

417

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505416	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/23/2013
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NAME OF PROVIDER OR SUPPLIER FOSS HOME & VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 13023 GREENWOOD AVENUE NORTH SEATTLE, WA 98133
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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 Foss Home on 10/22/2013-10/23/2013. A sample of 5 residents was selected from a census of 169.</p> <p>The following complaint was investigated as part of this survey: #2879008, 2891609</p> <p>The survey was conducted by: [REDACTED] MN, R.N.</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 C Creekside Two 20425 72nd Avenue South, Suite 400 Kent, WA 98032-2388</p> <p>Telephone: (253) 234 6003 Fax: (253) 395 5071</p> <p>[REDACTED] Residential Care Services Date <u>11-8-2013</u></p>	F 000	<p>COPIED 11/22/13 [REDACTED]</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [REDACTED] <i>Administrator</i>	TITLE	(X6) DATE 11/22/13
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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 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to operationalize procedures for immediate investigation and reporting of substantial injuries of unknown source for 1 of 5 residents sampled (Resident #1). Failure to immediately investigate and report a head injury and body bruises of unknown origin placed Resident #1 at risk for abuse.</p> <p>Findings include:</p> <p>According to record review of facility medical records on 10/22/2013, Resident #1 resided at the facility since 2011. Review of the facility Minimum Data Set (MDS) assessment dated 08/18/2013 revealed, Resident #1 had severe cognitive impairment and a memory problem. The MDS further revealed Resident #1 was dependent on staff with extensive assistance for bed mobility, transfer, dressing, eating, toileting, hygiene and totally dependent on staff for locomotion and bathing.</p> <p>Record review of the facility "Staff Statement" dated 09/21/2013, revealed on the night shift of</p>	F 226	Resident #1 was assessed and appropriate investigation was completed. Staff was re-educated following this occurrence on facility policy and procedure for reporting and investigation of injuries. Incident Reporting procedure will be updated as necessary to maintain a thorough investigation process. Clinical Care Managers will monitor compliance and Director of Nursing will assure correction.	12/6/13	

F 226
10/23/2013
05/15/13 08:55 AM

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F 226	<p>Continued From page 2</p> <p>beginning on 09/14/2013, Staff B observed "some rashy area on [Resident #1's] arm around humerus area". In addition, review of the written interview of Staff B by supervisor Staff C dated 10/04/2013 revealed, "Staff B noted a scratch on Resident #1's forehead" on the night shift beginning on 09/14/2013. Review of the facility "Alert Listing Report" dated 09/15/2013 at 05:30 a.m. noted "resident has a small cut on her forehead. nurse notified" on 09/15/2013 day shift. This substantial injury of unknown origin was not investigated immediately to rule out abuse and neglect.</p> <p>Further record review of facility "Staff Statement" dated 09/20/2013 revealed, Staff D observed an injury on Resident #1 during the day shift of 09/15/13 that was a "bump on her forehead, a small abrasion, a small cut" and Resident #1 "complained of pain of shoulder". According to the staff statement, Staff D showed the bump and told the nurse on duty about Resident #1's pain in the shoulder, but the injury and pain of unknown origin was not investigated to rule out abuse and neglect.</p> <p>In an interview on 10/22/2013 at 11:55 a.m., Staff D stated on 09/15/2013 during the day shift, Staff D "saw a small cut above the eyebrow [on Resident #1] and a raised bump, yellow color, a fresh cut...and during dressing [Resident #1] said "Ow, my shoulder hurts". Staff D confirmed she showed the injuries and reported the pain observed for Resident #1 to the nurse on duty on 09/15/2013 day shift.</p> <p>, but these injuries of unknown origin were not immediately investigated to rule out abuse and</p>	F 226		

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OCT 25 2013
DSH/REGISTRATION/CS Kent

