

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

PRINTED: 07/18/2013
FORM APPROVED
OMB NO. 0938-0391

1232

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505332	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/17/2013
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF THE SAN JUAN ISLANDS			STREET ADDRESS, CITY, STATE, ZIP CODE 660 SPRING STREET FRIDAY HARBOR, WA 98250		
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Life Care Center of San Juan on 07/17/2013. A sample of 6 residents was selected from a census of 49. The sample included 6 current residents.</p> <p>The following complaints were investigated as part of this survey:</p> <p>2819092 2832488</p> <p>The survey was conducted by: [REDACTED] MS, RN</p> <p>The survey team is from: Department of Social & Health Services Aging and Long-Term Support Administration Residential Care Services, Region 2, Unit B 3906 H1. Street NE, Suite 100 Arlington, WA 98223-4740</p> <p>Telephone: (360) 651-6850 Fax: (360) 651-6940</p>	F 000	<p>F000</p> <p>This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. 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 the plan does not constitute agreement by the facility that the surveyor's findings constitute deficiency, or that the scope or severity regarding any of the deficiencies cited is accurately applied</p>		

RECEIVED
JUL 26 2013
ADSA/RCS
Smokey Point

Robert Crawford 7/18/13
Residential Care Services Date

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Executive Director (X6) DATE 7/24/13

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 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement current care plan interventions for two of three sampled residents (Residents 2 and 3). Failure to consistently use appropriate transfer assistance devices for Resident 2 and remain present with Resident 3 when assisting with toileting placed residents risk for safety.</p> <p>Findings include:</p> <p>1. Resident 2 was admitted in [REDACTED] 2010 with diagnoses including [REDACTED], and [REDACTED]. She had a history of a [REDACTED]. Her most recent Minimum Data Set (MDS) assessment, dated 05/21/13, identified her memory and recall abilities as intact (15/15 points on the memory assessment tool). She required a 2 person assist for turning and positioning in bed. She was unable to walk and used a wheelchair as her primary means of mobility.</p> <p>On 06/19/13 Staff A entered the room of Resident 2 to assist her from the bed to her wheelchair. The care plan directive instructed staff to use a sit-to-stand mechanical device to transfer Resident 2. Staff A placed Resident 2 in the sit-to-stand device. Resident 2 complained it was</p>	F 282	<p>F282</p> <p>Correct deficiency</p> <p>Resident 2 has been re-assessed for injury and none noted. Transfer status assessed and plan of care/care guides have been updated</p> <p>Resident 3 has been assessed for injury and none found; no changes to plan of care/care guides from incident.</p> <p>Protect from similar situations</p> <p>DOH has been notified of Nursing Assistants involved in both cases; complaints closed as below threshold. Resident transfer status and safety interventions were reviewed and the plan of care/care guides reflects current interventions.</p> <p>Prevention Measures</p> <p>Nursing Assistants were trained by the SDC on (1) where to find information on resident care, (2) how to handle an incident wherein a resident chooses not to follow the plan of care, and (3) why the plan of care is specific to how a resident is transferred and the safety interventions required.</p> <p>Random transfer audits will be conducted weekly by the SDC to establish competency of understanding transfer intervention in the</p>	

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F 282	<p>Continued From page 2</p> <p>uncomfortable and asked Staff A to remove the device sling and perform a pivot transfer rather than use the mechanical device. Staff A removed the sling of the sit-to-stand device from around Resident 2. Staff A attempted a pivot transfer with Resident 2. Resident 2 was unable to bear weight, and Staff A lowered the resident to a sitting position on the floor.</p> <p>Review of the facility investigation revealed Resident 2 was sent to the hospital later when she complained of pain in her knees. The hospital identified a contusion (bruise) to her left knee. It was treated with ice. Staff A wrote she attempted the pivot transfer at the request of Resident 2. When Resident 2 started to fall, Staff A lowered the resident to the floor. Staff A knew the care directive read to use the sit-to-stand mechanical device for transferring Resident 2. Review of the care directive revealed it instructed staff to use the sit-to-stand for transfer of Resident 2. Physical therapy reassessed Resident 2 and recommended use of the Hoyer lift for all future transfers of Resident 2.</p> <p>On 07/17/13 at 8:37 a.m., Resident 2 recalled the fall of 06/19/13. She stated she had no feeling in her right foot and could not walk. She had no walked in some time. She did not recall what assistance she needed for transferring.</p> <p>On 07/17/13 at 12:15 p.m., the Director of Nursing Services (DNS) reported all staff, including Staff A were trained to use the sit-to-stand device and the care directive informed them to use it when transferring Resident 2. All staff were educated to follow care directive instructions for each individual resident.</p>	F 282	<p>plan of care. Any concerns noted will be immediately corrected.</p> <p>Monitor Compliance</p> <p>Results of the audits will be reported to the PI committee for further follow-up.</p> <p>Date Certain July 30, 2013</p> <p>Person responsible for compliance The Director of Nursing</p>	

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F 282	<p>Continued From page 3</p> <p>Whenever any resident declined care directive guidance, staff should notify the charge nurse or the DNS. Staff A did not follow the care directive or facility policy.</p> <p>Additionally, at 12:10 p.m., the Rehabilitation Manager reported although Resident 2 perseverated on walking 3-4 times during the year, she currently did not qualify for rehabilitation therapy. She first needed restorative therapy to help strengthen her legs prior to rehabilitation for walking. Resident 2 consistently refused restorative therapy.</p> <p>2. Resident 3 was admitted in [REDACTED] 2012 with diagnoses including [REDACTED] and [REDACTED]. Her most recent MDS assessment, dated 05/21/13, identified she had severe memory and recall impairment (4/15 points on the memory assessment tool). She was a one person assist for walking and toileting.</p> <p>On 05/31/13 at 6:55 p.m., staff heard Resident 3 yell loudly "I'm falling". She was found alone in the bathroom, hanging onto the grab bar and pushing with her feet in an attempt to pull herself upright. Staff entered the bathroom and lowered the resident to the floor. She did not suffer any identified injury.</p> <p>Review of the facility investigation revealed Staff B, who was assigned to care for Resident 3, wrote she left the resident alone in the bathroom and went to assist another resident. Her care plan directive, dated 03/12/13, instructed staff to remain with her whenever she was in the bathroom for toileting.</p>	F 282		

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F 282	Continued From page 4 At 12:15 p.m., the DNS reported all staff, including Staff B, knew Resident 3 was not to be left alone when in the bathroom as she was forgetful and at risk for falling. This intervention for safety was put in place after a previous fall for Resident 3. Staff B failed to follow the care directive.	F 282			

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