STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505243	A. BUILDING _____ B. WING _____	C 03/21/2013

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

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F 000	INITIAL COMMENTS	F 000		

This report is the result of an unannounced Abbreviated Survey conducted at Evergreen Nursing and Rehabilitation Center on March 21, 2013. A sample of 4 current residents and 1 discharged resident was selected from a census of 109.

The following complaints were investigated.
2771922
2767872
2773500
2773119
2772765

The survey was conducted by:

[redacted], R.N., B.S.N., Investigator

The Complaint Investigators were from:

Department of Social & Health Services
Aging & Disability Services Administration
Residential Care Services,
District 3, Unit C
P.O. Box 45819
Olympia, Washington 98504-5819
Telephone: 360.664.8420
Fax: 360.664.8451

This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report

RECEIVED
APR 09 2013
DSHS/ADSA/RCS

[redacted] 3-24-13
Residential Care Services Date

[redacted]

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 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 to ensure residents received the necessary care and services to attain or maintain the highest level of physical, mental and psychosocial well-being for 2 of 3 residents (#1 & 2) when assessments were not completed after fall incidents in accordance with facility protocol and physician direction regarding neurological checks. These failures placed residents at risk for not having their needs being met. Findings include: <Resident #1> Resident #1 was admitted to the facility on [redacted]/13 with diagnoses to include [redacted], [redacted] and a disease of the [redacted]. The resident's Minimum Data Set (MDS), an	F 309	1. Resident #1 has discharged from the facility. Resident #2 experienced no negative outcome from from this event. 2. Residents who have experienced falls in the last 14 days have had their records reviewed for completion of Neurological Assessments and Pain Assessments if indicated. 3. Nursing staff will be re-educated On completion of Neurological Assessments and Neurological Flowsheets following facility Policy as well as documentation and Physician notification of changes in pain following an event. 4. Residents who have been identified as needing Neurological Assessments and Neurological Flowsheets completed will be audited by the IDT through the daily clinical meeting until completion of the Assessment per policy.	

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F 309	Continued From page 2 assessment tool, dated 2/22/13 documented Resident #1 required an extensive assist of one person for transfers, dressing, eating, and required two persons for toileting and hygienic care. On 3/13/13 at 11:40 a.m., a nursing Progress note documented the Licensed Nurse A (LN) was called into Resident #1's room when a therapy staff person heard the resident calling out and was found on the floor. Resident #1 had sustained an injury to his head and shin. The facility medical director, not the resident's primary physician who managed the resident's care since he was admitted to the facility, was documented as being notified and ordered neurological checks to be performed per facility policy, to monitor the resident's injuries and a dressing for open areas. The facility protocol after residents had fallen and sustained an injury to the head, was to do a Neurological Assessment. The facility Neurological Assessment Flowsheet directed nursing staff to do a neurological assessment every 15 minutes x 4 times until stable, then every 30 minutes x 4 times until stable then, every 1 hour x 4 hours until stable, then every 4 hours x 4 times then every 8 hours. The nursing staff were to document the resident's vital signs, pupils, including if the pupil of each eye were equal and reactive to light. Motor function was to be documented after assessing hand grasps and all extremities, level of consciousness and the resident's pain response was to be documented. There was no further documentation to show the	F 309	The IDT will review residents pain records for changes in residents pain level and ensure physician notification as well as nursing interventions to alleviate the pain through the daily clinical meeting until pain is controlled. Results of these audits will be reviewed by the IDT and trends identified will be presented to the QPI meeting monthly x 3 months. IDT/DNS/Admin responsible for compliance. Date of Compliance: 04/30/13	

