PRINTED: 04/04/2013

		& MEDICAID SERVICES			1008		APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILL	LTIPLE C	(X3) DATI	SURVEY PLETED				
		505243	B. WING	·		04/	D 0 3/2013			
NAME OF PROVIDER OR SUPPLIER EVERGREEN NURSING & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 430 LILLY ROAD NORTHEAST OLYMPIA, WA 98506						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE			
F 000	INITIAL COMMENT	rs	F	000						
	Abbreviated Survey Nursing and Rehab 2013. A sample of	esult of an unannounced r-conducted at Evergreen illitation Center on April 3, 4 current residents and 4 ts was selected from a			This Plan of Corrections this facility's written till compliance for the deficite This submission of this placer acrection is not an admission agreement with the deficit	ation of incies cited an of ission of or iencies or				
	The following comp # 2776658 # 2780774 # 2780766 # 2780785 # 2782198	laints were investigated.			conclusions contained in Department's inspection in					
		nducted by: R.N., B.S.N., Investigator stigators were from:		-						
	Aging & Long-Term Division of Resident District 3, Unit C P.O. Box 45819 Olympia, Washingto Telephone: 360.664 Fax: 360.664 Residential Care Se	on 98504-5819 4:8420 4:8451 (4-4-13) ervices Date								
ABORATORY	DIRECTORS OR PROVID	ERISUPPLIER REPRESENTATIVE'S SK	NATURE		Admin Indoc	4-	(X6) DATE -19-13			

Any deficiency statement entiting 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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STATÉMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING				(X3) DAT	E SURVEY APLETED		
		505243	B. WING	, ;		·	C /03/2013
NAME OF PROVIDER OR SUPPLIER EVERGREEN NURSING & REHAB CENTER				43	EET ADDRESS, CITY, STATE, ZIP COD 30 LILLY ROAD NORTHEAST LYMPIA, WA 98506		00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 241, SS=D	The facility must pr	AND RESPECT OF romote care for residents in a environment that maintains or elident's dignity and respect in	F:	241	F241 - Dignity and Respect 1. Residents #2 and #3 assessed for psychological residence.	ogical harm	
	full recognition of h	is or her individuality.			and documentation re Care plans have been interventions as need 2. Residents with allega	effects findings, a updated with led. stions in the last	
	Based on observat review the facility for dignity for 2 of 3 sa reviewed for enviro			days have been review documentation of psychological harm with interventions as	n and care plans needed	l l	
	enhances each res recognition of their	sident's dignity and respect in individuality. This failure at risk for reduced quality of			3. Nursing and Social So re-educated on the ne of psychosocial harm documentation will occur during the meeting processes to reflects assessment.	ed to monitor Auditing of the center's clinical ensure documen Care plans will he	tation
1	Findings include:				at that time with any r	needed intervent	ions.
ı	All interviews took <resident #2=""></resident>	piace 4/3/2013.			reviewed by the IDT a identified will be press QPI meeting monthly	and irends ented to the	
`\	Resident #2 was ac	dmitted to the facility on bases to include the facility on bases to include the facility on the facility of t			Date of Compliance: 0 DNS/Admin, responsi		
	her needs to staff.	#2 was able to communicate.		-	compliance,		
·	assessment tool da	mum Data Set (MDS), an ated 1/10/13, documented the lively intact and was					
			1 ,			. ,	1 .

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Event ID: SWKK11

Facility ID: WA17800

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILL		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		505243	B. WING			1	C /03/2013
NAME OF PROVIDER OR SUPPLIER EVERGREEN NURSING & REHAB CENTER				4	REET ADDRESS, CITY, STATE, ZIP CODE 430 LILLY ROAD NORTHEAST DLYMPIA, WA 98506		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	QVLD BE	(X5) COMPLETION DATE
F 241	dependent on staff, assistance of two s transfers, toileting a	She required extensive taff persons for bed mobility, and hygienic care.	F2	241			
-	notes documented observed with determined that she for the state of th	p.m., a entry in the progress that Resident #2 was in her brief. The facility was not checked or changed m the previous night shift. The documented Resident #2 was naken and tearful."					
	stated she "wasn't o evening." The fax a	an documented Resident #2 checked or changed since last lso documented the resident n alert at this time for being."	-				
	have her psychosor for the licensed nur- check/change sche	for Resident #2 included to cial well-being monitored and ses to co-sign a 2 hour dule every 2 hours to ensure nge was being completed as acted staff.					
	licensed nurses to o changing program. physician order to n pyscho-social reacti no evidence the fac of nursing and social Resident #2's psych	nned included direction to the co-sign the 2 hour check and Although there was a nonitor the resident's ion to the incident, there was illity developed implementation al services care plan to ensure nosocial well being was red to ensure harm did not					
		her room and acknowleged roblems" with her care, her		,			

