

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

PRINTED: 03/13/2013
FORM APPROVED
OMB NO. 0938-0391

1308

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505326	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/06/2013
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NAME OF PROVIDER OR SUPPLIER HEARTWOOD EXTENDED HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1649 EAST 72ND TACOMA, WA 98404
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F 000

INITIAL COMMENTS

F 000

This report is the result of an unannounced Abbreviated Standard Survey conducted onsite at Heartwood Extended Care on 2/22, 3/1 & 3/6/2013. The sample included 16 residents out of a census of 106. The sample included 12 current residents and the records of 4 former residents.

The following are complaints investigated as part of this survey:

- #2724699 #2752043
- #2758452 #2753499
- #2762105 #2714883
- #2756336 #2758827
- #2762427 #2749656
- #2727448 #2748336
- #2754127 #2754782
- #2754122

The survey was conducted by:

██████████, R.N., MSN
██████████ RN, BSN

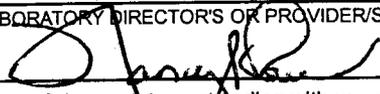
The surveyors are from:

Department of Social and Health Services
Aging and Disability Services
Residential Care Services, District 3, Unit B
1949 S. State Street
Tacoma, WA 98405-2850
Telephone: (253) 983-3800
Fax: (253) 589-7240

 3/13/13
Residential Care Services Date

RECEIVED
LSC - REGION 5
DCHS - DOW
RCS - REGION 5

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



TITLE

Administrator

(X6) DATE

3/27/13

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 observations, record review, and interview, the facility failed to ensure care plan interventions for fall prevention were followed for 1 of 10 residents (#1) reviewed for falls.</p> <p>This failure placed Resident #1 at risk for further injuries from falls.</p> <p>Findings include:</p> <p>Record review revealed Resident #1 admitted to the facility with multiple medical diagnoses including a history of [REDACTED] with [REDACTED] prior to admission.</p> <p>Review of facility investigations dated 2/10 and 2/11/13 revealed the resident fell and sustained an abrasion and skin tear on his elbow and knee respectively. Facility investigation showed the resident's care plan interventions were in place at the time of the above falls.</p> <p>Record review revealed an x-ray dated 2/12/13 showed a vertebral compression fracture (L-3) of indeterminate age. An outpatient procedure (vertebroplasty) was done on 3/1/13 to repair the fracture. Following the procedure, the resident needed to remain flat for 24 hours. A personal</p>	F 282	<p>The services provided or arranged by the facility will be provided by qualified persons in accordance with each resident's written plan of care. Staff J and K received written behavior/performance counseling regarding failure to follow the care directive to assure resident safety. Inservicing was directly initiated for all N.A.C.'s regarding enablers/devices and policy and procedures. (3/6/13 and 3/7/13). (Attachment #1). Including immediate reporting of maintenance repairs.</p> <p>The facility conducted inservicing to all nursing staff regarding rounds to be made initially to ensure all safety devices/enablers are in place, proper positioning of the resident and bed is in position as directed. (3/25/13). (Attachment #2). Identification and location of enablers/devices on care directives is reviewed on hire, quarterly, annually and ongoing as needed.</p> <p>Random, and ongoing audits will be done to assure compliance. These will be done as assigned to nursing staff as assigned by the Director of Nursing.</p>	4/10/13

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F 282	<p>Continued From page 2</p> <p>alarm was implemented on 3/1/13 to alert staff if the resident attempted self-transfer from bed.</p> <p>During observation rounds on 3/6/13 at 11:40 a.m., Resident #1 was observed sleeping on his back in a low bed with the bed against the wall and a mat on the floor next to the bed. A bed alarm and call light were not visible on or near the resident.</p> <p>Interview with Staff J (certified nursing assistant) at 11:40 a.m., revealed she was assigned to provide care for Resident #1. Staff J stated she knew the resident had an alarm; however, did not know where the alarm or the call light was located at that time. Staff A stated she did not put on the resident's alarm earlier in the morning. Staff A pulled the bed out from the wall; the alarm was observed on the floor, entangled with the call light and call light cord. Staff J attached the alarm to the resident's shirt and placed the call light within his reach.</p> <p>Review of Resident #1's care directives with Staff A, (posted in the resident 's closet), revealed use of the alarm was a current fall prevention measure dated 3/1/13. Staff I (care manager) was informed about the above observations.</p> <p>During rounds at 2:30 p.m. on 3/6/13, Staff K (certified nursing assistant) was observed coming out of Resident #1's room. Staff K stated she was assigned to care for the resident on the evening shift and was passing linens as she made rounds. Resident #1 was observed with the bed raised approximately 2 feet from the floor. The fall mat was not lined up with resident's position in bed; the top of the mat was lined up with the</p>	F 282		

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F 282	<p>Continued From page 3</p> <p>resident's shoulder which placed the resident at risk of potentially hitting his head during a fall from bed. The resident's alarm was not visible; Staff K stated she had not checked to see if the alarm was attached to the resident during rounds, did not notice the bed was not in the lowest position or the position of the mat.</p> <p>Staff K turned on the over bed light and located the alarm which was lying next to the resident in bed and attached to the resident's shirt. Staff K attached the alarm box to the headboard where it was visible for staff to see, lowered the resident's bed and adjusted the floor mat.</p> <p>Review of the care directives in the resident's room revealed in addition to the alarm, the low bed and mat on the floor were documented on the care directives as current interventions for resident safety.</p> <p>On 3/6/13 at 3:15 p.m. Staff A (director of nursing) was informed about the above observations and staff interviews.</p>	F 282		
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