

05/06/14 - MFCC/Onbed 'CS

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

PRINTED: 05/06/2014
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 04/30/2014
--	--	--	---

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 000

INITIAL COMMENTS

This report is the result of an unannounced Abbreviated Survey conducted at Woodland Convalescent Center on 04/30/2014. A sample of 7 current residents was selected from a census of 57.

The following complaints were investigated:

#2995881
#2997507

The survey was conducted by:

Rebecca Christiansen, RN, MS

The survey team is from:

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

Telephone: 360-397-9550
Fax: 360-992-7969

[Signature]
Residential Care Services Date

F 000

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.

RECEIVED
MAY 19 2014
DSHS/ADSA/RCS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 5-15-14
---	------------------------	----------------------

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: 05/06/2014
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 04/30/2014	
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 242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to honor resident choice for 1 of 7 residents (#4) regarding the resident's preference for a bath instead of a shower. This failure caused the resident to not have preferences honored.</p> <p>Findings include:</p> <p>Resident #4 was admitted to the facility on [REDACTED] with diagnoses to include [REDACTED]</p> <p>According to the Minimum Data Set (MDS) dated [REDACTED] the resident was alert and oriented and was dependent on staff for activities of daily living. The resident was not able to walk.</p> <p>On [REDACTED] at the time of admission, an "Initial Social Service History" form was completed by the Social Services Director (SSD). One of the questions on the form asked about bathing preferences. The resident response to the question was "I like to get in the bathtub. Shower is O.K., but I haven't taken a bath in a long time."</p>	F 242	<p>F-242</p> <p>For the specific resident in question she has had a bath attempted but due to her large frame and fear of the tub a notation has been made, care plan adjusted and she will receive showers per care plan.</p> <p>For all other residents- Social Service will comply with the P&P on Care which states that all residents will be assessed for choices of personal care on or before day 14, quarterly and with any significant changes in condition. This information will be incorporated into the care plan.</p> <p>Social Services Director will ensure corrective action is met.</p>	5/16/14

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 04/30/2014
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 242	Continued From page 2 The resident's plan of care did not address the resident preference for bathing. On 04/30/14 at 01:30 p.m., Nursing Assistant (NA) A stated "We have a bathtub, but I have only seen {Resident #4} take showers. I have never seen her in the bathtub." At 01:45 p.m., Resident #4 stated "I would give anything to be able to take a bath, I always feel cleaner when I can get into the bathtub instead of taking a shower. I didn't know they had a bathtub here. No one has offered to get me into the bathtub."	F 242			
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide medically related social services to attain the highest practicable physical, mental and psychosocial well-being for each resident for 2 of 7 residents (#s 1 & 4) when they failed to expedite discharge planning and when they failed to ensure a properly fitting wheelchair. These failures placed the residents at risk on not reaching their highest level of functioning.	F 250	F-250 For Resident #1- Discharge planning is in progress with 5/6 AFH refusing to take this resident. The 3 rd most likely will be able to admit her after her Medicaid assessment is completed. If, for any reason this placement does not succeed the facility will continue to and in an expeditious manner, locate alternate placement for her according to her choices and desires. For Resident #4-The wheelchair that had been ordered was obtained May 1.	5/16/14	

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 04/30/2014
--	---	--	---

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 3</p> <p>Findings include:</p> <p>1) Resident #1 was admitted to the facility on [REDACTED] with diagnoses to include [REDACTED]</p> <p>According to the Minimum Data Set (MDS), an assessment instrument, the resident was alert, but had memory problems, impulse control problems and difficulty in coping. These problems were primarily related to the resident's [REDACTED]. The resident required supervision with activities of daily living. The resident was substantially younger than most of the other residents of the facility by at least 20 or more years.</p> <p>On 01/07/2014, the admission MDS reflected the discharge plan was : "Expects to be discharged to the community."</p> <p>Active discharge planning efforts were not apparent in the medical record for the next several months time period.</p> <p>On 04/21/2014, according to a progress note, the staff "called guardian about looking at other placement for {the resident} due to the resident wants to be closer to the sister."</p> <p>On 04/30/2014 at 01:30 p.m., Licensed Nurses (LNs) A and B stated "The resident {#1} reports every day that another resident {#7} is calling her names and running over her with a walker. Every day at breakfast, lunch and dinner we are getting reports of this. We know it hasn't happened because we monitor both residents and both residents have been observed during the times of</p>	F 250	<p>For all other residents with similar needs, if adaptive equipment cannot be obtained by the normal channels within an appropriate time frame, the facility will consider use of its own equipment and/or use of rental equipment in accordance with therapy recommendations and interdisciplinary team review. Evaluation for needs will be completed according to care planning guidelines as mentioned above by social services director.</p> <p>Note: Resident #1 referred to on page 6 of 9 should be resident #4, as per indicated information.</p>	
-------	--	-------	---	--

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

PRINTED: 05/06/2014
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 04/30/2014	
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 4</p> <p>the alleged incident. I am pretty sure the event happened once, but it hasn't happened recently."</p> <p>At 01:50 p.m., resident #1 stated "I have a problem with one of the other residents here. She calls me names and runs over my feet with a walker. The staff tell me I just have to adjust to it. The problem happens 2-3 times a day. I think the real problem is I am too young to be here. This is not the right place for me. I want to be closer to my family and I feel upset over the situation here. I don't think anyone is taking me seriously."</p> <p>At 02:10 p.m., when asked about the resident conflict and about discharge planning, the Social Services Director (SSD) stated "The incident happened awhile ago, maybe in February. I have tried to meet with {resident #1} to see how she is doing. The best we can determine is, {resident #1} is not able to move past the incident. She was very happy here initially, but she is a good candidate to be with younger residents, like maybe an adult family home. The guardian is looking for placement."</p> <p>2) Resident #4 was admitted to the facility on [REDACTED] with diagnoses to include [REDACTED]</p> <p>According to the Minimum Data Set (MDS) dated [REDACTED] the resident was alert and oriented.. She was dependent on staff for activities of daily living and was confined to a wheelchair [REDACTED]</p> <p>On 09/12/13, an Occupational Therapy evaluation</p>	F 250		