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F 309	Continued From page 3 staff had performed the neurological assessment thoroughly as directed. A Pain data collection and assessment form dated 3/13/13, documented Resident #1's current condition that might be associated with pain was a [redacted] (blood filled area beneath the skin) to the forehead, a laceration to his left shin, and that there was a previous history of fractures. Resident #1 was documented as not having any limitations in his day to day activities for the past 5 days because of pain or difficulty sleeping. Resident #1's documented expected level of pain was 0 (none), and that it was "extremely important" to him to completely eliminate his pain. Resident #1 verbalized his pain as a "2" on a verbal numeric pain scale (0-10, 0 defined as no pain, and 10 being the "most intense pain imaginable"), a second pain scale, the Wong-Baker Face Scale, a series of 6 drawn faces that ranged from the face smiling, to a face crying, each with a numerical value underneath it. The smiling face was a 0 (" no hurt ") and the crying face was a 10 (" hurts worst "). The directions documented to have the resident to point to the appropriate face and explain the numerical value underneath it. Resident #1 was documented as a "2" (hurts little bit), although Resident #1 was blind. The pain location/type/frequency section of the form documented Resident #1's pain was located on his forehead and left shin and the reason for the assessment was Resident #1 had a change in condition. The pain assessment summary	F 309		

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F 309	Continued From page 4 documented, "Resident usually does not complain of pain. Fell-hematoma to forehead and laceration to left lower leg. Gave T[redacted] mg which seems to helped. Resident satisfied with current pain medication orders which is prn (as needed) [redacted]" On 3/14/13 at 10:00 a.m., a Progress note documented "fall with injury, resident complained of pain x 1." There was no evidence the resident had any further assessment of that pain, or if any nursing interventions were provided to alleviate that pain although LN A had done Resident #1's pain assessment the day prior where he verbalized it was extremely important to him not to have any pain. At 7:00 p.m., Resident #1 rated his pain as 5 out of 10, and was given [redacted] which was documented as being "helpful" but no further numerical value was given or description of pain relief level. On 3/15/13 at 12:00 p.m., the resident was given Tylenol 650 mg for complaints of pain rated as 5 out of 10. At 8:00 p.m., it was documented Resident #1 refused to eat. At 10:00 p.m., the resident complained of pain rated as 5 out of 10 and was given [redacted] again. The effectiveness of the medication was not documented, although this was a change in the resident's pain assessment after the fall. There was no evidence to show the Physician was notified of Resident #2's changes and no treatment or futher evaluation was completed.	F 309		

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F 309	Continued From page 5 On 3/16/13, at 3:40 a.m., the resident was found without a pulse or respiration, and was [redacted] There was no evidence Resident #1's neurological assessments were completed thoroughly as the facility protocol and form directed staff to do, the resident's physician was notified of his increase of pain from a level documented after the head injury as a "2" to a "5" in the 24 hours after his injurious fall that continued until he [redacted]. <Resident #2> Resident #2 was admitted to the facility on [redacted]/132 with diagnoses to include [redacted], [redacted] (walk), a history of falls and [redacted]. The resident's Minimum Data Set (MDS), an assessment tool, dated 3/6/13 documented Resident #2 required an extensive assist of one person for hygienic cares, dressing and required two persons for toileting, transfers and toileting. Resident #2 was documented as moderately impaired in his decision making with known memory deficits. On 3/7/13 at 4:15 p.m., Resident #2 was observed in his room pushing a wheelchair backwards when it tipped toward the resident and he fell onto the floor striking his head. At the time of the fall, the resident's vital signs were taken, and he was found with injuries to his head and left forearm. The resident had a temperature of	F 309		

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F 309	Continued From page 6 101.5 Fahrenheit (F). The physician was notified by fax. Orders were received to monitor the resident for the next 72 hours. The facility protocol after residents had fallen and sustained an injury to the head, was to do a Neurological Assessment. The facility Neurological Assessment Flowsheet directed nursing staff to do a neurological assessment every 15 minutes x 4 times until stable, then every 30 minutes x 4 times until stable then, every 1 hour x 4 hours until stable, then every 4 hours x 4 times then every 8 hours. It directed the nursing staff to document the resident ' s vital signs, pupils, including if the pupil of each eye were equal and reactive to light. Motor function was to be documented after assessing hand grasps and all extremities, level of consciousness and the resident's pain response was to be documented. There was no documentation to show the staff had performed the neurological assessment thoroughly as the form directed which was facility protocol. Record review revealed Resident #2 had had three previous falls since January 2013, where the resident had struck his head requiring neurological monitoring per the facility protocol and a total of 9 falls since his admission to the facility. There was no evidence the facility had monitored the resident thoroughly neurologically for each incident. Refer to F323	F 309		
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=D	Continued From page 7 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide sufficient supervision, monitoring and interventions to prevent falls for 1 of 3 residents (# 2) reviewed for accidents and incidents. This failure placed residents at risk for continued accidents that could cause harm. Findings include: <Resident #2> Resident #2 was admitted to the facility on [redacted]132 with diagnoses to include [redacted] (walk), a history of falls and [redacted] The resident's Minimum Data Set (MDS), an assessment tool, dated 3/6/13 documented Resident #2 required an extensive assist of one person for hygienic cares, dressing and required two persons for toileting, transfers and toileting. Resident #2 was documented as moderately impaired in his decision making with long and	F 323	1. Resident #1 experienced no decline in condition or change in his ADL's as a result of this event. 2. Residents who have been identified as a Fall risk by a fall assessment will have their Care Plans reviewed to ensure interventions are in place to reduce the resident's risk of falling. 3. Nursing staff will be inserviced on identifying residents who are at risk for falls and initiating individualized interventions that will reduce the resident risk of falling.	

