

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

PRINTED: 02/08/2013  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>505467 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br>C<br>02/06/2013 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>DELTA REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE<br>1705 TERRACE<br>SNOHOMISH, WA 98290 |
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| F 000 | <p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Abbreviated and Partial Extended Survey conducted at Delta Rehabilitation Center on 01/10/2013, 01/29/13 and 2/6/13. A sample of 11 residents was selected from a census of 117. The sample included 10 current residents and the record of one former and/or discharged resident.</p> <p>The following were complaints investigated as part of this survey:</p> <p># 2730178</p> <p>The survey was conducted by:</p> <p>██████████, RN, BSN<br/>██████████, RN, MSN<br/>██████████, RN, BSN</p> <p>The Survey team is from:</p> <p>Department of Social &amp; Health Services<br/>Aging &amp; Disability Services Administration<br/>Residential Care Services, District 2 Unit A<br/>3906 172nd St NE Ste 100<br/>Arlington, WA 98223</p> <p>Telephone: (360) 651-6850<br/>Fax: (360) 651-6940</p> <p><i>Terence R. [Signature]</i> 02/08/13<br/>Residential Care Services Date</p> | F 000 | <p>Preparation and implementation of this plan of correction does not constitute admission or agreement by Delta Rehabilitation Center with the facts, findings or other statements as alleged by the State Survey Agency dated 02/06/13. Submission of the plan of correction is required by law and does not evidence truth of any of the findings. Delta Rehabilitation Center specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action.</p> <p style="text-align: right;">RECEIVED<br/>FEB 22 2013<br/>ADSARCS<br/>Smokey Point</p> |  |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br><i>[Signature]</i> | TITLE<br>VP | (X6) DATE<br>2/22/13 |
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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<br>SS=H  | <p><b>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</b></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:<br/>Based on observation, interview, and record review the facility neglected to identify resident to resident altercations involving a pattern of unwanted physical contact with injury as abusive and take appropriate action to protect 4 of 6 sampled residents (1,2,4,5). Although the facility's abuse prevention policy identified behaviors such as hitting, pushing, shoving, squeezing, pinching and kicking as "types of abuse", facility staff failed to identify that multiple resident to resident altercations involving these behaviors between residents as abusive.</p> <p>Failure of the facility to ensure staff recognized abusive acts and were trained on how to identify and respond appropriately to such altercations resulted in 5 incidents of harm involving Resident 1, including at least 3 physical attacks to Resident 2's head and face resulting in injury, choking Resident 4 with resultant injury to his neck and jaw, and hitting Resident 5 during a period of 6 weeks.</p> <p>Findings include but were not limited to:</p> <p>The facility's Abuse and Neglect Policy defined physical abuse as "the willful infliction of injury ...</p> | F 226  | <p>This facility provides care for a unique population of residents with the primary diagnosis of traumatic brain injury. The statement of deficiency does not reflect a true complete picture of resident #1 with his physical and cognitive impairments nor his interactions with the other cognitively compromised residents.</p> <p>This statement of deficiency is citing a pattern of aggressive behavior when in fact there have been multiple incidents of immature childish behavioral interactions with this residents and other similarly impaired residents where 4 of the 8 incidents that the facility reported, that resident #1 was in fact the victim.</p> <p>Resident # 2, who in the statement of deficiency appears to be a helpless victim, is actually a rough house buddy of resident # 1. Resident #2 is frequently the instigator or agitator in their activities and is physically capable of escaping resident # 1's "attacks", but doesn't due to his aggressive perseverance. In regards to the "choking incident", it is well documented that resident # 4 (the victim) admitted to instigating and over stimulating resident # 1. Resident # 4 and the other room-mate specifically requested that resident # 1 return as their room-mate, both stating that they were not afraid of him.</p> |   |

