

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505395	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/25/2014
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NAME OF PROVIDER OR SUPPLIER STAFHOLT GOOD SAMARITAN CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 456 C STREET BLAINE, WA 98230
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Stafholt Good Samaritan Center on September 25, 2014. A sample of 8 current residents was selected from a census of 53.</p> <p>The following were complaints investigated as part of this survey:</p> <p>3030887 3040099</p> <p>The survey was conducted by:</p> <p>Nadyne Krienke, R.N., M.S.N. Steven Kindle, R.N., M.S.N.</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Disability 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</p> <p><i>Mari/La Ferguson-Wolf</i> 10/8/14 Residential Care Services Date</p>	F 000	<p>General Disclaimer</p> <p>Preparation and Execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirement of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations manual.</p> <p>RECEIVED OCT 27 2014 ADSA/CH Sherry Ford</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE <i>W. J. [Signature]</i>	TITLE A007	(X6) DATE 10/24/14
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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 her 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 323 483.25(h) FREE OF ACCIDENT
SS=G 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 ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 3 sample residents (1). Failure to transfer Resident 1 using 2 people with a gait belt resulted in a fall with harm. Resident 1 sustained a fracture. Findings include:

The facility Gait (Transfer) Belt procedure, dated September 2012, indicated Gait belts are to be used unless medically contraindicated for transfer.

Resident 1 was admitted to the facility in [REDACTED] with diagnoses to include [REDACTED]

The Minimum Data Set (MDS) assessment, dated 8/24/14, indicated Resident 1 required extensive assistance of 2 staff for bed mobility, transfers, and toileting.

The plan of care (POC), initiated 10/15/13, indicated the resident required "ext (extensive) assist of 2 staff" for transfers. The POC also indicated Resident 1 had "weakness of lower

F 323: Resident #1 will be transferred according to her care plan.

All residents will be transferred according to their care plan.

Staff member A, who was in her orientation period, received additional instruction/ return demonstration training and practice throughout the week immediately following the incident. In addition, all staff were re-instructed on use of gait belts and following care plans.

All new NA staff will continue to receive training with return demonstration r/t use of lifts/ transfers/ repositioning/ gait belt use prior to caring for residents. All NA staff will continue to receive annual return demonstration review of their practice r/t use of lifts/ transfers/ repositioning/ gait belt use. New NA staff will continue to be evaluated by NAC mentors and Staff Development during their orientation period. All training and evaluation will be documented.

Staff Development Coordinator will continue to monitor. Administrator will assure compliance.

Completion Date: October 24, 2014

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extremities," was non-ambulatory, and dependent on staff for getting in & out of bed, and turning. The KARDEX (care directive for nursing assistants) read Transfer: she required ext assist of 2 staff and sara lift to transfer.

On 9/25/14 at 11:00 a.m., Resident 1 was observed resting in bed. She had a splint on her leg. She stated she broke her leg during a fall in her bathroom.

The facility's investigative report, dated 9/12/14, revealed that "Nursing assistant thought she could transfer her (resident) safely as another NAC (nursing assistant certified) had watched her assist her onto bedside commode in the bathroom". A X-Ray report dated 09/12/14 revealed a fracture to Resident 1's leg.

Staff A, verified in her witness report that she had not used a gait belt when she transferred Resident 1 by herself.

On 9/25/14 at 3:15 p.m., the Director of Nursing (DNS) confirmed Staff A did not follow Resident 1's POC and had transferred the resident by herself. The DNS verified Resident 1's POC directed staff that a two person assist is required for all transfers and also that a gait belt should have been used.

On 9/25/14 at 4:45 p.m., during an interview with Staff B, she verified Staff A did not follow the POC for Resident 1 and had attempted a one person transfer without a gait belt from the commode. Staff B also stated the resident had a history of lower extremity muscle weakness and was unable to walk. Staff B also stated that after the fall on 9/12/14, Resident 1 experienced

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

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increased pain and required narcotic pain medications to control her pain.

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