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Event ID: SWKK11

Facility ID: WA17800

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		505243	B. WING			(na/)3/2013
NAME OF PROVIDER OR SUPPLIER EVERGREEN NURSING & REHAB CENTER				43	EET ADDRESS, CITY, STATE, ZIP CODE 30 LILLY ROAD NORTHEAST DLYMPIA, WA 98506	<u> </u>	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION , DATE
F 241	move during the co that the nursing ass as well as the NAs #2 declined to elabor	ge 3 instruction to another hall, and istants (NA) didn't know her from her other wing. Resident brate further on the transition of the wanted to remain residing	F2	241			
	appeared upset who	not make eye contact and en the investigator brought up lent, but would make eye issues (food service, shower scussed	•				
	12 with diagno	esident #3 was able to					
	assessment tool da resident was cogniti extensive assist of t	mum Data Set (MDS), an ted 1/31/13, documented the ively intact and required an wo staff persons for bed offeting and hygienic care.				:	
		n not associated with the heard a staff member "yell at up."					
٠.	incident. She stated inappropriate tone, abused. Resident # routine well, and that	her room and recalled the the NA spoke to her in an but she did not feel she was 3 stated the NA knew her at she did not know if the NA with her ever again.					

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Event ID: SWKK11

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILE		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		505243	B. WING	·			04/0	; 3/2013	
NAME OF PROVIDER OR SUPPLIER EVERGREEN NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 430 LILLY ROAD NORTHEAST OLYMPIA, WA 98506						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		BE IATE	(X5) COMPLETION DATE			
F 241	Resident #3 stated Services (DNS) dis	the Director of Nursing cussed the incident, but did #3 of the outcome of the	F:	241					
	not having the NA, with her, or by not b outcome of the inci-	she felt an emotional "ioss" return to care for, or speak being made aware of the dent. Resident #3 stated she rt of a "group" with the NA and aff.					-	, .	
	physician was notifi	report documented the ed with orders to monitor the cility action to the incident was or 72 hours.			•				
	documented the inc yelling at the reside documented as, "re of psych harm relat- interventions were (Social Services) in	avior Symptom f care, dated 3/24/13, cident where "staff were heard nt to shut up." The goal was sident will have no evidence ed to the incident." The documented as "alert, SS tervention, Lantern group" vices and nursing to provide							
••	book documented Froom number, and to yelling/verbal abuse	on the facility alert charting Resident #3's last name, her the reason as "yelling out/staff" as the reason the resident blumn where it directed what was blank.		.** •			•		
	Manager (RCM) As	l) A and Resident Care tated the facility procedure is or 72 hours for what each		•		<i>(</i>	·	· · · · · · · · · · · · · · · · · · ·	