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| F 226  | <p>Continued From page 2</p> <p>with resulting physical harm, pain or mental anguish. Types of physical abuse listed included, " hitting, pushing, shoving, squeezing, pinching and kicking " .</p> <p>The Department ' s Nursing Home Guidelines, dated February 2012, documents, " A variety of actions fall within the definition of abuse. An action can be abusive even if there is no intent to cause harm " . " In general, you must presume that abuse has occurred whenever there has been some type of impermissible, unjustifiable, harmful, offensive or unwanted contact..."</p> <p>The facility ' s Mandated Reporting of Abuse/Neglect Policy, dated 8/04, read, " When there is reasonable cause to believe that, ...abuse or neglect of a vulnerable adult has occurred mandated reporters shall immediately report to the department " .</p> <p>The Department's Nursing Home Guidelines defines a Mandated Reporter as an employee of a facility.</p> <p><b>RESIDENTS</b><br/>Residents 1,2,4, and 5 lived in the same building. Residents 1 and 4 were roommates.</p> <p>Resident 2 was a [redacted] year old male with diagnoses including [redacted] injury and [redacted]. He was wheelchair confined and able to self-propel about the facility. Resident 2 was followed by Mental Health for mood and behavioral issues.</p> <p>Resident 4 was a [redacted] year old male with</p> | F 226   | <p><b>F-226 Develop/Implement/Abuse/Neglect, Etc Policies</b></p> <p><b>How the nursing home will correct the deficiency as it relates to the resident.</b><br/>Resident #1 was relocated to another unit in the facility, away from residents #2, 4 and 5 and has not evidenced and similar behavioral issues.</p> <p><b>How the nursing home will protect residents in similar situations.</b><br/>Facility policy for Incident Identification/Investigation/Reporting has been changed.</p> <p><b>Measures the Nursing Home will take or systems it will alter to ensure that the problem does not recur.</b><br/>Facility policy for Identification/Investigation/Reporting has been updated to implement a tracking system that will reflect patterns and trends of behavior. Also a visual tool has been developed so that reoccurring trends or patterns of resident's incidents or behaviors can be easily observed. The facility incident investigator is responsible for the daily entries onto the incident/trend tracking system and will alert the behavior management team after any resident with two concurrent incidents, so that the team can respond to the issues and develop and/or propose corrective plan.</p> | 2/22/13  |

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| F 226  | <p>Continued From page 3</p> <p>diagnoses including ██████████ of ██████████ and ██████████ with no purposeful movement of his arm and leg and moderate cognitive deficits .</p> <p>Resident 5 was a ██████████ year old male with diagnoses including a ██████████ and left sided ██████████. He was impulsive with poor safety judgment and was followed by mental health due to increased agitation.</p> <p>Resident 1 was a ██████████ year old male with diagnoses including ██████████, ██████████, ██████████ difficulty, agitation and aggression. He was confined to a wheelchair that he was capable of self-propelling in the hallway. Resident 1 had known aggressive behaviors toward other residents for which he was on 15 minute checks.</p> <p>From 11/20/12 to 12/21/12 Resident 1 was the aggressor in 7 resident- to- resident altercations. On 12/15/12, a Licensed Nurse (LN) documented, " the LN considers the resident to be a danger to peers in building 3. "</p> <p>Incidents included but were not limited to the following:</p> <p>1. On 11/20/12 Resident 1 was observed pushing Resident 2's head down by the back of his neck. According to staff documentation they "were able to intervene before harm occurred " . Resident 1 stated " Sorry, sorry " when told to stop. Resident 2's face was red, but neither resident appeared upset. The facility's investigation conclusion revealed they were unable to determine if the incident was a result of fighting or</p> | F 226  | <p>A Mandatory All Staff Meeting will be held on 02/26/13 to inform staff on the new policy and tracking system and to ensure the staffs participation in this program to identify repetitive abusive behavior between residents. All staff will be informed of their responsibilities as a Mandated Reporter to not only report the incident to their supervisor but to make an official report to the Complaint Resolution Unit.</p> <p><b>How the nursing home plans to monitor its performance.</b></p> <p>The Facility Incident Investigator will report all abusive incidents with special notification of any incidents that reflect patterns or trends to the Administrator and the Director of Nursing as well as the Quality Assurance Committee.</p> <p><b>Title of the person responsible to ensure correction.</b></p> <p>The Director of Nursing will ensure correction.</p> | 2/26/13   |

