

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

PRINTED: 03/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  03/01/2013
NAME OF PROVIDER OR SUPPLIER  WASHINGTON VETERAN HOME-RETSIL			STREET ADDRESS, CITY, STATE, ZIP CODE 1141 BEACH DRIVE RETSIL, WA 98378	
(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	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Washington Veterans Home-Retsil on 2/20/13, 2/21/13, 2/22/13, 2/25/13, 2/26/13, 2/27/13, 2/28/13 and 3/1/13. A sample of 42 residents was selected from a census of 230. The sample included 38 current residents and the records of 4 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>Jane Adams, RN, BSN, MSN Tara Hawks, RN, BSN Wanda Terry, RN, BSN Marilyn Edwards RN, MSN Sandy Mayes, RN, MSN</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Disability Services Administration Residential Care Services, District 3, Unit A 1949 South State Street, MS: N27-24 Tacoma, Washington, 98405-2850</p> <p>Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p> Signature</p> <p>3/6/13 Date</p>	F 000	<p>ADDENDUM TO PLAN OF CORRECTION</p> <p>Submission of the Response and Plan of Correction is not legal admission that a deficiency exists of that this Statement of Deficiency was correctly cited, and is also not to be construed as admission of interest against the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute and admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, the Facility has prepared and submitted this Plan of Correction solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the Plan of Correction within this timeframe should in no way be considered or construed as agreement with the allegations of non-compliance or admissions of the facility.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

 Administrator 03/20/2013

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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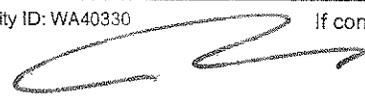
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F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review, it was determined that the facility failed to monitor 1 of 3 Sampled Residents (#57) reviewed for skin conditions and failed to maintain proper positioning for 2 of 3 Sampled Residents (#s 74 &amp; 172) reviewed for positioning out of the 42 sampled residents included in the Stage 2 review. This failure placed Resident #57 at potential risk for not receiving timely skin treatment if needed and placed Resident #74 and #172 at potential risk for a decline in skin condition.</p> <p>Findings include:</p> <p>RESIDENT #57 On 02/21/2013 09:24 a.m. Resident #57 had an abrasion on the right forearm measuring approximately two to three millimeters (mm). The resident stated his skin tears very easily.</p> <p>On 2/27/13 at 11:37 a.m. Resident #57 was observed to have multiple fading bruise like discolorations on both arms. No abrasions were noted. The resident reported he had taken a blood thinning medication in the past and stated</p>	F 309	<p>Resident #57—Skin assessed on 2/27/2013. Bruises documented on the non-ulcer evaluation form.</p> <p>Weekly skin checks to be completed and documented each week per facility process. DNS/ADNS to ensure compliance.</p>	<p>4-15-13</p>
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F 309	<p>Continued From page 2 that is why his arms look that way.</p> <p>Record review showed Resident #57 was re-admitted to the facility on [REDACTED] A Non-Ulcer Evaluation Form (WVH #595) dated 1/31/13 was used to document each skin condition and additional space on the form was to be used to monitor and document ongoing assessments made by staff of each skin condition. On 1/31/13, using multiple WVH #595 forms, the resident was assessed as having a 3.0 centimeter (cm) x 1.0 cm bruise on the right upper elbow; a skin tear measuring 1.0 cm x 0.05 cm on the right dorsal hand; multiple scattered bruises on the right arm; a 1.5 cm x 0.5 cm bruise on the right hand; a right wrist bruise measuring 2.0 cm x 1.0 cm; a right hand bruise measuring 4.0 cm x 2.0 cm; a left hand bruise measuring 2.0 cm x 2.0 cm. As of 2/27/13 at 12:24 p.m. no other assessments had been completed of Resident #57's non pressure ulcer skin conditions identified by staff when the resident was re-admitted on [REDACTED]</p> <p>On 2/27/13 at 12:24 p.m. review of the February 2013 medication administration record and February 2013 treatment records noted no ongoing assessments after [REDACTED] of the residents bruise like discolorations of both arms (non pressure ulcer skin conditions).</p> <p>Review of the facility's "Assessment-Skin Integrity Management" policy page 4 Section D "Weekly Skin Assessments:" Item b. "Non Ulcer Other Skin Conditions" item (i) directed the designated unit nurse to update the weekly "Non Ulcer Other Skin Condition Report" (WVH #595) to document any skin condition/issue other than a</p>	F 309			

