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

PRINTED: 04/04/2013
FORM APPROVED
OMB NO. 0938-0391

1008

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 04/03/2013

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

(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 Evergreen Nursing and Rehabilitation Center on April 3, 2013. A sample of 4 current residents and 4 discharged residents was selected from a census of 98. The following complaints were investigated. # 2776658 # 2780774 # 2780766 # 2780785 # 2782198 The survey was conducted by: [redacted] R.N., B.S.N., Investigator The Complaint Investigators were from: Department of Social & Health Services Aging & Long-Term Support Administration Division of Residential Care Services, District 3, Unit C P.O. Box 45819 Olympia, Washington 98504-5819 Telephone: 360.664.8420 Fax: 360.664.8451 [signature] 4-4-13 Residential Care Services Date	F 000	*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*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 4-19-13

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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review the facility failed to promote and enhance dignity for 2 of 3 sampled residents (#2 & 3) reviewed for environment that maintains or enhances each resident's dignity and respect in recognition of their individuality. This failure placed all residents at risk for reduced quality of life.

Findings include:

All interviews took place 4/3/2013.

<Resident #2>

Resident #2 was admitted to the facility on [redacted]/12 with diagnoses to include [redacted], [redacted], [redacted], [redacted] [redacted], [redacted] of an [redacted] and a [redacted] [redacted]. Resident #2 was able to communicate her needs to staff.

The resident's Minimum Data Set (MDS), an assessment tool dated 1/10/13, documented the resident was cognitively intact and was

F241 – Dignity and Respect

1. Residents #2 and #3 have been assessed for psychological harm and documentation reflects findings. Care plans have been updated with interventions as needed.
2. Residents with allegations in the last 30 days have been reviewed for documentation of psychological harm and care plans updated with interventions as needed.
3. Nursing and Social Service staff will be re-educated on the need to monitor of psychosocial harm. Auditing of the documentation will occur during the center's clinical meeting processes to ensure documentation reflects assessment. Care plans will be updated at that time with any needed interventions.
4. The above audits will be reviewed by the IDT and trends identified will be presented to the QPI meeting monthly x 3 months

Date of Compliance: 04/30/13

DNS/Admin. responsible for compliance.

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F 241	Continued From page 2 dependent on staff. She required extensive assistance of two staff persons for bed mobility, transfers, toileting and hygienic care. On 3/24/13 at 2:30 p.m., a entry in the progress notes documented that Resident #2 was observed with [redacted] in her brief. The facility determined that she was not checked or changed for [redacted] from the previous night shift. The progress note also documented Resident #2 was observed "visibly shaken and tearful." A fax to the physician documented Resident #2 stated she "wasn't checked or changed since last evening." The fax also documented the resident would be "placed on alert at this time for psychosocial well- being." The physician order for Resident #2 included to have her psychosocial well-being monitored and for the licensed nurses to co-sign a 2 hour check/change schedule every 2 hours to ensure the brief check/change was being completed as the plan of care directed staff. The facility care planned included direction to the licensed nurses to co-sign the 2 hour check and changing program. Although there was a physician order to monitor the resident's pyscho-social reaction to the incident, there was no evidence the facility developed implementation of nursing and social services care plan to ensure Resident #2's psychosocial well being was assessed or monitored to ensure harm did not occur. Resident #2 was in her room and acknowleged there were some "problems" with her care, her	F 241		

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F 241	Continued From page 3	F 241		

move during the construction to another hall, and that the nursing assistants (NA) didn't know her as well as the NAs from her other wing. Resident #2 declined to elaborate further on the [redacted] incident because she wanted to remain residing in the facility.

Resident #2 would not make eye contact and appeared upset when the investigator brought up the [redacted] incident, but would make eye contact when other issues (food service, shower schedules) were discussed.

<Resident #3>

Resident #3 was admitted to the facility on [redacted]/12 with diagnoses to include [redacted], [redacted], [redacted], [redacted], [redacted] and [redacted]. Resident #3 was able to communicate her needs to staff.

The resident's Minimum Data Set (MDS), an assessment tool dated 1/31/13, documented the resident was cognitively intact and required an extensive assist of two staff persons for bed mobility, transfers, toileting and hygienic care.

On 3/24/13 a person not associated with the facility reported they heard a staff member "yell at the resident to shut up."

Resident #3 was in her room and recalled the incident. She stated the NA spoke to her in an inappropriate tone, but she did not feel she was abused. Resident #3 stated the NA knew her routine well, and that she did not know if the NA was allowed to work with her ever again.