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| F 226 | <p>Continued From page 4</p> <p>playfulness between the two residents. Abuse was ruled out. Facility interventions put in place included continuing 15 minute checks for Resident 1, and monitoring Resident 2 for psychological harm.</p> <p>Staff met on 11/21/12 to review Resident 1's behavior. His Health Care Provider (HCP) was contacted, regarding the incident. The HCP ordered the medication, Inderal, twice daily to reduce agitation and impulsivity. Resident was added to the list for the Mental Health Provider (MHP) to see on their next visit 12/14/12.</p> <p>2. On 11/25/12, as staff entered the hallway Resident 2 was observed attempting to kick Resident 1. Resident 1 was attempting to push Resident 2 away. Staff intervened. Resident 2 was observed to have a 3 centimeter mark on his right lower cheek that required antibiotic ointment applied.</p> <p>The facility concluded neither of the residents seemed upset, the incident was isolated and may have been a playful act. Facility interventions: Trimmed and filed both of the resident's fingernails. Resident 2 was to be monitored for pain or discomfort. Abuse was ruled out.</p> <p>On 12/4/12 staff documented that there had been no appreciable change in Resident 1's behavior since starting the Inderal on 11/24/12.</p> <p>3. On 12/9/12 Resident 1 was involved in three altercations. At 3:15 p.m. Resident 5 was observed to bump into Resident 1's wheelchair. It startled Resident 1, who then turned around and hit Resident 5 in the head three to four times.</p> | F 226 |  |  |
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| F 226  | <p>Continued From page 5</p> <p>4. On 12/9/12 at 4:30 p.m., Resident 1 was in the hall yelling at Resident 2. Another resident who witnessed the incident stated Resident 1 had "instigated" a fight with the resident.</p> <p>5. On 12/9/12, at 6:30 p.m., a resident sitting outside the TV room "was yelling and pointing into the TV room." Upon investigation staff found Resident 1 grabbing Resident 2's hands and wheelchair. Staff documented "Residents separated again".</p> <p>The facility investigated all three incidents on 12/9/12 together. The facility concluded that the incident with Resident 5 was a witnessed impulsive unplanned aggression by Resident 1 due to irritation/overstimulation related to the inability to appropriately problem solve or react to negative irritating stimuli.</p> <p>On 12/14/12, Resident 1 was seen by the mental health provider, who recommended increasing the Resident's [redacted] and starting [redacted] three times a day. This recommendation was not initiated at this time.</p> <p>6. On 12/15/12, Resident 1 was observed going into the dining room. Resident 1 grabbed Resident 2's face and "Was shaking the resident's head back and forth with force. LN documentation in the progress notes read "{Resident 2} in wheelchair and compromised and unable to defend self. ... {Resident 2} appeared upset ". A LN assessment of Resident 2 revealed the resident had scratches on both sides of his face. The LN documented in her incident report " This LN considers this</p> | F 226  |   |   |

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| F 226  | <p>Continued From page 6</p> <p>resident to be a danger to peers {other residents} on building 3. The facility conclusion read " Appears to be an isolated incident with small superficial scratches to both of Resident 2's lower cheek/jaw." Abuse was ruled out.</p> <p>7. On 12/21/12, a staff member heard Resident 4 calling " Help, help. " Upon entering the 3-resident bedroom, staff observed Resident 1 with his hands around Resident 4's neck. According to a staff witness statement, Resident 4 was being choked, " bleeding and yelling for help. " The two residents were separated and assessed by the LN. Resident 4 was found to have what " Appeared to be finger marks with the top layer of skin scratched, and to the right side of his neck and his jaw area were 5 abrasions". Resident 4's shirt was slightly torn and the resident kept saying " I help him and why would he do this ". Staff documented that Resident 4 " Appeared upset " and complained about his neck hurting.</p> <p>The conclusion to the facility's investigation revealed this attack was unprovoked and Resident 1 now had "a pattern of unprovoked similar incidents".</p> <p>The Police were notified of the incident. Resident 1 was transported to the hospital for a mental health evaluation. Both residents present in the room during the incident were upset by the incident and were monitored for psychological harm.</p> <p>It was not until 12/21/12, after Resident 1 was observed " Trying to choke a resident " {Resident 4} did the facility determine the resident</p> | F 226  |   |   |

