

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

PRINTED: 08/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505313</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/09/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HALLMARK MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>32300 FIRST AVENUE SOUTH FEDERAL WAY, WA 98003</b>
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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 INITIAL COMMENTS

F 000

This report is the result of an unannounced Abbreviated Survey conducted at Hallmark Manor conducted on 07/09/13. The sample of three residents was based on a census of 112.

The following complaint was investigated as part of this survey:

2837942

The survey was conducted by:

Susan Loewen, MSN, RN Complaint Investigator

The survey team is from:

Department of Social & Health Services  
Aging & Disability Services Administration  
Residential Care Services, District 2, Unit F  
20425 72nd Avenue South, Suite 400  
Kent, WA 98032-2388

Telephone: (253) 234-6039

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**IDR AMENDED**

*[Handwritten Signature]*  
Residential Care Services Date **8/27/13**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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><b>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</b></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 observation, interview and record review the facility failed, for one (Resident #1) of three residents reviewed for accident prevention, to implement care planned interventions for a safe transfer. Failure to transfer Resident #1 with two persons and the mechanical sit to stand lift, caused the resident to sustain a laceration to the outer left ankle that required First Aid treatment.</p> <p>Findings included:</p> <p>According to the 9/25/12 and 5/18/13 Minimum Data Sets (MDS), Resident #1 had diagnoses of dementia, history of a stroke with complications and osteoporosis, never or rarely was able to make decisions and required extensive assistance of two staff for activities of daily living including bed mobility, transfers, dressing, toileting and personal hygiene.</p> <p>The resident was observed on 7/9/13 enjoying lunch with family. The left ankle was dressed in gauze. The resident offered limited information through verbal interview as a result of decreased ability to communicate related to the history of stroke and current diagnosis of dementia. Staff</p>	F 323		

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F 323	<p>Continued From page 2</p> <p>E, a registered nurse, interviewed on 7/9/13 at 12:30 p.m., said the wound, as observed on 7/8/13, was "not red" but "weeping clear fluid".</p> <p>The therapy department assessed the resident to require two person assistance with transfers using the mechanical sit to stand device on 6/20/13 and 4/9/12 and according to Staff F a therapist, interviewed on 7/9/13 at 3:40 p.m. Staff used the MDS and therapy assessment to develop the 03/26/13 Care Plan (CP), which indicated the resident required, "total assist with:...transfer..." An undated hand written entry included, "2 assist sit-stand transfers". Review of the 12/05/12 Care Directives, revealed instruction to direct-care staff, "...Transfers Assist 2 Sit/Stand..."</p> <p>According to Staff H, the Staff Development Coordinator, interviewed on 07/09/13 at 11:50 a.m., and review of educational documents, Staff D received in-service education on reviewing and following the Care Directives on 03/01/13 and 05/24/13.</p> <p>According to the facility's 06/27/13 evidence of investigation, Staff D transferred Resident #1 without the sit to stand device or a second staff member. Staff D said in an interview on 7/9/13 at 11:35 a.m., after providing morning care, "I forgot (the resident) was two person...I transferred (the resident) to the wheelchair I used a gait belt." Staff D demonstrated how the resident was transferred using a stand pivot method and no mechanical device. Staff D indicated the resident's left leg "caught on the wheel" and the resident suffered a "scrape" on the leg. Staff documented the resident suffered a three by three centimeter "cut" above the left ankle "while</p>	F 323	<b>IDR AMENDED</b>	

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F 323	Continued From page 3 being transferred..."bumped ankle on (wheelchair) wheel".  According to Staff B, the Director of Nursing, interviewed on 07/09/13 at 4:10 p.m., Staff D did not follow the care planned interventions to ensure the resident's safety allowing the resident to sustain a laceration to the left leg that required First Aide treatment.	F 323		

**IDR AMENDED**