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F 241	Continued From page 4 Resident #3 stated the Director of Nursing Services (DNS) discussed the incident, but did not notify Resident #3 of the outcome of the facility investigation. Resident #3 stated she felt an emotional "loss" not having the NA, return to care for, or speak with her, or by not being made aware of the outcome of the incident. Resident #3 stated she felt like she was part of a "group" with the NA and two other named staff. The facility incident report documented the physician was notified with orders to monitor the resident, and the facility action to the incident was to be documented for 72 hours. The Mood and Behavior Symptom Assessment/Plan of care, dated 3/24/13, documented the incident where "staff were heard yelling at the resident to shut up." The goal was documented as, "resident will have no evidence of psych harm related to the incident." The interventions were documented as "alert, SS (Social Services) intervention, Lantern group" directing Social Services and nursing to provide those interventions. On 3/25/13 an entry on the facility alert charting book documented Resident #3's last name, her room number, and the reason as "yelling out/staff yelling/verbal abuse" as the reason the resident was on alert. The column where it directed what shift to document was blank. Licensed Nurse (LN) A and Resident Care Manager (RCM) A stated the facility procedure is to chart every shift for 72 hours for what each	F 241		

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F 250	Continued From page 6 All interviews took place 4/3/2013 <Resident #3> Resident #3 had diagnoses to include [redacted], [redacted]y, and [redacted]. The resident was cognitively intact and was dependent on staff for bed mobility, transfers, toileting and hygienic care. On 3/24/13 a person not associated with the facility reported they heard a staff member "yell at the resident to shut up." Resident #3 was in her room and recalled the incident. She stated the NA spoke to her in an inappropriate tone, but she did not feel she was abused. Resident #3 stated the NA knew her routine well, and that she did not know if the NA was allowed to work with her ever again. Resident #3 stated she felt a "loss" not having the NA, or really knowing the outcome of the incident as she felt like she was part of a "group" with the NA and two other named staff. Resident #3 stated in the past she had been offered to speak with someone in the past from the "Latern Group" but was not made aware of what services they provided for residents. Resident #3 indicated if there was someone to speak with in regards to her feelings, frustrations and the new loss she experienced with the incident, she would be interested. The facility incident report documented the physician was notified with orders to monitor the resident, and the facility action to the incident was documentation for 72 hours.	F 250	psychological adjustment difficulty/harm following an incident with a staff member. The resident will be documented on per facility policy and interventions put into place by the IDT to alleviate the residents emotional distress regarding the incident if indicated. 4. Residents who have been identified as needing interventions for psychological adjustment following an incident with a staff member will have their records reviewed by the IDT through the daily clinical meeting. Trends identified from the audits will be presented to the QPI committee x 3 months. Date of Compliance: 04/30/13 DNS/Admin. Responsible for compliance.	

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F 241	Continued From page 5 alert the resident is being monitored. The medical record was reviewed. There was no evidence of nursing or Social services documentation until 7 days later on 4/1/13, where the LN documented Resident #3 as "upset due to favorite aide moved to different wing today." There was no evidence of any interventions offered to alleviate the resident's emotional distress regarding the incident. Refer to F250	F 241		
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 interview and record review the facility failed to provide medically-related social services to attain the highest practicable mental and psychosocial well-being for 1 of 3 (#3) residents reviewed for psychological adjustment difficulty/harm.. This failure placed Resident #3 at risk for unrecognized depression and/or worsening depression. Findings include:	F 250	F250 Medically Related Social Services 1. Resident #3 has been assessed for mood decline and psychosocial harmby Social Services. Care plan has been updated as needed. 2. Residents who are at risk for suffering emotional distress following an incident will have their records reviewed to ensure there are interventions in offered to alleviate the residents emotional distress regarding the incident. 3. Nursing and Social Service staff will be re-educated on assessing residents for	

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F 250	Continued From page 7 The Mood and Behavior Symptom Assessment/Plan of care, dated 3/24/13, documented the incident where "staff were heard yelling at the resident to shut up." The goal was documented "resident will have no evidence of psych harm related to the incident." The interventions were documented as "alert, SS (Social Services) intervention, Lantern group" directing Social Services and nursing to provide those interventions. The medical record was reviewed. There was no evidence of nursing or Social services documentation until 1 week later on 4/1/13, where the LN documented Resident #3 as "upset due to favorite aide moved to different wing today." There was no evidence of any interventions offered to alleviate the resident's emotional distress regarding the incident.	F 250		