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| F 226  | <p>Continued From page 7</p> <p>was a threat to others, and transferred the resident to the hospital for a mental health evaluation. The conclusion of the facility investigation of the incident read "As resident {Resident 1} has a pattern of unprovoked similar incidents, he was discharged to the hospital ER for mental health evaluation.</p> <p>Resident 1 was readmitted to the facility on [REDACTED]/12, after having his behavior medications readjusted. He was admitted to the same unit and same room as before he went to the hospital. He was placed on 15 minutes checks as before. At least 4 additional resident -to-resident incidents occurred during the 11 days after his readmission.</p> <p>8. On 12/31/12, Resident 1 was observed to raise his hand to slap Resident 2 across the face. Staff was able to verbally stop the resident.</p> <p>9. On 1/2/13, Staff passing by the TV room observed Resident 1 squeezing Resident 2' s face. Resident 1 immediately released his hold on the residents face when staff asked him to. The residents were separated. Resident 2 was found with a 0.3 cm by 0.5 cm scratch on the right side of his face.</p> <p>The facility concluded the incident was unprovoked and that the resident stated "sorry" when asked what happened. The facility Investigator documented, "not premeditated but simply a spontaneous incident of opportunity, although it was unwanted physical contact between residents." She continued, "It appears to be an isolated incident with a small superficial scratch". Supervision was not increased. Abuse</p> | F 226  |   |   |

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| F 226  | <p>Continued From page 8 and neglect were ruled out.</p> <p>On 1/3/13 the health care provider was notified of the incident on 1/2/13, and the resident began the [REDACTED], which had been recommended on 12/14/12 yet had not been started. The resident was started the Depakote on 1/3/13, 20 days after it was recommended by mental health.</p> <p>According to Licensed Staff (LN) A on 1/10/13, Resident 1's behavior over the last month made it difficult to know when to give him medication. She stated one minute he was being good, then agitated and not easily redirected, then he was calm again. She stated his behavior was unpredictable and impulsive, " I saw no reason to give it after he was calm. " We try to "eyeball him often to be sure he and other residents are safe."</p> <p>On 01/10/13 at 11:15 a.m., Resident 1 was observed sitting in his wheelchair in the hallway. A female resident approached him and told him to get out of the hall. Resident 1 kept asking her what and she kept repeating herself. In less than 2 minutes a staff member came and removed the female resident form the area.</p> <p>On 1/10/13 at 1:45 p.m., a nursing assistant, Staff B stated resident seemed calmer since being [REDACTED]. She stated current interventions for the resident included, "We keep him in the hallway away from other people."</p> <p>When the Director of Nursing Services was asked on 1/10/13 what they were doing to protect Resident 2 from repeated aggression from</p> | F 226  |   |                      |

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| F 226  | <p>Continued From page 9</p> <p>Resident 1, she stated staff was trying to keep the two residents out of the TV/dining room area at the same time. When asked if that intervention had been effective? She stated, " No, but I don't think Resident 1 means to hurt him; we are keeping both of their fingernails trimmed and he is on 15 minute checks. We are not able to provide 1-to-1 supervision."</p> <p>10. On 1/9/13, Resident 2 grabbed Resident 1's arm in the hallway. No injury resulted.</p> <p>12. On 1/11/13, Resident 1 grabbed the back of Resident 2's head in the hallway. No injury resulted. Resident 1 was moved from his room into the lounge in the same building.</p> <p>The facility investigated both of these incidents together. The facility's investigation concluded, "Some behaviors are related to Resident 1's condition with poor safety judgment and impulsivity related to moderate cognitive deficits, his diagnosis, his know and predictable interactions with his surroundings, or know sequence of proper events." Abuse and neglect were ruled out.</p> <p>On 1/14/13, the facility's behavioral management team met and decided Resident 1 should be moved to another building.</p> <p>In a telephone interview on 1/16/13, the facility investigator stated she considered anything that occurred once as an isolated incident. When asked how she determined that the repeat incidents between Resident 1 and Resident 2 were isolated, she stated that at first she had thought the residents were " just playful ". She</p> | F 226  |   |   |

