STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505243	A. BUILDING _____ B. WING _____	09/17/2013

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EVERGREEN NURSING & REHAB CENTER	430 LILLY ROAD NORTHEAST OLYMPIA, WA 98506

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0225 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**1) Hire only people with no legal history of abusing, neglecting or mistreating residents; or 2) report and investigate any acts or reports of abuse, neglect or mistreatment of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on interview and record review, the facility failed to thoroughly investigate incidents to rule out abuse, neglect, or mistreatment in accordance with CFR 483.13(c)(2)(3)(4) for 3 of 5 current sampled residents (#s 1, 2, & 3) reviewed for incidents. This failure placed residents at risk of ongoing abuse and mistreatment. Findings include: All interviews took place on 9/17/13 unless otherwise indicated. <Resident #2> Resident #2 was admitted [DATE] to the facility with [DIAGNOSES REDACTED]. On 7/29/13, the resident stated to a staff person, his catheter had leaked, saturating his bed and he laid in it for several hours. Resident #2 stated when a nursing assistant (NA) had come to his room, he told her about being wet and instead of being changed, the NA opened the window and left the room. Although the Social Services Assistant (SSA) stated she had called the allegation of neglect to the state agency hotline, no facility documentation could be found to support the abuse/neglect allegation incident was thoroughly investigated. The DNS stated it had not been logged in the reportable incidents log to the state. Failing to thoroughly investigate the incident to determine why the resident was left by staff without receiving the necessary care and services placed all residents at risk for continued neglect. <Resident #3> Resident #3 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #3 stated on 7/10/13 while he slept, another resident had come into his room and began poking him with his finger in his side. Resident #3 stated when he asked the other resident what he was doing, the other resident poked him in the ribs again, and said, I have to admit, it really did hurt. The Assistant Director of Nursing (ADON) stated she knew the incident had been reported, but could not find evidence the incident was logged into the state required log and in accordance with State requirements or that the incident had been investigated. <Resident #1> Resident #1 was admitted to the facility admitted on [DATE], with [DIAGNOSES REDACTED]. On 8/28/13, Resident #1 stated to staff she had to wait for 2 hours after activating her call light to summon help from staff. She also stated she had been left in a wet bed, had not been given proper food and had open sores from not receiving care. Resident #1 stated she had told staff her concerns, I don't feel like I get quality care, they just do what they want to do, and that she wanted to discharge from the facility because of it. Resident Care Manager (RCM) A stated she was aware of Resident #1's concerns about being neglected, but did not think an investigation was done because the resident did not give a specific date for when the neglect occurred. According to the facility State reporting incident log, the abuse/neglect allegation(s) had not been logged. The Director of Nursing (DNS), ADON and SSA stated the facility process of abuse/neglect allegations was to call the hot line, log the incident, investigate the allegation, monitor the resident involved for psychological harm every shift for 72 hours and update the plan of care. The process was not implemented for the incidents involving Resident #1, 2 and #3. Refer to WAC 388-97-0640(5)(a)(6)(a)(b)(c) .
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, interview and record review, the facility failed to review and revise care plans to ensure interventions for psychological well being, including monitoring for potential or latent psychological harm related to allegations of abuse/neglect for 4 of 5 residents (#s 1, 2, 3 & 4) reviewed. Failure to develop comprehensive, individualized care plans to identify current problems and interventions, placed the residents at risk to receive inappropriate and/or inadequate care to meet their individualized needs. Findings include: All interviews took place on 9/17/13 unless otherwise indicated. <Resident #1> Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE], with [DIAGNOSES REDACTED]. On 8/28/13, Resident #1 stated to staff she had to wait 2 hours after activating her call light to summon staff for assistance. She stated she had been left in a wet bed, had not been given proper food, and has open sores from not receiving care. According to the facility documentation there was no identification of the potential for psychological harm as a result of the resident's perceived allegations of neglect. No follow up was conducted to monitor the resident for psychological harm. Her plan of care had not been updated to include interventions to ensure her psychological well being related to the allegation. Resident #1 stated she had told staff her concerns, I don't feel like I get quality care, they just do what they want to do, and that she wanted to be discharged from the facility because of it. <Resident #2> Resident #2 was admitted [DATE] to the facility with [DIAGNOSES REDACTED]. On 7/29/13, the resident stated to a staff person, his catheter had leaked, saturating his bed and he laid in it for several hours. Resident #2 stated when a nursing assistant had come to his room, he told her about being wet, instead of being changed the NA opened the window and left the room. According to the facility documentation there was no identification of the potential for psychological harm as a result of the resident's perceived allegations of neglect. No follow up was conducted to monitor the resident for psychological harm. His plan of care had not been updated to include interventions to ensure his psychological well being related to the allegation. <Resident #3> Resident #3 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident #3 stated on 7/10/13, while he slept, another resident came into his room and had repeatedly poked him with his finger into his ribs. Resident #3 stated when he asked the other resident what he was doing, the other resident poked him again in the ribs. Resident #3 stated, I have to admit, it really did hurt. According to the facility documentation, there was no evidence the facility identified Resident #3's potentially being affected by the incident and having psychosocial problems as a result. The facility did not develop a plan of care for potential psychosocial harm. No interventions were implemented to monitor, or to assist the resident to ensure his psychological well being related to the incident. <Resident #4> Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #4 was observed in his room and stated on 7/24/13, he was told by a facility staff person he could not get out of bed for 4 hours because there was no one to help her. Resident #4 stated he felt like he was being confined to his room and punished because he required the assistance of two staff persons and a mechanical lift. Resident #4 told another facility staff person who called the incident into the state hotline. The abuse allegation/incident was investigated, but according to the facility documentation, there was no care plan with interventions to ensure Resident #4's psychological well being related to the incident. The Administrator (ADM) and DNS stated that each of the named residents should have been monitored per the facility protocol, every shift for 72 hours, and had care plans with interventions regarding the abuse/neglect allegation incidents.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.