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F 323	Continued From page 8 short term memory deficits. Resident #2's Fall/Injury Assessment Prevention and Management Plan of Care documented Resident #2 had prior falls on 9/11/12, 10/4/12, 10/23/12, 12/5/12, 1/2/13, 2/24/13 and 3/3/13. Resident #2's care planned fall prevention nursing interventions were documented on the care plan for the resident to have non-skid socks, neurological checks per protocol, therapy consult by nursing referral, encouraging the resident to keep briefs in dresser, removal of the resident's cane from his room, reminding the resident to lock his wheelchair brakes when getting up and re-orienting the resident to his room and call light. On 3/7/13 at 4:15 p.m., Resident #2 was observed in his room pushing a wheelchair backwards when it tipped toward the resident and he fell onto the floor striking his head. At the time of the fall, the resident's vital signs were taken and he was found with injuries to his head and left forearm. The physician was notified by fax. Orders were received to monitor the resident for the next 72 hours. The facility protocol after residents had fallen and sustained an injury to the head, was to do a Neurological Assessment. The facility Neurological Assessment Flowsheet directed nursing staff to do a neurological assessment every 15 minutes x 4 times until stable, then every 30 minutes x 4 times until stable then, every 1 hour x 4 hours until stable, then every 4 hours x 4 times then every 8 hours. It directed the nursing staff to document the resident's vital signs, pupils, including if the pupil of each eye	F 323	4. Residents who have been identified as having a fall will have their Care Plans audited by the IDT to ensure Completion of their Neurological Assessments and individual Interventions have been added to their Plan of Care to reduce the risk of further falls. Trends identified from the audits will be presented to the QPI committee x 3 months. IDT/DNS/Admin responsible for compliance. Date of compliance: 04/30/13	

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F 323	Continued From page 9 were equal and reactive to light. Motor function was to be documented after assessing hand grasps and all extremities, level of consciousness and the resident's pain response was to be documented. Licensed Nurse (LN) B, Resident Care Manager (RCM) A, the Assistant Director of Nursing (ADNS), and the Director of Nursing Services (DNS) stated the facility protocol for neurological checks was to follow the form and continue neurological checks for 72 hours. There was no documentation to show the staff had performed the neurological assessment thoroughly as the form directed which was facility protocol. The care planned intervention after the fall on 3/7/13 to prevent future falls was documented as "Frequent visual check while in room." There was no direction to the staff what was considered "frequent" or documentation to show "frequent" checks were done. RCM B stated the intervention was not specific and could not be assessed as effective in prevention of falls. Record review revealed Resident #2 had had a total of nine falls since his admission to the facility; all of the falls where he resident had struck his head and required neurological monitoring per the facility protocol had no evidence that the facility had monitored the resident thoroughly neurologically or attempted to provide adequate individualized nursing	F 323		

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F 323	Continued From page 10 interventions to prevent further falls. Resident #2 was known to have altered cognition, thought processes and impaired memory and a previous fall history. The care planned nursing interventions to prevent Resident #2 from falling were not individualized to the resident's abilities or sufficient to prevent falls. Refer to F309	F 323		