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| F 226  | <p>Continued From page 10</p> <p>stated, as things continued, "I did not see the behavior as a pattern but thought the incidents were more a result of opportunity." She continued, "I felt they were not purposeful actions."</p> <p>A total of 11 resident to resident altercations occurred involving Resident 1 and 3 other residents who lived in his building. Four of these altercations occurred after Resident 1's emergency hospitalization for agitated behaviors from 12/21/12-12/31/12. The majority of the resident to resident physical altercations occurred between Residents 1 and 2. The facility did not look at these aggressive incidents of unwanted physical contact with injury as meeting the definition of abuse. On 12/14/12, mental health recommended a new medication to help control Resident 1's aggressive behavior. A period of 20 days (12/14/12-1/3/13) and an emergent hospitalization for aggressive behaviors passed before the recommendation was transcribed and initiated by the facility. Almost 3 months passed (11/20/12 - 1/14/13) until the facility realized Residents 1 and 2 should not be in the same building.</p> <p>On 1/17/13, Resident 1 was moved to another building.</p> <p>On 1/29/13, a return visit to the facility found no additional resident to resident incidents for Resident 1.</p> <p>On 2/6/13, from 8:15 a.m. to 9:30 a.m., facility staff were interviewed regarding what their responsibility was when they witnessed abuse. Ten employees were interviewed regarding</p> | F 226  |   |                      |

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| F 226  | Continued From page 11<br>abuse. They identified types of physical abuse to include: hitting, grabbing, slapping, squeezing or fighting. When asked who they reported abuse to, 5 of 10 employees ( P, F, O, K, N) stated they notified their supervisor or the designated facility investigator and did not immediately report to the Department as a mandated reporters.  | F 226   |   |   |
| F 309<br>SS=D  | <b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b><br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the facility failed to ensure a resident's medical orders were transcribed and implemented in a timely manner for 1 of 6 sampled residents (Res. 1). The failure to transcribe a recommendation from Mental Health Provider (MHP) and notify attending Physician in a timely manner, resulted in a 20 day delay in initiation of a new medication for Resident 1's behaviors and may have contributed to an emergent hospitalization for mental health evaluation.<br><br>Findings include but are not limited to:<br><br>Between 11/20/12 and 12/21/12 Resident 1 was involved in 7 resident-to-resident altercations. | F 309   | <b>F-309 Provide Care/Services for Highest will Being</b><br><br>This is an extremely isolated incident, the first time in 20 years, which was due to a medical complication of the transcriptionist. The normal turn around time on dictation from the Mental Health Provider is less than forty-eight (48) hours.<br><b>How the nursing home will correct the deficiency as it relates to the resident.</b><br>The medication as per recommended by the Mental Health Provider was ordered by the attending physician and initiated after the residents re-admission.<br><b>How the nursing home will protect residents in similar situation.</b><br>Any medication and/or medical recommendations by the Mental Health Provider will be faxed by the Director of Nursing or Supervisor of Nursing to the attending physician within a timely manner.<br><b>Measures the nursing home will take or systems it will alter to ensure that the problem does not recur.</b><br>A back-up transcription agency will be retained to ensure that a reoccurrence with a delay in receipt of transcription does not recur. | 2/27/13   |

