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

PRINTED: 10/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505403		C 10/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY AT SILVER LAKE	2235 LAKE HEIGHTS DRIVE EVERETT, WA 98208

(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 Bethany at Silver Lake on 10/10/2013 and 10/15/2013. A sample of 5 residents was selected from a census of 105. The sample included 5 current residents. The following were complaints investigated as part of this survey: 2870559 2873171 2874683 The survey was conducted by: Robin Boyer, RN, BSN, MS The survey team is from: Department of Social and Health Services Aging and Long Term Services Administration Residential Care Services, District 2 A 3906 172nd Street NE, Suite 100 Arlington, WA 98223 Telephone: (360) 651-6850 Fax: (360) 651-6940 Lynne Decker 10/17/13 Residential Care Services Date	F 000	This Plan of Correction is submitted as required under Federal and State statutes and regulations. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the state surveyors' findings or conclusions are accurate, that the findings constitute deficiencies, or that the scope and severity determinations regarding the alleged deficiencies were correctly applied. RECEIVED NOV - 1 2013 ADSA/RCS Smokey Point	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mel Everett — TITLE: Administrator — (X6) DATE: 11/1/13

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 323 SS=G	483.25(h) FREE OF ACCIDENT 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 interview and record review, the facility staff failed to recognize and evaluate environmental hazards in the building and intervene to maintain safety for Resident 2. Failure to assess the area of damp carpet as a potential safety hazard, adequately supervise and consistently implement nursing interventions to protect residents resulted in a fall with harm of a fractured arm and pelvis for Resident 2 and placed other residents at risk of falls. Findings include: Resident 2 was admitted in September in [redacted] with multiple diagnoses including [redacted] and [redacted]. Her Minimum Data Set assessment, dated 08/08/13, identified she had impaired vision and had unsteady balance. She needed one person assistance for transfer, standing and walking. She used a walker as a mobility device. Her care plan identified a history of falls and a continuing risk for falls. During the morning of 09/09/13, Staff A and Staff B entered the special care unit and cleaned a large area of soiled hallway carpet. The carpet	F 323	The facility will continue to ensure that the resident environment remains as free of accident hazards as is possible. Each resident will receive adequate supervision and appropriate assistance devices to prevent accidents. Resident #2 remains a resident on the Special Care Unit. The care guide for Resident #2 was updated to reflect changes in mobility, environment, self care and toileting. A pain assessment was done and pain management put in place to attain comfort. Resident #2 was also evaluated by skilled therapies and a restorative program has been established with the goal of this resident returning to prior level of function. The procedure for carpet cleaning has been reviewed and cleaning will be done in smaller areas as an added safety measure to ensure safety for all residents. In-service education for all employees will be done regarding keeping the environment as free of hazards as possible and ensuring residents receive adequate supervision and	11/18/13

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F 323 Continued From page 2

was damp after the cleaning process was completed. About 4:45 p.m. that afternoon, Resident 2 was found lying on the floor with her walker sideways on the ground and her legs under it. Nursing assessment identified an abrasion, about 3 centimeters (cm) x 3 cm on her left shoulder and another bruise on her left forehead. Additionally, Resident 2 complained of pain in her right shoulder. Resident 2 told staff she slipped on the "wet carpet." Resident 2 reiterated she slipped on the carpet, including pointing to the carpet, to other staff members later that same day. The next morning, 09/10/13, Resident 2 complained of pain in her right should and refused to get out of bed for breakfast. Resident 2 was sent to the hospital where x-ray identified a fracture to her right humerus and pelvis. She returned to the building with an arm immobilizer (sling) on the right arm.

On 10/10/13 at 10:10 a.m., Resident 2 was observed seated in a chair in the hallway wearing a sling/arm immobilizer on her right arm. She was able to recall she fell, but she was unable to provide any details. She advised the investigator to be careful when the investigator prepared to walk away down the hallway.

On 10/15/13 at 10:20 a.m., Staff A reported she was one of the two staff who cleaned the hallway carpet on 09/09/13. A staff person told her of Resident 2's fall a couple of days after it happened. Staff A recalled there were multiple spill stains on the hallway carpet over a large area. It was very dirty in many places. Staff A stated usually housekeeping cleaned only part of the carpet and left part for later cleaning. In this instance, because of the spills, the hallway carpet was very dirty. On 09/09/13, Staff A explained to

F 323

appropriate assistance devices to prevent accidents.

Random environmental safety audits will be done by the department directors or designee and report to the administrator and the Continuous Quality Improvement committee.

The Director of Nursing and Nurse Managers will monitor and the Administrator will ensure compliance.

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F 323 Continued From page 3

F 323

the nursing staff she and Staff B would clean the entire hallway carpet, a larger area than usual. Staff A stated nursing staff said this was ok. Staff A and Staff B placed signs cautioning the damp carpet at the ends of the hallways and around the living room area after the cleaning was completed. They also placed mats at the entrance to each resident room, so when a person stepped from the freshly cleaned carpet, they would step onto the mat to wipe/dry their feet and then onto the linoleum flooring of the rooms. This was a safety precaution against slipping on the floors with wet footwear. Staff A stated they told the nurses the carpet was wet. Staff A reported she saw Resident 2 stand up from the chair in the hallway and she told the nurses to remind Resident 2 of the wet carpet. Resident 2 independently entered her room, used the bathroom facility and returned to the chair in the hallway that was surrounded by damp carpet. Staff A was concerned Resident 2 used the chair in that hallway where they had cleaned the carpet. She told the nurses to watch Resident 2 and be careful. Staff A stated the nurses acknowledged her statement and told her Resident 2 was fine.

At 11:10 a.m., Staff C reported she was in the unit where Resident 2 resides on 09/09/13. Staff C stated housekeeping should do "only half of a half of hallway" when cleaning carpet. Generally, they clean sections only, not such a large area. Staff C stated a couple of other staff told her the carpet seemed "wetter" than usual and Staff C noticed this as well. She wondered whether the equipment worked properly when the carpet was cleaned, but she did not ask anyone about it. Staff C reported Resident 2 consistently told different staff members that she slipped on the

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F 323	Continued From page 4 "wet" carpet. On 10/16/13 at 12:15 p.m., the Administrator reported he reenacted the carpet cleaning procedure and found the equipment worked as it should, extracting the moisture as expected. He stated the carpet was slightly "damp" after the cleaning. Review of the facility investigation revealed evidence of documentation Resident 2 and multiple staff wrote Resident 2 slipped on "wet" carpet. Review of the care plan for Resident 2, dated 06/19/13, revealed Resident 2 required "extensive assist" with transfer as well as walking at times. She used a walker for ambulation. Additionally, Resident 2 had a history of falls and staff were to "do safety checks frequently" throughout the day and offer to assist Resident 2 to the bathroom as needed.	F 323		