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Event ID: SWKK11

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

EFICIENCIES RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		COMPLET		
	505243	B. WING			04/0:	3/2013
NAME OF PROVIDER OR SUPPLIER EVERGREEN NURSING & REHAB CENTER			43	O LILLY ROAD NORTHEAST		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	DBE .	(X5) COMPLETION DAYE
esident #3> sident #3 had dia sident #3 had dia sident #3 had dia dent was cognit endent on staff sting and hygien 3/24/13 a perso lity reported the resident to shut sident #3 was in dent. She stated apropriate tone, sed. Resident # ine well, and the allowed to worl ident #3 stated or really knowin the felt like she	agnoses to include , and the state of the lively intact and was for bed mobility, transfers, ic care. In not associated with the y heard a staff member "yell at up." The room and recalled the if the NA spoke to her in an but she did not feel she was a stated the NA knew her at she did not know if the NA k with her ever again. She felt a "loss" not having the not the outcome of the incident was part of a "group" with the	F2	250	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 psychologic adjustment following an incident with a staff member will have their records review by the IDT through the daily clinical meeting. Trends identified from the aud will be presented to the QPI committee x 3 months.	y al ved	
red to speak wit "Latern Group" It services they p ident #3 indicate ak with in regare the new loss sh lent, she would facility incident sician was notificant, and the fac	th someone in the past from but was not made aware of provided for residents. The interest of the ed if there was someone to it to her feelings, frustrations are experienced with the be interested. The interest of the ed with orders to monitor the cility action to the incident was			DNS/Admin. Responsible for compliance.		
	DER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L retinued From pa nterviews took p esident #3 had dia dent was cognit endent on staff ding and hygien 3/24/13 a perso lity reported they resident to shut sident #3 was in dent. She stated propriate tone, sed. Resident # ine well, and tha allowed to worl ident #3 stated or really knowir the felt like she and two other na ident #3 stated or really knowir the felt like she and two other na ident #3 stated ine well, and tha allowed to speak wit "Latern Group" t services they p ident #3 indicate ak with in regard the new loss sh lent, she would facility incident sician was notific ident, and the facility incident sician was notific ident, and the facility incident	DER OR SUPPLIER DER OR SUPPLIER NURSING & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 6 Interviews took place 4/3/2013	DENTIFICATION NUMBER: 505243 B. WING DER OR SUPPLIER NURSING & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 6 Interviews took place 4/3/2013 Desident #3 had diagnoses to include The definition of the past of the incident was cognitively intact and was endent on staff for bed mobility, transfers, string and hygienic care. 3/24/13 a person not associated with the lity reported they heard a staff member "yell at resident to shut up." Indent #3 was in her room and recalled the dent. She stated the NA spoke to her in an propriate tone, but she did not feel she was sed. Resident #3 stated the NA knew her ine well, and that she did not know if the NA allowed to work with her ever again. Ident #3 stated she felt a "loss" not having the or really knowing the outcome of the incident the felt like she was part of a "group" with the and two other named staff. Ident #3 stated in the past she had been red to speak with someone in the past from "Latern Group" but was not made aware of the services they provided for residents. Ident #3 indicated if there was someone to ak with in regards to her feelings, frustrations the new loss she experienced with the lent, she would be interested. Facility incident report documented the sician was notified with orders to monitor the dent, and the facility action to the incident was	DER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Fritinued From page 6 Interviews took place 4/3/2013 Desident #3 had diagnoses to include interviews took place 4/3/2013 Desident #3 had diagnoses to include interviews took place 4/3/2013 Desident #3 had diagnoses to include interviews took place 4/3/2013 Desident #3 had diagnoses to include interviews took place 4/3/2013 Desident #3 had diagnoses to include interviews took place 4/3/2013 Desident #3 had diagnoses to include interviews took place 4/3/2013 Desident #3 had diagnoses to include interviews took place 4/3/2013 Desident #3 had diagnoses to include interviews took place 4/3/2013 Desident #3 had diagnoses to include interviews took place 4/3/2013 Desident #3 had diagnoses to include interviews took place 4/3/2013 Desident #3 had diagnoses to include interviews took place 4/3/2013 Desident #3 had diagnoses to include interviews took place 4/3/2013 Desident #3 had diagnoses to include interviews took place 4/3/2013 Desident #3 had diagnoses to include interviews took place 4/3/2013 Desident #3 had diagnoses to include interviews took place 4/3/2013 Desident #3 had diagnoses to include interviews took place 4/3/2013 Desident #3 had diagnoses to include interviews took place 4/3/2013 Desident #3 had diagnoses to include interviews took place 4/3/2013 Desident #3 was in her room and recalled the licent took place 4/3/2013 Desident #3 was in her room and recalled the lace 4/3/2013 Desident #3 was in her room and recalled the lace 4/3/2013 Desident #3 was in her room and recalled the lace 4/3/2013 Desident #3 was in her room and recalled the lace 4/3/2013 Desident #3 was in her room and recalled the lace 4/3/2013 Desident #3 was in her room and recalled the lace 4/3/2013 Desident #3 was in her room and recalled the lace 4/3/2013 Desident #3 had diagnoses to include 1/3/2013 Desident #3 had diagnoses to local took place 4/3/2013 Desident #3 had d	DER OR SUPPLIER NURSING & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Trinued From page 6 Interviews took place 4/3/2013 PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROPRIATION SHOULD CROSS-REFERENCED TO CROSS-REFERENCED TO THE APPROPRIATION SHOULD CROSS-REFERENCED TO THE APPROPRIATION SHOULD CROSS-REFERENCED TO CROSS-REFERENCED TO CROSS-REFERENCED TO CROSS-REFERENCED TO CROSS-REFERENCED TO THE APPROPRIATION TO CROSS-REFERENCED TO CROSS-REFERENCED TO CROSS-REFERENCED TO THE APPROPRIATION TO CROSS-REFERENCED TO	DEFORM SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 430 LLLY ROAD NORTHEAST OLYMPIA, WA 98506 SUMMARY STATEMENT OF DEFICIENCIES TAS PROVIDERS PLAN OF CORRECTION (ACH CORRECTION ACTION BE ADDRESS.) PROVIDERS PLAN OF CORRECTION (ACH CORRECTION FACTOR BE ADDRESS.) FROM DAY ACTION OF THE APPROPRIATE DEFICIENCY) TAS PROVIDERS PLAN OF CORRECTION (ACH CORRECTION FACTOR BE ADDRESS.) PROVIDERS PLAN OF CORRECTION (ACH CORRECTION FACTOR BE ADDRESS.) PROVIDERS PLAN OF CORRECTION (ACH CORRECTION FACTOR BE ADDRESS.) PROVIDERS PLAN OF CORRECTION (ACH CORRECTION FACTOR BE ADDRESS.) PROVIDERS PLAN OF CORRECTION (ACH CORRECTION FACTOR BE ADDRESS.) PROVIDERS PLAN OF CORRECTION (ACH CORRECTION FACTOR BE ADDRESS. PROVIDERS PLAN OF CORRECTION (ACH CORRECTION FACTOR BE ADDRESS. PROVIDERS PLAN OF CORRECTION (ACH CORRECTION FACTOR BE ADDRESS. PROVIDERS PLAN OF CORRECTION (ACH CORRECTION FACTOR BE ADDRESS. PROVIDERS PLAN OF CORRECTION (ACH CORRECTION FACTOR BE ADDRESS. PROVIDERS PLAN OF CORRECTION (ACH CORRECTION FACTOR BE ADDRESS. PROVIDERS PLAN OF CORRECTION (ACH CORRECTION FACTOR BE ADDRESS. PROVIDERS PLAN OF CORRECTION (ACH CORRECTION FACTOR BE ADDRESS. PROVIDERS PLAN OF CORRECTION (ACH CORRECTION FACTOR BE ADDRESS. PROVIDERS PLAN OF CORRECTION (ACH CORRECTION FACTOR BE ADDRESS. PROVIDERS PLAN OF CORRECTION (ACH CORRECTION OF CORRECTION (ACH CORRECTION OF CORRECTION (ACH CORRECTION OF CARREST PROPORTIES The resident will be documented on per facility policy and incident with a staff member. The resident will be documented to residents. I

