

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

PRINTED: 02/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PANORAMA CITY CONV & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 SLEATER KINNEY ROAD SE LACEY, WA 98503
---	---

(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	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Off-Hours Quality Indicator Survey conducted on consecutive days at Panorama City Convalescent & Rehabilitation Center in Lacey on 2/18/14, 2/19/14, 2/20/14 and 2/21/14. The survey included data collection on 2/18/14 beginning 7:05 p.m. to 9:20 p.m. A sample of 36 residents was selected from a census of 140. The sample included 23 current residents and the records of 13 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>Deborah Barrette, RN, BSN Michelle Darnell, BSS Sandra Mayes, RN, BSN Candice Mohar, PhD, RN, MSN</p> <p>The survey team is from:</p> <p>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</p> <p>Telephone: 360.664.8429 Fax: 360.664.8451</p> <p><i>Joan B. Peice</i> 2-25-14 Residential Care Services Date</p>	F 000	<p style="text-align: center;">RECEIVED MAR 10 2014 DSHS/ADSA/RCS</p>	
-------	---	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Shawn R. D.</i> NAA	TITLE	(X6) DATE 3-9-14
---	-------	----------------------------

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.

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

PRINTED: 02/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/21/2014	
NAME OF PROVIDER OR SUPPLIER PANORAMA CITY CONV & REHAB CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 SLEATER KINNEY ROAD SE LACEY, WA 98503		
(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	Continued From page 1	F 000		
F 247 SS=D	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE</p> <p>A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, it was determined the facility failed to provide advanced notice to 2 of 26 current sampled residents (#113 & 312) reviewed for notification of roommate changes. This failure placed residents at risk for difficulty adjusting to a new roommate and potential diminished quality of life.</p> <p>Findings include:</p> <p>1) Resident #113 was admitted to the facility on [REDACTED] 14 with diagnoses of diabetes and renal disease. The resident's Minimum Data Set, an assessment tool, dated 02/13/14 indicated the resident was cognitively intact.</p> <p>On 02/19/14 at 3:57 p.m., Resident #113 stated he had received a new roommate on 02/19/14 without advanced notice prior to the roommate moving in. The resident stated he returned from a bereavement meeting and found the new roommate had moved into the room. Resident #113 stated his spouse had died the previous</p>	F 247	<p>F247</p> <p>The facility will assure that residents are given notice in advance of receiving a roommate.</p> <p>1) Resident #113 was discharged home on [REDACTED] 14.</p> <p>2) Resident #312 received a new roommate on 2/14/14. The admission assistant prepared the room for the new admission while resident #312 was in the room. When the resident was interviewed on 3/04/14, she could not recall if she was given verbal notice of a roommate moving in, because by her own admission, she was not as alert and coherent as she is now. Resident is currently well adjusted to her roommate and there is no apparent diminished quality of life for either resident.</p> <p>The nurse managers or house supervisors (in the absence of the managers), will be responsible to assure that residents are notified of a new roommate and make a written entry in the residents medical record to reflect the notification.</p> <p>The facility "Room Change" policy has been reviewed, and a separate policy has been written to address roommate notification. Licensed staff has been educated on the policy revision.</p>	3/31/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/21/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER PANORAMA CITY CONV & REHAB CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1600 SLEATER KINNEY ROAD SE LACEY, WA 98503
---	---

(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 247	<p>Continued From page 2 week.</p> <p>On 02/21/14 at 5:38 p.m., Licensed Nurse A stated the Admission Assistant introduces potential new roommates and there should be documentation in the chart. Upon record review, LN A stated, "It looks like we did not introduce the new resident."</p> <p>At 6:41 p.m., the Administrator (ADMN) stated, "Everyone should receive notice they are getting a new roommate and it should be documented."</p> <p>2) Resident #312 was admitted to the facility on [REDACTED] 14 and received a new roommate into the room on 02/14/14.</p> <p>At 7:33 p.m., LN A confirmed there was no documentation to support that Resident #312 received advanced notice of receiving a new roommate.</p>	F 247	<p>F247</p> <p>Health information will audit charts for compliance to include notification of residents when a roommate is expected to move in. This will include in house transfers as well as new admissions to the facility.</p> <p>The Director of Nursing is responsible for assuring compliance.</p>	3/31/14
-------	--	-------	--	---------