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

729

PRINTED: 05/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	505254		05/22/2013

NAME OF PROVIDER OR SUPPLIER
ROO-LAN HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1505 SOUTHEAST CARPENTER ROAD
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	INITIAL COMMENTS This report is the result of an unannounced Quality Indicator survey conducted at Roo-Lan Healthcare Center on 5/16/13, 5/17/13, 5/20/13, 05/21/13, and 5/22/13. A sample of 35 residents was selected from a census of 91. The sample included 31 current residents and the records of 4 former and/or discharged residents. The following complaint was investigated as part of this survey: #2789307 The survey was conducted by: [redacted] RN, BSN [redacted], MSW [redacted], BSS [redacted] RN, BSN 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 Joan Price 5-24-13 Residential Care Services Date	F 000	The submission of this plan of correction does not constitute admission by the provider of any fact or conclusion set forth in the statement of deficiency. This plan of correction is being submitted because it is required by law. Please accept this submission of the plan of correction as our allegation of substantial compliance effective, July 8, 2013 The submission of this plan of correction does not constitute admission by the provider of any fact or conclusion set forth in the statement of deficiency. This plan of correction is being submitted because it is required by law. Please accept this submission of the plan of correction as our allegation of substantial compliance effective, July 8, 2013 RECEIVED JUN 07 2013 DSHS/ADSA/RCS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 6/5/2013

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 000	Continued From page 1	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: The facility failed to develop an accurate and complete care plan for 1 of 10 (#4) residents reviewed for behaviors. This deficiency placed residents at risk not receiving necessary care and services. Findings Include: Resident #4 was admitted to the facility on [redacted]/12 with diagnoses of [redacted] and	F 279	**Correction as it relates to the resident:** New behavior intervention sheets were added to care plan. Hoyer lift is now used for transfers and this has decreased behaviors. **Action taken to protect residents in similar situations:** Monitor behavior interventions quarterly and as needed. **Measures taken or systems altered to ensure the problem does not recur:** Monitor MDS coding for behavior and interventions to correlate on an as needed basis and quarterly. **Plans to monitor performance to ensure solution is sustained:** Quarterly reviews and as needed in coordination with weekly meetings. **Date corrective action completed:** July 8, 2013 **Title of person responsible for correction:** Administrator and Director of Nursing	

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F 279	Continued From page 2 [redacted]. The resident's Minimum Data Set (MDS), an assessment tool, dated 03/03/13 indicated the resident required two person assistance for Activities of Daily Living and was able to make needs and wants known. The resident's 90 day assessment indicated daily behavior of physical behavioral symptoms directed toward others. Upon record review, it was determined that the facility failed to include interventions on the resident's care plan for the behaviors indicated on the 03/03/13 MDS assessment. On 05/20/13 at 1:02 p.m., Licensed Nurse (LN) A stated, "the resident gets scared during transfers and grabs at staff." On 05/20/13 at 3:10 p.m., Nursing Assistant (NA) A stated, "she gets a little scared sometimes during transfers." On 5/21/13 at 9:55 a.m. LN B stated Resident #4 can be grabby and fearful during transfers but during one on one communication she is not combative. At 10:25 a.m., LN C was asked to describe the behavioral concerns identified on the resident's MDS. LN C stated the resident was fearful during transfers and was grabby toward staff. At 10:40 a.m., the Director of Nursing Services (DNS) was asked about changes on the MDS and how those changes would be reflected in an updated care plan, the DNS stated the Social Services Director (SSD) helps with the behavioral care plan.	F 279		

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F 279	Continued From page 3 On 5/21/13 at 11:15 a.m., the SSD stated, "we all talk about it. I usually do the typing. To be honest, I missed this one."	F 279		
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure vision care was provided for 1 of 3 (#4) residents sampled for vision. This failure placed the resident at risk for a diminished quality of life. Findings Include: Resident #4 was admitted to the facility on [redacted]/12 with the diagnoses of [redacted] and [redacted]. The resident's Minimum Data Set (MDS), an assessment tool, dated 03/03/13 indicated the resident required two person assistance for Activities of Daily Living and was visually impaired.	F 313	**Correction as it relates to the resident:** Have requested MD referral for eye appointment **Action taken to protect residents in similar situations:** Assess vision of residents upon admission, quarterly reviews with the MDS, and on an as needed basis. **Measures taken or systems altered to ensure the problem does not recur:** Through quarterly MDS review of residents vision address residents and family requests for vision care. **Plans to monitor performance to ensure solution is sustained:** Through quarterly MDS review, weekly meetings, and as needed basis. **Date corrective action completed:** July 8, 2013 **Title of person responsible for correction:** Administrator and Director of Nursing	

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F 313	Continued From page 4 The resident's admission Nursing Assessment dated 11/26/12 documented the resident had broken glasses. The resident's vision and communication care plan documented the resident had broken glasses and the most recent eye appointment had been approximately four (4) years prior. On 05/20/13 at 12:55 p.m., when asked if Resident #4 had glasses, Licensed Nurse (LN) A stated the resident had not been to an eye appointment. LN A stated she thought the resident's glasses were reading glasses." At 1:35p.m., the resident's family member stated, "Her last glasses were broken. If she is eligible for an eye appointment I would like her to have one." At 1:30 p.m., the Director of Nursing (DNS) stated, "When a resident is admitted, we conduct an initial assessment and review quarterly. If glasses break or the family and/or resident requests an appointment, we will make arrangements for one." At 3:05 p.m., Resident #4 was asked about her broken glasses. She stated she would like new glasses.	F 313		