

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

PRINTED: 08/30/2013  
FORM APPROVED  
OMB NO. 0938-0391

1098

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505473	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/21/2013
NAME OF PROVIDER OR SUPPLIER  UNIVERSITY PLACE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5520 BRIDGEPORT WAY WEST UNIVERSITY PLACE, WA 98467	
(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	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Standard Survey conducted onsite at University Place Care Center on 8/19, 8/20 &amp; 8/21/2013. The sample included 10 residents out of a census of 82. The sample included 8 current residents and the records of 2 former residents.</p> <p>The following are complaints investigated as part of this survey:</p> <p>#2836006 #2861539 #2860492 #2834972</p> <p>The survey was conducted by: [REDACTED] RN, MN</p> <p>The surveyor is from: Department of Social and Health Services Aging and Long-Term Support Administration Division of Residential Care Services District 3, Unit B 1949 S. State Street Tacoma, WA 98405-2850</p> <p>Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p><i>Christine Miller</i> 8/30/13 Residential Care Services Date</p>	F 000	<p><u>The following written allegation of compliance is intended to meet the requirements for a plan of correction under state and federal law and is not an admission that the survey findings are correct or that they rise to the level of deficiencies under applicable law</u></p>	

RECEIVED  
SEP 23 REC'D  
DSHS - ADSA  
RCS - REGION 5

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Christine Miller*

TITLE

LNHA

(X6) DATE

9/12/13

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	<p>Continued From page 3 care directive.</p> <p>On 8/20/13 at 2:16 p.m., during an interview, the Director of Nursing (Staff A) stated the care directive in the residents chart should match the care directive located in the resident's room behind the closet door for the NA's to follow. Staff A reported the dysom could have been in the chair at the time of the fall, and stated the dysom may have been removed.</p> <p>The incident report did not confirm that dysom was in the chair at the time of the fall, but only included to continue with the dysom as earlier care planned. Furthermore, staff who cared for the resident did not know that the resident's wheelchair was supposed to have dysom as an intervention, and it was not documented on the NA's care directive located in the residents room behind the closet door.</p> <p><b>WHEELCHAIR EVALUATION</b></p> <p>On 8/20/13 at 3:34 p.m., during an interview, Staff A stated when a resident receives a new wheelchair, the wheelchair should be evaluated to ensure safety and a proper fit. Staff A stated an Occupational Therapist (OT) evaluation for Resident #1's wheelchair should have been done. Staff A and the Restorative Nurse (Staff B) confirmed that the wheelchair evaluation had not been done for Resident #1. Staff B stated the physician order to have the wheelchair evaluated had been discontinued by OT, and should have been communicated to the nursing staff.</p> <p>Review of the record revealed a physician's order dated 6/26/13, documented OT evaluation and treatment for wheelchair positioning. Further</p>	F 323		
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F 323	<p>Continued From page 4</p> <p>review revealed a physician's order dated 7/9/13 which documented to discontinue orders for OT evaluation and treatment for wheelchair as family provided their own.</p> <p>On 8/21/13 at approximately 12:45 p.m., during an interview, the OT (Staff C) stated the wheel chair appeared to have been a little too high so he requested to have a wheelchair evaluation. Staff C stated he asked a vendor to bring in a wheelchair more suitable, and the vendor offered the family a discounted wheelchair, but the family brought in a wheelchair of their own. Staff C stated he later received an order to discontinue the wheelchair evaluation because he realized the resident may not be able to afford the recommended wheelchair.</p> <p>During the same interview, Staff C stated it had come to his attention that the resident was in a wheelchair that was not optimal for positioning and comfort, and had been unaware that an evaluation was requested related to falls from the wheelchair. Staff C stated the previous wheelchair required the resident to slide forward a little to stand which may have contributed to the fall. Staff C stated the current wheelchair the family brought in did not appear to optimally fit either, and stated a wheelchair evaluation had not been done for the current wheelchair the family provided.</p> <p>The resident had another non-injury fall from the wheelchair on 7/2/13. The "resident occurrence report," documented, in part, "I saw the end part of the resident's wheelchair go into the bathroom, and as I entered the bathroom, I witnessed the resident falling."</p>	F 323		

*Christine Miller, LNHA 9/12/13*