

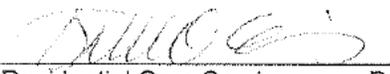
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

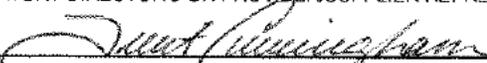
PRINTED: 10/30/2013
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505325 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 10/22/2013 |
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| NAME OF PROVIDER OR SUPPLIER ISLAND HEALTH & REHAB CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 835 MADISON AVENUE NORTH BAINBRIDGE ISLAND, WA 98110 |
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| F 000 | <p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Standard Survey conducted onsite at Island Health and Rehabilitation Center on 10/22/13. The sample included 4 current residents and 1 discharged resident out of a census of 56.</p> <p>The following are complaints investigated as part of this survey:</p> <p>#2879491</p> <p>The survey was conducted by:</p> <p> RN, MN</p> <p>The surveyor is from:</p> <p>Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, District 3, Unit A PO BOX 45819 MS: N27-24 Olympia, WA 98504-5819</p> <p>Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p> 10/30/13 Residential Care Services Date</p> | F 000 | <p>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.</p> <p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">NOV 15 REC'D</p> <p style="text-align: center;">DSHS - ADSA RCS - REGION 5</p> | 11/15/13 |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE Administrator | (X6) DATE 11/8/13 |
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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 323 SS=D | <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to adequately evaluate and analyze hazards and/or risks associated with the resident's fall for 1 of 5 residents (Resident #1) reviewed for falls, and failed to implement interventions to help prevent additional falls and/or injury. This failure placed the resident at risk for fall related injuries.</p> <p>Findings include:</p> <p>The resident was admitted to the facility with multiple diagnoses to include [REDACTED].</p> <p>Care plan dated 8/9/13 revealed the resident was at risk for falls related to unsteady gait and leaning.</p> <p>The care plan dated 8/20/13 documented the resident ambulated with care giver assist with the use of the front wheeled walker and required minimal assist with transfers.</p> <p>Review of the record revealed the resident had a self-reported fall on 9/7/13. The resident told a nursing assistant that she fell in the dining room</p> | F 323 | <p>F - 323 (D)</p> <p>I. How the nursing home will correct the deficiency as it relates to the resident:</p> <p>Resident # 1 has been reviewed for appropriate interventions related to falls. The Care Plan has been updated to reflect these interventions per state and federal regulations.</p> <p>II. How the nursing home will act to protect residents in similar situations:</p> <p>The facility has reviewed current residents who have had a fall in the Facility within the past 90 days for appropriate interventions. The Facility followed up with required documentation to include Care Plan revisions per state and federal regulations.</p> | 11/15/13 | |

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| F 323 | <p>Continued From page 2</p> <p>and rose herself up to her wheelchair. According to the progress note, a staff member who was in the dining room reported the resident did not fall. The facility concluded the fall did not occur and did not analyze it further.</p> <p>The nurse note dated 9/14/13 documented the resident was found sitting on the bed, and reported she had a fall. The nurse assessed the resident and the resident did not report pain. There was no documented evidence that an initial evaluation of the fall occurred. The interdisciplinary team (IDT) progress note dated 9/16/13, two days later, documented the resident would have required assistance in order to get up had she fallen, therefore the IDT determined the fall was unlikely and did not evaluate possible risks and/or hazards related to the fall.</p> <p>On 10/22/13 at 3:22 p.m., during an interview, the Director of Nursing (Staff A) stated further analysis of the fall on 9/14/13 did not occur, because the IDT team determined the resident was unable to get up from the floor without staff assistance.</p> <p>On 10/22/13 at 2:45 p.m., during an interview, Staff B reported she found the resident sitting on the side of the bed, and when she asked the resident what happened the resident stated she had fallen. Staff B reported the resident would ambulate independently and get out of bed on her own without staff assistance.</p> <p>Review of the record revealed on 9/18/13 Resident #1 was found sitting on the floor in front of the bathroom door. The resident complained of mid upper back pain that radiated to the front of her chest, and was medicated with as needed</p> | F 323 | <p>III. Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <p>Staff members have been re-educated regarding the requirement to report and perform an investigation for resident self-reported falls. The investigation is to be documented on the Electronic Accident and Incident Report (eAI), which runs its user through the proper steps of an investigation to include identifying possible risks and or hazards associated with a resident's self-reported fall. Appropriate interventions will be noted therein.</p> <p>IV. How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <p>Accident and Incident reports will be reviewed by the Resident Care Manager RN to ensure that a comprehensive investigation has been performed for witnessed and self-reported falls. Investigation findings will be reviewed during the daily Clinical Meeting process as well. Findings will be reviewed during the next three scheduled QA meetings to ensure that ongoing compliance is sustained.</p> | 11/15/13 | |

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| F 323 | Continued From page 3 pain medication. The resident later complained of back pain and pain with breathing. Review of the x-ray report dated 9/18/13 documented, "mild compression of a mid-thoracic vertebral body, age uncertain without old studies for comparison." Resident #1 had two recent self reported falls which facility staff concluded did not occur. The facility failed to identify possible risks and or hazards associated with the resident's self-reported falls, and the resident was later found on the floor by staff. This failure may have contributed to the resident possibly sustaining a mild compression of the mid thoracic vertebral body. | F 323 | V. Dates when corrective action will be completed: Nov 15, 2013 VI. The title of the person/s responsible to ensure correction: Administrator, Director of Nursing, Educational Training Director, Resident Care Managers | 11/15/13 | |