

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505508	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/17/2014
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NAME OF PROVIDER OR SUPPLIER ROCKWOOD AT HAWTHORNE	STREET ADDRESS, CITY, STATE, ZIP CODE 101 EAST HAWTHORNE ROAD SPOKANE, WA 99218
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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 Rockwood at Hawthorne on 6/17/14. A sample of 3 residents was selected from a census of 19. The sample included 3 current residents.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#3014626</p> <p>The survey was conducted by:</p> <p>Danielle McLain R.N., B.S.N.</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Long-term Support Administration Residential Care Services, District 1, Unit B 316 West Boone Avenue, Suite 170 Spokane, Washington 99201</p> <p>Telephone: (509) 323-7303 Fax: (509) 329-3993</p> <p><i>L. Cramer for District</i> Residential Care Services Date 8/29/14</p>	F 000	<p style="text-align: center;">RECEIVED SEP 09 2014 DSHS ADSA RCS SPOKANE WA</p> <p style="text-align: center;">IDR AMENDED by Lisa Cramer</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jack Juhantac</i>	TITLE <i>Executive Director</i>	(X6) DATE 9/9/14
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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 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	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</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 interview and record review, the facility failed to ensure the resident had adequate interventions in place to prevent accidents for 1 of 3 residents (#1). This resulted in harm for Resident #1.</p> <p>The findings include:</p> <p>Resident #1, per record review, had diagnoses of dementia, degenerative joint disease, and osteoporosis. She required extensive assistance with activities of daily living (ADL's), including transfers and toileting. Per the facility fall risk assessment dated 10/10/13, the resident scored as "high risk" to fall. The care plan dated 5/22/14, directed the staff to use a safety alarm in wheel chair/room chair, keep the call light within reach, encourage the resident to call for assistance before she transferred, answer the call light promptly, frequent checks every 30 minutes, and toilet every 2 hours. Per review of the toileting care plan dated 5/22/14, the resident required extensive assistance with toileting and could experience dizziness related to low blood pressure.</p>	F 323	<p>With an unanticipated change in the resident's pattern of behavior that resulted in a fall on 05/29/2014, the Plan of Care was modified the same date to reflect changes appropriate to the new circumstances of resident's pattern. The Plan of Care was revised to state the resident is not to be left unattended when toileting in the bathroom, to make certain resident has her walker with her, and anticipate resident doesn't always remember to call for help and remind her to do so while interacting with her.</p> <p>The Director of Nursing Services in-serviced the licensed staff and the nursing assistants to emphasize the integration and implementation of a care plan change as resident condition or needs change, whether acute or more chronic.</p> <p>To ensure that an anticipated or unanticipated change of condition is properly assessed, a procedure will be implemented to tighten the practice of a Plan of Care review and subsequent update based on any MDS change in condition. The procedure will initiate notification</p>	7/10/14

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F 323	<p>Continued From page 2</p> <p>Per review of the latest facility assessment dated 4/21/14, the resident had a general decline in ADL's and was unsteady when transferring between surfaces and required partial physical support for balance.</p> <p>Per the last annual assessment dated 2/22/14, the resident triggered for falls related to difficulty maintaining sitting balance, standing position, impaired balance during transitions, and unsteady gait.</p> <p>Per review of the facility investigation dated 5/29/14, Staff #D left the resident in the bathroom unattended and she fell and hit her head. She sustained a laceration/hematoma to her head, a skin tear on her left elbow, and pelvic pain.</p> <p>On 6/17/14 at 2:00 p.m., Staff #C reported the resident was high risk for falls and she would not have left her unattended in the bathroom.</p> <p>On 6/17/14 at 2:20 p.m., Staff #E discussed she would not have left the resident unattended in the bathroom.</p> <p>On 6/17/14 at 3:40 p.m., Staff #F reported she would never leave the resident unattended in the bathroom, because she was "weak and fragile." She thought the policy was if the resident was high risk to fall the staff were not able to leave them in their bathroom unattended.</p> <p>On 6/17/14 at 4:30 p.m., Staff #A reported when staff noted increased weakness with a resident, they may choose to stay with that resident in the bathroom and would report it to the nurse. She reported Resident #1 had never attempted to get off of the toilet on her own.</p> <p>The facility failed to protect Resident #1 from falls despite assessment information indicating the resident had multiple risk factors for falling and needed a wheelchair/room chair safety alarm.</p>	F 323	<p>by the MDS Coordinator directly to the RN Restorative Nurse to evaluate and update any falls prevention strategies that should be added or changed on the resident Plan of Care.</p> <p>To monitor performance to maintain solutions, the RN Nurse Manager will monitor the Minimum Data Sets triggered by a condition change and review those Plans of Care to ascertain that appropriate falls prevention strategies, where determined to be necessary, were implemented. Variations in consistent practice will be brought to the attention of the Director of Nursing by the Nurse Manager.</p>	7/10/14
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