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F 226	Continued From page 3 neglect. Review of the medical record revealed no documentation of any investigation or reporting done by the facility for the substantial injuries: bump on head, abrasion/cut on the forehead with a rashy area and pain in the [redacted] shoulder for Resident #1 on 09/14/2013 or 09/15/2013.	F 226			
	Review of the facility "Staff Statement" dated 09/20/2013 revealed, Staff E observed a bruise on the [redacted] forehead, bruises on the armpit and [redacted] upper arm, and bruises to the [redacted] breast on 09/16/2013 during the day shift. According to the written statement, Staff E told the nurse on duty about the injuries. In addition, record review of facility "Staff Statement" dated 09/20/2013 revealed, Staff F observed a scab on the [redacted] side of Resident #1's forehead 1 centimeter by 1 centimeter on 09/16/2013 in the evening. The substantial injuries of unknown origin including the head injuries, arm bruising, and bruising to the [redacted] breast were not immediately investigated by the facility to rule out abuse and neglect.				
	Additional record review of facility "Staff Statement" dated 09/20/2013 revealed, Staff G, a licensed nurse, stated there was no report or documentation of any injuries for Resident #1 on night shift 09/17/2013 to morning of 09/18/2013. Staff G stated no knowledge of Resident #1's substantial injuries, no information given or documented by previous nurse shifts on 09/17/2013.				

DOH-3-AD-9-2013 Kent

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F 226	Continued From page 4 Review of the facility records revealed no documentation of any investigation or reporting of the unknown substantial injuries for Resident #1's head injury, arm, armpit and breast bruising with pain from 09/14/2013 to the morning of 09/18/2013, a delay of four days from the first observation of injuries of unknown origin. Failure of facility staff to investigate and report substantial injuries of unknown cause for Resident #1 for four days after the first observation of injuries, placed the resident at risk for abuse.	F 226		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR 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 to assess, monitor and treat substantial injuries including a head injury, body bruises, and arm pain when observed by facility staff for 1 of 5 residents sampled (Resident #1). Failure to monitor substantial injuries of unknown origin placed the resident at risk for complications and delayed healing.	F 309	Resident #1 was assessed for injury, evaluated by therapy and appropriate treatment and monitoring was implemented. Care plan was updated to reflect changes in care. Staff was re-educated following this occurrence on facility policy and procedure for assessing, monitoring and treating injuries. Facility will re-educate nursing staff on implementation of alert charting related to injuries and observation of any subsequent skin or pain issues. Clinical Care Managers will monitor injury assessment and appropriate treatment and review findings with interdisciplinary team. Director of Nursing will assure correction.	12/6/13

10/23/2013
13023 Greenwood Avenue North
Seattle, WA 98133
FOSS HOME & VILLAGE

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F 309	<p>Continued From page 5</p> <p>Findings include:</p> <p>--also see F226--</p> <p>According to record review of facility medical records on 10/22/2013, Resident #1 was ● years old and resided at the facility since 2011. Review of the facility Minimum Data Set (MDS) assessment dated 08/18/2013 revealed, Resident #1 had severe cognitive impairment and a memory problem. The MDS further revealed Resident #1 was dependent on staff with extensive assistance for bed mobility, transfer, dressing, eating, toileting, hygiene and totally dependent on staff for locomotion and bathing.</p> <p>Record review of the facility "Staff Statement" dated 09/20/2013 revealed, on the evening of 09/14/2013, Staff A observed that Resident #1 "complained of pain on the ● shoulder" and Staff A observed "what appeared like a rash" on the ● shoulder.</p> <p>Review of the medical record revealed no documentation of assessment of the "rash" area on the ● shoulder, no monitoring for healing, and no pain assessment or treatment given for the ● arm rash or ● arm/shoulder pain on 09/14/2013.</p> <p>Record review of the facility "Staff Statement" dated 09/21/2013, revealed on the night shift of</p>	F 309		

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10/23/2013
DANIEL ...