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

PRINTED: 05/19/2014
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 04/30/2014
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 5</p> <p>noted the resident's chair was not a correct fit for the resident and would initiate the process of obtaining a new wheelchair. It was also noted the resident refused to try a larger wheelchair or a tilt wheelchair and refused to get up unless in her own wheelchair.</p> <p>On 02/07/2014, a SSD note reflected {resident #4's prior facility} "Called to report the resident's electric wheelchair was there at the facility, and resident was attempting to locate. Will report to family and therapies to see if resident can have electric wheel chair in the facility."</p> <p>On 03/14/14, during a care conference, the need for a new chair was discussed and noted the facility was "Working to try and get approved through the state for a new chair. Therapy felt electric chair not safe."</p> <p>On 04/30/2014 at 10:05 a.m., the resident was observed to be sitting in a wheelchair that appeared too small for her body size. The sides of her legs fit tightly against armed sides of the wheelchair. The leg rests were not able to be elevated and the resident's left leg was visibly swollen and dangling in a dependent position.</p> <p>At 01:50 p.m., the resident stated "This wheelchair is too small for me, I have an electric wheelchair {at the other facility} but I have no way to get it here. It fits me better and I would have a lot more mobility if I could get around by myself. Plus this chair does not have leg rests that lift up and my foot swells, unless I am in bed or in the recliner chair in my room.</p> <p>At 02:10 p.m., the SSD stated {Resident #4} does have a power chair in the other facility. We didn't</p>	F 250			

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 04/30/2014
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 6 have any way to get the chair here. Therapy didn't know if the resident would be safe in the power chair. If she had a power chair, then the manual process would stop. It appeared the facility ignored the resident's electric wheelchair and did not again re-visit offering the resident other options for a chair that would fit, during the process of insurance approval for the new chair.	F 250		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to 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 when they failed to monitor and address the weight and disease process for 1 of 7 residents (#6). This failure caused the resident to experience a delay in intervention when the resident experienced a substantial weight gain.	F 309	F-309 For specific resident in question the MD has been made aware of weight gain and ongoing weight fluctuations with orders ongoing. For all other residents the Weight Policy has been reviewed with the interdisciplinary team and will be followed. Weight changes will be monitored and reported to the MD per policy, state and federal guidelines as they relate to weight changes and MD notifications. Director of nurses will ensure compliance is met.	5/16/14

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 04/30/2014
--	---	--	---

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 309	<p>Continued From page 7</p> <p>Findings include:</p> <p>Resident #6 was admitted to the facility on [REDACTED] with diagnoses to include [REDACTED]</p> <p>According to physician orders written on 01/15/2014, the resident was to be weighed daily. No guidelines were given to staff for when they should be concerned or when the physician should be notified.</p> <p>According to the American Heart Association, heart failure is a chronic condition, where the heart is not able to pump effectively enough to keep up with supplying the body's oxygen needs. Heart failure affects how the body can use salt and water. Sometimes fluid can back up in the patient's legs or lungs and can cause swelling or breathing problems. Sudden weight gain, swelling of the feet and legs, or a cough should be reported to the physician as these symptoms indicate a fluid build up. Medications, diet changes or position changes can be effective in helping the resident manage heart failure.</p> <p>According to the Minimum Data Set (MDS), an assessment instrument, the resident was alert and oriented with minor memory problems. The resident required extensive assistance with activities of daily living.</p> <p>According to the resident's "Weight sheet", between January 15, 2014 and April 26, 2014, (a total of 101 days), the resident was weighed on 43% of the days, leaving 57% of the days where weights were not completed.</p> <p>On 03/21/2014, the resident's weight was recorded as 240.1 pounds. The next recorded</p>	F 309		
-------	--	-------	--	--

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

PRINTED: 05/06/2014
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 04/30/2014
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 309	<p>Continued From page 8</p> <p>weight, taken on 03/26/2014 (5 days later) was 254 pounds, or a 13.9 pound increase in 5 days. The physician was not notified and a nursing assessment was not completed.</p> <p>On 03/31/2014, the resident's weight was recorded as 259 pounds, or an additional increase of 5 pounds in 4 days (now a total of 9.9 pounds in 10 days). The physician was not notified and a nursing assessment was not completed.</p> <p>On 04/04/2014, the resident's weight was recorded as 272 pounds, or an additional 13 pounds during a 4 day period of time, (a total of 31.9 pounds gained during 14 days). A nursing assessment stated "Blisters [REDACTED] with clear serous drainage noted bilateral (both) shins without strong odor."</p> <p>On 04/05/2014, the physician was contacted regarding the weight gain and orders were obtained to increase a medication to help the body get rid of additional fluid.</p> <p>On 04/30/2014 at 03:25 p.m., Licensed Nurse (LN) A stated "The nursing assistants or bath aides do the weights. They were recording the weights and the nurses were not aware of the weight changes. We discovered issues with the nursing assistants not reporting weight changes. We now have new forms where the person weighing the resident has to notify the licensed nurse if there has been a change of 3 pounds (gain or loss) or more since the last weight. We missed the weight increase for {resident #6} and that caused us to look at our system."</p>	F 309			