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| F 309  | Continued From page 12<br>On 12/14/12 Resident 1 was seen by the MHP, who recommended the resident be started on a mood stabilizer medication, [REDACTED], three times a day, and for staff to increase the usage of the resident's as needed [REDACTED] medication.<br><br>Resident 1's Health Care Provider was not notified of the MHP's recommendation for [REDACTED] until 1/2/13. That was not until after Resident 1 had several more altercations, was sent to the hospital for a mental health evaluation, was readmitted from the hospital, and was demonstrating continued aggressive behavior. The resident began receiving the [REDACTED] on 1/3/13.<br><br>When asked about the delay in starting the [REDACTED] as recommended by the MHP on 12/14/12, the DNS stated the delay was due to the facility transcriptionist being ill for at least a week, which delayed getting the documentation to send to the physician. By the time the transcriptionist came back, she stated the resident had been admitted to the hospital.<br><br>Resident 1 was readmitted to the facility on [REDACTED] 12 after having his behavior medications readjusted. A backup plan to ensure a similar delay in transcription of recommended changes in medications would not occur was not put in place by the facility. | F 309   | <b>How the nursing home plans to monitor it's performance.</b><br>Medical records will report to the Administrator any delays or potential delays with dictation so that other arrangements can be implemented to ensure that dictation will be completed in a timely manner.<br><b>Title of the person responsible to ensure correction.</b><br>Medical records will ensure that dictation is received in a timely manner.<br><br><b>F-490 Effective Administration /Resident well Being</b><br><br><b>How the nursing home will correct the deficiency as it relates to the resident.</b><br>The facility has developed a plan and policy to protect residents from patterns of abusive behavior in order to protect the residents from incidents of unwanted physical contact or injuries.<br><b>How the nursing home will protect residents in similar situations.</b><br>The facility has implemented policy changes and has implemented a tracking system that will reflect patterns and trends of behavior. Incidents will continue to be investigated. Any repeat or reoccurring incident will be deemed as a pattern or trend and will be referred to the behavior management team for review. |   |
| F 490<br>SS=H  | 483.75 EFFECTIVE<br>ADMINISTRATION/RESIDENT WELL-BEING<br><br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial  | F 490   |   | 2/26/13   |

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| F 490  | <p>Continued From page 13 well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on observation, interview and record review, the facility's administration failed to ensure 4 of 6 residents sampled (1, 2, 4, 5), attained their highest practicable level of well-being. Staff failed identify resident to resident altercations as a pattern of abusive behavior, which resulted in residents not being protected from further incidents of unwanted physical contact with injuries.</p> <p>Findings include:</p> <p>Facility administration failed to develop and implement an immediate plan to prevent and protect residents from further unwanted physical contact. There was no documented evidence the facility had identified the behaviors as a pattern which required interventions for protection.</p> <p>Facility employees failed to follow their procedure regarding "Mandated Reporting of Abuse/Neglect". Staff failed to identify and immediately report suspected abuse to the Department.</p> <p>Refer to CFR 483.13(c) , F226- Develop/Implement Abuse/Neglect policies</p> | F 490  | <p><b>Measures the nursing home will take or systems it will alter to ensure that the problem does not recur.</b></p> <p>The incident/trend tracking system will identify a repeat incident so that it can be referred to the behavior management team for review and development of corrective plan of care, which may include mental health intervention, medication review and/or room change.</p> <p>A mandatory staff meeting will be held on 02/26/13 to review policy changes, tracking system and each individual's role as a mandated reporter. The mandated reporter and the facility incident investigator will report any abusive incidents to the Complaint Resolution Unit (CRU).</p> <p><b>How the nursing home plans to monitor it's performance.</b></p> <p>Facility incident investigator will report all abusive incidents with special notification of any incidents that reflect patterns or trends to the Administrator and the Director if Nursing as well as the Quality Assurance Committee.</p> |   |
| F 496<br>SS=F  | <p>483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING</p> <p>Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation</p>  | F 496  |   |   |

