

02/04/2012 - TFCU/Umbrella/CLIA/Comp

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

749

PRINTED: 02/01/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/29/2013
--------------------------------------------------	------------------------------------------------------------------	------------------------------------------------------------------	---------------------------------------------------

NAME OF PROVIDER OR SUPPLIER WOODLAND CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 310 FOURTH STREET WOODLAND, WA 98674
------------------------------------------------------------------	----------------------------------------------------------------------------------

(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)	DATE OF COMPLETION
--------------------	------------------------------------------------------------------------------------------------------------------------	---------------	-----------------------------------------------------------------------------------------------------------------	--------------------

F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Woodland Convalescent Center on 01/29/2013. A sample of 6 residents was selected from a census of 48. The sample included 5 current residents and the record of 1 former and/or discharged resident.</p> <p>The following complaints were investigated:</p> <p>#2739548 #2742608 #2746685</p> <p>The survey was conducted by: [REDACTED] RN, MS</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, District 3, Unit D 5411 East Mill Plain Blvd., Suite 203 Vancouver, WA 98661</p> <p>Telephone: 360-397-9550 Fax: 360-992-7969</p> <p><i>Daniel Jones</i> 2/1/13 Residential Care Services Date</p>	F 000		
-------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------	--	--

RECEIVED
FEB 19 2013
DSHS/ADSA/RCS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Chad Clay</i>	TITLE Administrator	(X6) DATE 2-12-13
-------------------------------------------------------------------------------------------	------------------------	----------------------

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: 02/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/29/2013
NAME OF PROVIDER OR SUPPLIER WOODLAND CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 FOURTH STREET WOODLAND, WA 98674		
(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 250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide medically-related social services for 1 of 6 (#2) residents when they failed to identify and pursue supportive options for a resident that had been allegedly treated roughly by staff. This failure placed the resident at risk for possible undue anxiety, fear or other psychosocial concerns.</p> <p>Findings include:</p> <p>Resident #2 was admitted to the facility on [REDACTED]/07 with diagnoses to include [REDACTED] and [REDACTED]. According to the Minimum Data Set (MDS), an assessment tool, dated 12/18/2012, the Resident was easily annoyed, had trouble concentrating and had physical behaviors of hitting, kicking, pushing and grabbing. The Resident was dependent on staff for activities of daily living (ADL) care. Two caregivers were expected to provide care because the Resident was known to have resistive behaviors. The Resident was rarely or never able to be understood and was non-interviewable.</p> <p>On 01/24/2013, according to facility documents,</p>	F 250	<p>FACILITY REPORTED INCIDENT FOLLOW-UP PLAN OF CORRECTION</p> <p>Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.</p> <p>F 250 CFR 483.15(G)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE, SS=D</p> <p>Woodland Convalescent Center recognizes the importance of providing all residents with the necessary medically related services to support with managing their everyday physical, mental, and psychosocial needs. These services are provided primarily by social service staff, but nursing and administrative staff also support residents with these services as needed.</p> <p><i>Cont.</i></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/29/2013
NAME OF PROVIDER OR SUPPLIER WOODLAND CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 FOURTH STREET WOODLAND, WA 98674		
(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 250	<p>Continued From page 2</p> <p>the Director of Nursing received an employee allegation that another employee had been rough in the provision of care for Resident #2 during the previous day. An investigation was initiated, statements were obtained, additional residents were interviewed. Appropriate logging, reporting, notification and employee discipline was completed.</p> <p>Facility staff did not address the possible impact of rough handling upon the resident.</p> <p>On 01/24/2013, a nursing note was written in Resident #2's chart stating "Incident reported of rough handling with care. All parties have been notified and all precautions are in place at this time. See incident report for complete information."</p> <p>On 01/29/2013 at 01:00 p.m., no additional information was found regarding the alleged rough treatment of Resident #2.</p> <p>At 01:50 p.m., Licensed Nurse (LN) B stated "Typically we would place a resident on alert after an incident. Our process with all incidents is to put the resident on alert. Social Services should have been part of the process. We should have placed the Resident on our 24 hour report and on alert charting for at least 72 hours to monitor the Resident's well-being. I don't know how we missed charting on the Resident {#2} after this incident was reported."</p> <p>At 03:05 p.m., the Social Services Director (SSD) stated "Any time there is a resident incident, they usually have me interview the resident about if they feel safe or if they are frightened. I was not</p>	F 250	<p>AFFECTED RESIDENT- The resident directly involved in this incident was immediately assessed by the Director of Nursing as well as the Charge Nurse. The assessment conducted was both for physical injury and psychological distress. Although the resident did not initially exhibit symptoms of distress during the examination, the Director of Nursing interviewed caregivers assigned in the last couple of weeks to assess changes in the mental and physical well-fare of the resident and to investigate more detail about the employee involved in the incident. The facility's normal process would be to initiate a 48 to 72 hour alert documentation. (Nursing assessment of specified resident condition(s) that could indicate a worsening physical, medical, or mental condition). Administrative and Nurse Management Staff have completed a thorough process of interviewing various staff members to be able to conclude there has been no change in the affected resident's mood or behaviors that could be brought on by mental anguish or psychological harm.</p> <p>AFFECTED RESIDENTS- During the initial stage of incident investigation management's focus was to identify if any other resident(s) of similar nature (non-interviewable residents) were affected by the unacceptable care technique of the terminated employee. There were no negative findings. Nursing has conducted a second phase investigation involving expanded resident interviews to identify any other possibly affected residents. Conclusive findings did not detect any harm, physical or mental. (Second phase interviews completed 2/1/13).</p> <p>CONT.</p>		

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

PRINTED: 02/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/29/2013
NAME OF PROVIDER OR SUPPLIER WOODLAND CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 310 FOURTH STREET WOODLAND, WA 98674	
(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 250	Continued From page 3 informed of {the above referenced} incident. I found out yesterday morning. I was not asked to see the Resident." When asked how she would monitor someone that was unable to communicate verbally, the SSD stated "I would monitor psychosocial well-being by evaluating the resident's actions and behaviors. I would check to see if there was increased moodiness, crying, hitting, anger, isolation or behaviors with staff members. I was not at work when this incident happened. We really don't have anyone to cover for me when I am out of the facility."	F 250	SYSTEMIC CHANGES- The facility's current policy supports the criteria established by this regulation. A check-off tool will be added to the facility's current incident/occurrence process as an additional step to insure all pertinent actions are taken to document assignment and completion timeframe of each step of the investigation process. Regardless of the incident, the employee who initiates the incident report will be responsible for assignment of staff members for completion of all investigation, documentation, and notification steps. This tool will be reviewed in the daily interdisciplinary morning report as part of the quality assurance process. QUALITY ASSURANCE MONITORING- The Quality Assurance Team will audit, review and revise as necessary, policies/procedures to ensure acceptable thresholds are met on an on-going basis. <i>Plan of Correction date: 2/12/2013</i> <i>Correction Assurance Manager:</i> Candy Hayes, Administrator	