminished self-esteem.</p> <p>Findings include:</p> <p>Discharged Resident #1 was admitted to the facility on [REDACTED] 2014 with multiple medical diagnoses. He required extensive assistance with all daily living tasks including dressing and grooming.</p> <p>On 7/13/15 at 9:00 a.m., during interview with the Resident's legal representative, it was learned the resident was transported to a hospital appointment on [REDACTED] 2015. Upon arrival, the Resident lost the blanket that was wrapped around him. The legal representative, hospital staff and other public persons observed the resident to be wearing only an adult brief and a shirt that was partially opened and buttoned incorrectly. He was not wearing an undershirt, jacket or pants. The legal representative stated the resident was "very embarrassed" and attempted to pull the blanket up over him. Having the resident publicly exposed in this manner upset the representative as well as she felt the facility should have known to dress the resident appropriately.</p> <p>On 7/14/15 at 5:00 p.m., during interview with the facility Social Services Director (SSD), Director of Nursing Services (DNS) and Assistant DNS, it was learned the resident may have been late for the appointment and could have been hastily dressed for transfer. All said this was not the</p>	F 241	<p>How the nursing home will correct the Deficiency as it relates to the resident:</p> <p>Resident # 1 no longer resides in the facility. Other residents may have potential to be affected.</p> <p>How the nursing home will act to protect residents in similar situations:</p> <p>Staff education was provided regarding dignity and respect prior to resident transfer for appointments and documentation of residents refusal of care or assistance prior to transfer.</p> <p>Measure the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <p>Licensed staff educated on completion of the Resident Appointment Transfer form. DNS will audit the use of form weekly X 3 months.</p> <p>How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <p>Resident Appointment Form will Be audited by DNS or RCM weekly and Results reported to QAPI monthly X 3 to ensure compliance.</p> <p>Dates when corrective action will be Completed and title of person Responsible to endure correction:</p> <p>August 5, 2015</p> <p>Director of Nursing or designee will be responsible for correction.</p>	8/5/15

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F 241	Continued From page 7 normal procedure for resident transfers and would follow up with staff members.	F 241		
F 325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure measures were implemented for 1 of 1 sampled Residents (#1) reviewed for weight management. This failure placed residents at risk for nutritional decline and diminished quality of life.</p> <p>Findings include:</p> <p>Discharged Resident #1 was admitted to the facility on [REDACTED] 2014 with multiple medical diagnoses including [REDACTED] and [REDACTED]. He had [REDACTED].</p> <p>[REDACTED] He required extensive assistance with transfers, positioning and bed mobility. He was incontinent of bowel and</p>	F 325	<p>How the nursing home will correct: The deficiency as it relates to the Resident: Resident # 1 no longer resides in the facility. All residents have the potential to be affected if their nutritional status are not maintained in acceptable parameters. How the nursing home will act to protect residents in similar situations:</p> <p>Weights for past 3 months will be reviewed for all residents. Those identified with significant weight change will be referred to RD via Dietitian Referral Log for reassessment at next bi-weekly visit. Nutritional Status Policy and Procedures education provided to staff member.</p>	8/5/15

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F 325	<p>Continued From page 8 bladder.</p> <p><Nutrition> The resident's admission weight was [REDACTED] pounds. His assessment indicated he needed oversight and set up only for meals. An assessment dated 1/18/15 indicated no change.</p> <p>On 2/6/15, the facility documentation showed a weight of # [REDACTED]. On 2/9/15 the lab report indicated the resident had a low Albumin of 2.1 (reference range 3.4 to 5.0) which is needed to aid in healing wounds.</p> <p>On 2/11/15 the Registered Dietitian (RD) recommended enhanced meals three times per day and a special high protein (Prostat) to be added daily to "aid in wound healing of pressure ulcers." The assessment dated 2/15/15 indicated he needed extensive assistance of 1 person during meals.</p> <p>On [REDACTED] 15, the hospital admission record indicated the resident weighed # [REDACTED].</p> <p>The resident returned from the hospital on [REDACTED] 15. The facility's next documented weight was noted on [REDACTED] 15 as [REDACTED].</p> <p>On 3/11/15 a fax note to the Physician Assistant (PA) indicated: "Per RD recommendations, add enhanced food to meals, three times per day; add Prostat twice each day ...Resident had significant weight loss during discharge and readmission. Increased protein to aid in wound healing." The record indicated implementation on [REDACTED] 15.</p> <p>On 3/11/15 the PA wrote: "The patient needs 1 on 1 assistance with meals."</p>	F 325	<p>Measures the nursing home will take or systems it will alter to ensure that the problem does not recur:</p> <p>A weight/nutrition meeting will be Held weekly during Daily Clinical Meeting with RD present to review Residents with significant weight change.</p> <p>Care Tracker reports of potentially Inadequate food or fluid intake will be reviewed at Daily Triage for possible follow up at Daily Clinical Meeting.</p> <p>Licensed Staff will be re educated on weight monitoring following Policy and Procedures.</p> <p>How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <p>Monthly Clinical System Review of Weights/nutrition will be conducted Per policy.</p> <p>Weight trends reviewed in QAPI Monthly X 3 to ensure compliance. Dates when corrective action will be completed and title of person responsible to ensure compliance:</p> <p>August 5, 2015 Director of Nursing or designee Will be responsible for compliance.</p>	8/5/15

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F 325	<p>Continued From page 9</p> <p>On 7/13/15 at 9:00 a.m., during interview with the Resident's legal representative, it was learned she had not been informed/consulted about the worsening pressure ulcers or the type of care and service/treatments provided for wound healing.</p> <p>When asked about the resident's weight loss, she said she could tell the resident was losing weight because of his loosely fitting clothes and he was not eating when she visited. She said many times either she or family members would feed the resident.</p>	F 325		