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F 309	<p>Continued From page 6</p> <p>09/14/2013 to morning 09/15/2013, Staff B observed "some rashy area on [Resident #1's] arm around humerus area". In addition, a written interview of Staff B noted by a supervisor Staff C dated 10/04/2013, "Staff B noted a scratch on Resident #1's forehead" on that same night shift 09/14/2013-09/15/2013. Review of the facility "Alert Listing Report" entered by Staff B on 09/15/2013 at 05:30 a.m. revealed, "resident has a small cut on her forehead. nurse notified". The facility had no documentation of assessment, monitoring or treatment of the substantial injury or skin condition of unknown origin.</p> <p>Further record review revealed a facility written "Staff Statement" dated 09/20/2013 that noted, Staff D observed an injury on Resident #1 during the day shift of 09/15/13 that was a "bump on her forehead, a small abrasion, a small cut" and Resident #1 "complained of pain of shoulder". According to the staff statement, Staff D showed the bump and told the nurse on duty about Resident #1's pain in the shoulder on 09/15/2013 day shift.</p> <p>In an interview on 10/22/2013 at 11:55 a.m., Staff D stated that on 09/15/2013 during the day, Staff D "saw a small cut above the eyebrow [on Resident #1] and a raised bump, yellow color, a fresh cut...and when dressing [Resident #1] said "Ow, my shoulder hurts". Staff D further stated Resident #1 usually "hugs" the Staff D during assisted dressing to help her sit up, but on 09/15/2013, Resident #1 could not do that because she said her shoulder hurt, and Resident #1 did not know how it happened. Staff D confirmed she showed the injuries and reported</p>	F 309		
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FOSS HOME & VILLAGE
10/23/2013
10:00 AM

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F 309	<p>Continued From page 7</p> <p>pain observed with Resident #1 to the nurse on duty on 09/15/2013 day shift.</p> <p>Review of the medical record revealed no facility documentation of any assessment, monitor for healing, or any treatment for the abrasion/cut and bump on the forehead, or for [REDACTED] shoulder pain for Resident #1 on 09/15/2013.</p> <p>Review of the facility "Staff Statement" dated 09/20/2013 revealed, Staff E observed a bruise on the [REDACTED] forehead, bruises on the armpit and [REDACTED] upper arm, and bruises to the [REDACTED] breast on 09/16/2013 during the day shift. According to the written statement, Staff E told the nurse on duty about the injuries.</p> <p>Additional record review of facility "Staff Statement" dated 09/20/2013 revealed, Staff F observed a scab on the [REDACTED] side of Resident #1's forehead 1 centimeter by 1 centimeter on 09/16/2013 in the evening.</p> <p>Review of the medical record revealed no facility documentation of any assessment, monitoring or treatment for the injuries to Resident #1's head, arm, armpit or breast on 09/16/2013.</p> <p>Further review of the facility "Staff Statement" dated 09/20/2013 revealed, Staff E observed Resident #1 complaining of pain in her [REDACTED] armpit</p>	F 309			

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F 309	<p>Continued From page 8 during the day shift on 09/17/2013.</p> <p>Review of the medical record revealed no facility documentation of any injury or pain assessment, monitoring or treatment for Resident #1 on 09/17/2013.</p> <p>Record review of facility "Staff Statement" dated 09/21/2013 revealed, Staff H stated that on 09/18/2013, a caregiver (Staff E) reported Resident #1 had pain and discolorations in the [redacted] shoulder to the nurse on day shift.</p> <p>Review of the medical record revealed no documentation of any assessment, monitor or treatment for [redacted] shoulder pain on 09/18/2013 or 09/19/2013 for Resident #1.</p> <p>Record review of the facility "periodic Care Review" dated 08/19/2013, revealed Resident #1 "receives no routine pain medication, used [redacted] one time in a month for general discomfort, and had no problems with arm or shoulder pain prior to the [redacted] shoulder injuries and pain first observed 09/14/2013.</p> <p>The facility failed to assess, monitor and treat substantial injuries for Resident #1 on 09/14/2013, 09/15/2013, 09/16/2013, and 09/17/2013, four days since the first injury observation by facility staff.</p>	F 309		

Handwritten notes and stamps at the bottom of the page, including a date stamp that appears to be 10/23/2013.

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F 309	Continued From page 9 The facility failed to assess, monitor and treat Resident #1's shoulder/arm pain on 09/14/2013, 09/15/2013, 09/17/2013, 09/18/2013 and 09/19/2013, five days since the first injury and pain observation by facility staff. This failure placed Resident #1 at risk for inadequate healing of substantial injuries and untreated pain.	F 309			