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F 309	<p>Continued From page 3</p> <p>pressure ulcer; (ii) An RN reviews and assesses the Non Ulcer Other Skin Condition Report WVH #595 weekly and initials in the "Comments" area.</p> <p>On 2/27/13 at 12:24 p.m. Staff C, who participates in resident assessments, reviewed Resident #57's skin documentation and agreed there were no ongoing assessments of the resident's non pressure ulcer skin conditions after the initial assessment of the resident's skin conditions had been completed on [REDACTED] the day the resident was readmitted to the facility. Staff A reported it is expected that weekly skin assessments will be completed and documented.</p> <p>On 2/27/13 at 12:48 p.m. Staff D, who is in charge of Resident #57's care, reported it is expected skin checks are done weekly and documented.</p> <p><b>RESIDENT #74</b> Resident #74 is in a wheelchair and is dependent on staff for locomotion and all care needs. Resident #74 also had a specialized wheelchair that had the ability to recline into different positions for comfort and shifting pressure. Review of Resident #74's record revealed he had a history of [REDACTED]</p> <p>2/22/13 Observations on 2/22/13 at 8:40 a.m. revealed Resident #74 was in his wheelchair in front of the television. The wheelchair was positioned straight up. Observations the same day revealed Resident #74 was brought back to the unit after</p>	F 309	<p>LN's will be in-serviced on proper weekly documentation of skin issues by 4/15/2013. Charge Nurses or Neighborhood Coordinators will audit for compliance on an ongoing basis.</p> <p>Resident #74 and #172 were assessed for skin issues on 2/28/2013. No skin issues found. Residents #74 and #172 will continue to be repositioned every 2 hours with cares and PRN to maintain comfort and skin integrity. This facility continues to follow care plan/NCD per process.</p> <p>DNS/ADNS to ensure compliance. All findings will be submitted to the QA Committee for review for 90 days.</p>	

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F 309	<p>Continued From page 4</p> <p>breakfast and placed in front of the television. Observations at 10:30 a.m. revealed Resident #74 was in front of the television in his wheelchair. During all observations the wheelchair remained in the same upright position.</p> <p>2/25/13 Observations on 2/25/13 at 9:30 a.m. revealed Resident #74 was sitting in front of the television with his wheelchair in an upright position. The volume to the television had been turned down and was not able to be heard by the surveyor. Observations at 10:25 a.m. revealed Resident #74 remained in front of the television. Resident #74 was turning his head observing staff and other resident in the hall. Continued observations on 2/25/13 at 11:20 a.m. revealed Resident #74 remained in front of the television with his wheelchair in the same position. At 11:45 a.m. Resident #74 was taken to the dining room where he remained in his wheelchair, in the same position, until he was returned to the unit at 1:20 p.m. At 1:20 p.m. Resident #74 was placed in front of the television in the same position, where he remained until staff assisted him to bed at 1:34 p.m. Throughout all observations on 2/25/13 Resident #74's wheelchair was in the same upright position.</p> <p>2/26/13 Observations on 2/26/13 at 9:05 a.m. revealed Resident #74 was taken out of the dining room and placed in front of the television with his chair in a straight upright position. Observations at 9:40 a.m., 10:00 a.m. and 11:00 a.m. revealed the resident remained with his wheelchair in the same spot and in the same position until 11:19</p>	F 309			

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F 309	<p>Continued From page 5</p> <p>a.m. when he was taken to the dining room for lunch.</p> <p>Continued observations revealed Resident #74 remained in the dining room until 12:50 p.m., at which time he was taken back to his wing and placed in front of the television; his chair remained in the same upright position. Resident #74 then remained in front of the television until 1:25 p.m., when he was taken to bed.</p> <p>2/27/13</p> <p>Observations on 2/27/13 at 7:35 a.m. revealed Resident #74 was sitting in the dining room with his chair upright, awaiting breakfast. Resident #74 was taken from the dining at 9:25 a.m. and placed in front of the television in the same position. At 10:00 a.m. Resident #74 was taken to an activity area where his wheelchair remained in the same position. At 10:45 a.m. Resident #74 was taken out of the activity and taken to the therapy room, where his chair remained in the same position. At 11:00 a.m. Resident #74 was taken out of the therapy room and placed in front of the television. There was no change in the resident's position in the chair throughout the morning.</p> <p>Resident #74 remained in front of the television until 11:30 a.m. when he was taken to the dining room where he sat in the same position while waiting for lunch, which was not served until after 12:00 noon. At 1:00 p.m. Resident #74 was taken from the dining room and placed in front of the television until staff returned him to bed. Throughout all observations the resident's chair remained upright.</p>	F 309			

