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

764

PRINTED: 02/14/2014
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
	505412		C 02/05/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLVILLE TRIBAL CONVALESCENT C	PO BOX 150 NESPELEM, WA 99155

(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 Colville Tribal Convalescent Center on 2/5/14. A sample of 3 residents was selected from a census of 22. The following complaints were investigated as part of this survey: #2951501 #2958407 The survey was conducted by: [redacted], R.N. The survey team is from: Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services, District 1, Unit A Rock Pointe Tower 316 W. Boone Avenue, Suite 170 Spokane, Washington 99201-2351 Phone: (509) 323-7327 Fax: (509) 329-3993 2/14/14 Residential Care Services Date	F 000	RECEIVED FEB 24 2014 DSHS ADSA RCS SPOKANE WA	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[redacted]	Nursing Home Administrator	2/21/2014

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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	**F 225**-Resident #1 has had his care plan reviewed and revised to include specific check and/or changes after breakfast, before lunch, and after lunch as well as every 2 hours following by his assigned NAC. Refusal of a check and/or change by Resident #1 for a NAC will be re-approached by another NAC or LS for a second try. The DON, Clara Carson had a staff meeting with all LS & NACs on 2/12/2014 to in-service them on NAC/LS work responsibilities. Random checks will be completed by DON to monitor that NACs are completing assigned care and that LS are making sure care is completed by NACs. Additional in-services for NAC/LS will be conducted as needed after random checks are completed by DON. The DON will ensure that all alleged violations involving mistreatment, neglect, or abuse, are reported properly and thoroughly investigated. DON will ensure correction by 2/21/2014.	

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F 225	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to recognize, thoroughly investigate, and report an allegation of neglect to the State as required by CFR 483.13(c)(1)(4) for 1 of 3 sample residents (#1). Findings include: Neglect is defined as an act or omission that demonstrates a serious disregard of consequences of such a magnitude as to constitute a clear and present danger to the vulnerable adult's health, welfare, or safety. Resident #1 had diagnoses that included [redacted] fracture and generalized [redacted]. Per the record, the resident required assistance with transfers, toileting, and repositioning. The resident was frequently incontinent of urine and was at high risk for skin breakdown. On 1/21/14, a licensed nurse left a note for the Director of Nursing indicating that anursing assistant failed to provide incontinent care to the resident, who was left in the same wet brief from 7:20 a.m. to 1:50 p.m. (6.5 hours). During an interview on 2/5/14 at 1:45 p.m. the Director of Nursing stated she received the note on 1/22/14 and looked into what she saw as, "Just a thing between staff." The nursing assistant involved was questioned about the incident, but no further investigation was conducted. The Director of Nursing stated she did not realize the lack of incontinent care constituted an incident of potential neglect and therefore did not thoroughly investigate or report the incident to the State as required. The facility's failure to identify, thoroughly investigate, and report an incident of alleged neglect placed residents at risk for actual neglect.	F 225		