

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

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

588

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505217	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/27/2013	
NAME OF PROVIDER OR SUPPLIER STAFFORD HEALTHCARE AT RIDGEMONT		STREET ADDRESS, CITY, STATE, ZIP CODE 2051 POTTERY AVENUE PORT ORCHARD, WA 98366		
(X4) ID PREFIX TAG F 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS This report is the result of an unannounced Abbreviated Standard Survey conducted onsite at Stafford Healthcare At Ridgemo on 8/26 & 8/27/2013. The sample included 9 current residents out of a census of 92. The following are complaints investigated as part of this survey: #2867396 #2860748 #2862257 #2861980 The survey was conducted by: [REDACTED], RN, MN The surveyor is from: Department of Social and Health Services Aging and Long-Term Support Administration Division of Residential Care Services District 3, Unit B 1949 S. State Street Tacoma, WA 98405-2850 Telephone: (253) 983-3800 Fax: (253) 589-7240 <i>Annette Crawford</i> 8/29/13 Signature Date	ID PREFIX TAG F 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby denied. The submission of the Plan does not constitute agreement by the facility that surveyor's findings constitute deficiency or that scope or severity regarding any of the deficiencies cited are correctly applied.	(X6) COMPLETION DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Annette Crawford ADMINISTRATOR TITLE
9.18.13 (X6) DATE

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 interview and record review, it was determined that the facility failed to prevent further potential abuse when the facility did not implement their own policy by not immediately removing the suspected staff from resident care during the investigation and failed to conduct a thorough investigation for 1 of 4 Sampled Residents (Resident #2) reviewed for abuse and neglect. This failure placed residents at risk for abuse.</p> <p>Findings include:</p> <p>Resident #2 was admitted to the facility on [REDACTED]/13 with multiple diagnoses to include [REDACTED] the resident's care plan dated 8/22/13 documented the resident required extensive assist for dressing, grooming and hygiene.</p> <p>Review of the facility's undated "abuse prohibition policy" documented, in part, the following:</p> <p>1) In the event of physical abuse, or suspected abuse, the licensed nurse will take immediate action to remove the suspected individual from resident care areas 2) The nurse will interview the victim and other staff and residents in the vicinity and obtain</p>	F 226	<p>Facility will continue to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>On the evening of 8/20/13, the nursing assistant, staff B, self reported to his charge nurse when resident #2 was refusing care from him. The nurse assisted the nursing assistant in caring for resident #2 at that time and resident did not make any negative statements about Staff B during the nurse's interview with resident. Later at the end of the shift, when resident made statement to female nursing assistant regarding Staff B, the licensed nurse assessed the situation and removed staff B as care giver. Since it was at the end of the shift, and the nurse did not suspect abuse, the nurse did not send staff B home and he worked for 20 additional minutes on a different unit. Staff B is an on call employee.</p>		

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F 226	<p>Continued From page 2</p> <p>statements either verbally or in writing</p> <p>3) Staff will take immediate action to protect resident safety and expedite the subsequent investigation. The alleged staff person will be suspended and asked to leave the facility pending an investigation.</p> <p>On 8/26/13 at 2:15 p.m., during an interview, Resident #2 was asked if she felt safe in the facility. Resident #2 stated she does not feel safe when the Nursing Assistant (Staff B) is in the building. Resident #2 stated Staff B made sexual inappropriate comments to her and she did not like it when he was in the building.</p> <p>Review of the daily staffing schedule revealed Staff B had not been scheduled to work in the facility since the allegation had been made.</p> <p>Review of the facility's "resident incident report" dated 8/20/13 revealed Resident #2 reported (Staff B) made sexual inappropriate comments. The incident report revealed Resident #2 reported the incident to Nursing Assistant (Staff D), who reported the incident to the Licensed Nurse (Staff C). According to Staff C's written statement, Staff C asked Staff D to take over Resident #2's care.</p> <p>On 8/27/13 at 2:35 p.m., during an interview, Staff D stated Resident #2 reported the incident at 10:00 p.m. Staff D stated when the resident reported the allegation of sexual inappropriate comments, she immediately reported the incident to the Licensed Nurse (Staff C). Staff D stated she was told to take over Residents #2's care. Staff D stated, Staff B continued to work with his other assigned residents until the end of their shift, which ended at 10:30 p.m.</p>	F 226	<p>Nursing management did not suspend the on call employee in writing, as it was determined that facility would not call him to return to work until the investigation was completed. Facility self reported this incident according to DSHS Nursing Home Guidelines. The next day, 8/21/13, Resident #2 denied making any allegations about Staff B and has continued to refuse care from female caregivers as well as male caregivers due to confusion and agitation.</p> <p>Staff B or any other male nursing assistant has not cared for resident #2 since her allegation on 8/20/13.</p> <p>Other residents that were cared for by Staff B were interviewed on 8/26/13 with no complaints voiced. An audit was completed to review all past incident investigations for 2013 to assure resident interviews were completed when appropriate, with 100% compliance found.</p>	