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F 309	<p>Continued From page 6 2/28/13 Observations on 2/28/13 at 11:00 a.m. revealed Resident #74 was sitting in front of the television until he was taken to the dining room at 11:15 a.m. Resident #74 remained in the dining room until 12:45 p.m. when he was taken down the hall and placed in front of the television. Throughout all observations the resident 's chair was upright.</p> <p>During an interview on 2/28/13 at 12:45 p.m. Staff E confirmed residents who are at risk for skin breakdown should be repositioned every two hours.</p> <p>Failure to reposition Resident #74's specialized wheelchair placed him at potential risk for discomfort and possible skin breakdown.</p> <p>RESIDENT #172 Resident #172 is [REDACTED] uses a wheelchair, relied on staff for all movement and care, and had a history of [REDACTED]. The resident is not interviewable.</p> <p>Review of Resident #172's medical record revealed a Braden Skin Assessment dated [REDACTED] with a score of 11, indicating the resident is at high risk for developing a pressure ulcer.</p> <p>Review of Resident #172's care plan dated 2/8/13 confirmed the resident was at high risk for skin breakdown, and had interventions in place, including reposition the resident every 2 hours and lay down between meals.</p> <p>2/22/13 Observations on 2/22/13 at 8:40 a.m. revealed</p>	F 309		

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F 309	<p>Continued From page 7</p> <p>Resident #172 was asleep in her wheelchair in front of the television near the nurse's station. Observations at 10:30 a.m. revealed the resident remained in front of the television with her chair in an upright position. Observations after the lunch meal revealed Resident #172 was again in front of the television in the same position.</p> <p>2/25/13 Observations at 9:33 a.m. revealed Resident #172 sitting in front of the television with her wheelchair in the upright position. Further observations reveal the resident remained in the same position in front of the television on 10:25 a.m. and 11:20 a.m. At 11:45 a.m. Resident #172 was taken from the television to the dining room for lunch where she placed at a table with her chair in the same position.</p> <p>Resident #172 remained in the dining room until 1:00 p.m. when she was returned to her hall and placed in front of the television. Resident #172 remained in front of the television until 1:25 p.m., when staff assisted her to bed.</p> <p>Resident #172's wheelchair remained in the same upright position throughout the observations.</p> <p>2/26/13 Observation at 8:50 a.m. revealed Resident #172 in the dining room for breakfast. At 8:55 a.m. the resident was taken out of the dining room and placed in front of the television.</p> <p>Observations at 9:40 a.m. reveal Resident #172 remained in front of the television and was asleep. Observations at 10:00 a.m. revealed the</p>	F 309		

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F 309	<p>Continued From page 8</p> <p>resident in the same position in front of the television and remained asleep. At 11:15 a.m. Resident #172 was woken and given her medication while sitting in front of the television. At 11:50 a.m. Resident #172 was taken from the TV area to the dining room. At 12:40 p.m. Resident #172 was taken from the dining room and placed back in front of the television. Observations at 1:05 p.m. revealed Resident #172 in the same spot in front of the television.</p> <p>Further observations at 1:16 p.m. revealed Resident #172 was awake in front of the television when she was taken and placed in bed.</p> <p>Resident #172 was sitting upright in her chair throughout all observations.</p> <p>2/27/13</p> <p>Observations at 7:35 a.m. revealed Resident #172 sitting in her wheelchair in the dining room. At 8:00 a.m. the resident remained in the same position still awaiting her breakfast.</p> <p>At 8:49 a.m. facility staff took Resident #172 out of the dining room and placed her in front of the television where she remained in the same position in her chair.</p> <p>At 9:30 a.m. Resident #172 was taken from the television area to an activity room for a bible reading. Observations at 10:00 a.m. revealed Resident #172 was asleep in the activity room until 10:15 a.m. when she was returned to the unit and placed in front of the television.</p> <p>Observations at 11:00 a.m. revealed Resident #172 to be sitting in the same spot in front of the</p>	F 309			