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| F 496 | <p>Continued From page 14</p> <p>requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.</p> <p>Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.</p> <p>If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Based on interview and record review the facility failed to verify the OBRA Registry had been completed and/or updated for 7 of 7 employees (Staff D, E, F, G, H, I, M) . Failure to identify nursing assistance eligibility to care for vulnerable adults placed residents at risk for possible abuse, neglect or misappropriation of property.</p> | F 496 | <p><b>F-496 Nurse Aide Registry Verification Retraining</b></p> <p><b>Measures the nursing home will take or systems it will alter to ensure that the problem does not recur</b></p> <p>Facility has routinely checked the OBRA registry upon hire for a nursing assistants eligibility to care for vulnerable adults. An OBRA check of all current nursing assistant is being completed by the facility scheduler. Facility will now continue to check the OBRA registry upon hire and annually on the individual's anniversary date.</p> <p><b>How the nursing home plans to monitor its performance</b></p> <p>Staff development will monitor the scheduling coordinators on-going checks of OBRA status of all new hires and current nursing assistant staff annually.</p> | 2/22/13 |
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| F 496  | Continued From page 15<br>Findings include:<br><br>A review of 6 Nursing Assistant Certified (NAC) employee records was done on 2/06/2013. The hire dates ranged from February 2007 through May 2011. Staff D, E, G, H, I, and M, who were still working at the facility, were not found on the NA registry. The NA registry for Staff F, an NAC, had expired on 5/06/2009.<br><br>The facility's abuse and neglect policy and procedure for screening of "NAC's and NAR's" (Nursing Assistant Registered) stated the applicants would be screened using the OBRA registry.<br><br>An interview on 2/06/13 at 3:00 p.m. with Staff L verified that she only contacted the OBRA registry upon hire.       | F 496   | <b>Title of the person responsible to ensure correction</b><br>Staff Development coordinator will ensure correction. Any problems will be reported to the Quality Assurance Committee. |   |
| F 497<br>SS=F  | 483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE<br><br>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. | F 497   |  |   |

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Continued From page 16  
This REQUIREMENT is not met as evidenced by:  
Based on interview and record review, the facility failed to perform competency skill reviews for nursing assistants and to provide in-service education for 44 of 57 nursing assistants. These failures placed the residents at risk for not having their care needs appropriately met.

Findings include:

On 2/6/13, the NACs' "Employee Evaluation Records" were reviewed for 8 of 8 NACs (D, E, F, G, H, I, M, & Q), who had worked at the facility for one to six years. There was no documented evidence that the competency of their skills had been evaluated.

The Assistant Director of Nursing and the Restorative Nurse stated there was no tool used for evaluating the skills for yearly NAC performance evaluations. They stated that when an evaluator placed a check next to "performs routine tasks" on the NAC's evaluation, that meant the NAC's skills had been verified.

Review of the facility's "Nursing Assistants" job description, dated 5/89, outlined the performance requirements of their job duties. The job responsibilities included that the nursing assistants were to attend in-service educational as a part of their regular assignment of duty.

Review of the in-service records for 2012 found only two recorded in-services. One on 11/20/12 covered Abuse and Neglect, Mandatory Reporting and Infection Control. The second in-service was on 12/6/12, covered fire safety, disaster

F 497

**F-497 Nurse Aide performance Review**  
**12 hour/year inservice**  
**Measures the nursing home will take or systems it will alter to ensure that the problem does not recur.**  
Staff development will implement monthly inservices for nursing assistants to ensure the continuing competence of the nursing assistants and to meet the 12 hour educational per year inservice requirement. These educational inservices will address any special needs of the facility population as well as competency skill reviews and informational updates as they relate to the safety and functioning of the facility. Annual performance reviews will continue to be completed but will be altered to more specifically address an individual's performance and competence.  
**How the nursing home plans to monitor its performance.**  
Staff development coordinator will monitor all monthly educational inservices and will maintain an on-going educational log for each nursing assistant.  
**Title of the person to ensure correction**  
Staff development coordinator will ensure correction and will report any problems to the Quality Assurance Committee.

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| F 497  | Continued From page 17 preparedness and residents' rights.<br><br>Review of the facility's in-service book revealed there was no documentation regarding the required 12 hours of annual in-service training for nursing assistants. | F 497   |   |                      |   |

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