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Event ID: SWKK11

Facility ID: WA1780

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	SURVEY PLETED	
,		5 05243	B. WING		DA/r	3/2013
	PROVIDER OR SUPPLIER	HAB CENTER	4	REET ADDRESS, CITY, STATE, ZIP CODE 430 LILLY ROAD NORTHEAST DLYMPIA, WA 98506		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 241		being monitored. was reviewed. There was no	F 241			·
	the LN documented favorite aide moved	or Social services 7 days later on 4/1/13, where Resident #3 as "upset due to to different wing today."				
!	offered to alleviate to distress regarding to Refer to F250	the resident's emotional the incident.				
F 250 SS=D	RELATED SOCIAL The facility must proservices to attain or	ovide medically-related social maintain the highest	F 250	F250 Medically Related Soc Services 1. Resident #3 has been	, .	
	well-being of each r	, mental, and psychosocial esident.	,	for mood decline ar psychosocial harmb Care plan has been	y Social Service updated as need	
	by: Based on interview failed to provide me to attain the highest psychosocial well-be	and record review the facility dically-related social services practicable mental and eing for 1 of 3 (#3) residents		2. Residents who are a suffering emotional following an incide have their records reto ensure there are in offered to allevia residents emotional	distress nt will eviewed nterventions te the	
		failure placed Resident #3 at depression and/or		regarding the incide 3. Nursing and Social staff will be re-educe assessing residents	ent. Service ated on	
, ,	Findings include:			mooning residents) ~.	
	· ·			<u> </u>		٠,

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Event ID: SWKK11

Facility ID: WA17800

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FORM OMB NO): 04/04/2013 1 APPROVED): 0938-0391	
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505243				CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
,				·		04	C /03/2013	
	ROVIDER OR SUPPLIER EEN NURSING & RE	HAB CENTER	. (STREI 430 OL				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 250	Continued From pa	ge 7	F:	250	·			
	documented the inc yelling at the reside documented "reside psych harm related interventions were (Social Services) in	f care, dated 3/24/13, cident where "staff were heard int to shut up." The goal was ent will have no evidence of to the incident." The documented as "alert, SS tervention, Lantern group" vices and nursing to provide						
	evidence of nursing documentation until the LN documented favorite aide moved	1 week later on 4/1/13, when I Resident #3 as "upset due to I to different wing today."	e			•		
		ence of any interventions the resident's emotional he incident.				•		
					·			
		· ·						
						• ,		

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