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F 309	Continued From page 9 television until 11:30 a.m. when she was taken to the dining room for lunch. At this time the resident was still wearing her clothing protector she was given at breakfast. Resident #172 then remained in the dining room until 12:47 p.m., when she was taken back to the television. Resident #172 remained in front of the television until staff were done in the dining room and returned to put her to bed at 1:15 p.m.  Throughout all observations Resident #172 was sitting upright in her chair.  During an interview on 2/28/13 at 12:50 p.m. Staff E confirmed Resident #172 should be repositioned every two hours.  Failure to ensure Resident #172 had frequent changes in position placed her at potential risk for skin breakdown.	F 309			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329			

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F 329	Continued From page 10 as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by: Based on observation interview and record review, it was determined that the facility failed to monitor the effectiveness of hypnotic medications [REDACTED] a medication used to induce sleep) for 2 of 10 Sampled Residents (#s 69 & 90) reviewed for unnecessary medications out of the 42 sampled residents included in the Stage 2 review. Failure to monitor the effectiveness of this medication used for sleep placed both Resident #60 and Resident #90 at potential risk for receiving an unnecessary medication.  Findings include:  RESIDENT #69 On 2/25/13 at 9:32 a.m. Resident #69 was dressed neatly and seated in an overstuffed chair in his/her room. The resident reported feeling fine today.  Record review noted Resident #69 was admitted on [REDACTED] Review of the resident's admission physician orders noted an order for [REDACTED] mg to be given by mouth at hour of sleep.	F 329	Resident #69 and #90—Sleep monitor initiated on 2/25/2013 and completed. Residents on hypnotics – hours of sleep will be documented per facility process ongoing evaluation. LN's will be in-serviced on proper documentation of effectiveness of PRN medication on ongoing basis per facility process. DNS/ADNS to ensure compliance. All findings will be submitted to the QA Committee for review for 90 days.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505517	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  03/01/2013
NAME OF PROVIDER OR SUPPLIER  WASHINGTON VETERAN HOME-RETSIL		STREET ADDRESS, CITY, STATE, ZIP CODE 1141 BEACH DRIVE RETSIL, WA 98378		
(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 329	<p>Continued From page 11</p> <p>Review of Resident #69's medication administration record for [REDACTED] through [REDACTED] noted the resident was given [REDACTED] each night with no monitoring of the effectiveness of each dose given.</p> <p>Review of Resident #69's medication administration record for February 2013 noted the resident was given [REDACTED] nightly with no monitoring of the effectiveness of the medications.</p> <p>Review of Progress notes from 1/10/13 through 2/23/13 noted no monitoring the effectiveness of [REDACTED]</p> <p>On 3/1/13 at 7:57 a.m. Staff F, who is in charge of Resident #69's care, agreed the resident was getting [REDACTED] for sleep with no monitoring of the effectiveness of the medication. Staff F reported staff are now documenting hours the resident sleeps with each dose of [REDACTED]</p> <p>Resident #90 On 2/27/13 at 8:52 a.m. Resident #90 reported sometimes needing to take a sleeping medication to sleep.</p> <p>Review Resident #90's MD orders signed and dated 2/8/13 noted [REDACTED] take one tablet by mouth at bedtime as needed for insomnia.</p> <p>Review of Resident #90's medication administration record for December 2012 noted the resident received [REDACTED] on 26 days of the month with no monitoring for effectiveness of 22 of the 26 doses given.</p>	F 329		

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

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F 329	<p>Continued From page 12</p> <p>Review of Resident #90's January 2013 medication administration record noted [REDACTED] given 16 times during the month with no documentation of the effectiveness of these doses.</p> <p>Review of Resident #90's February 2013 medication administration record noted the resident received 11 doses of [REDACTED] during the month with the effectiveness of one dose documented.</p> <p>On 3/1/13 at 8:30 a.m. Staff F, who is in charge of Resident #90's care, reported she/he expects residents to be monitored for how much they sleep when they are taking a hypnotic medication.</p>	F 329		