

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505383	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/12/2014
NAME OF PROVIDER OR SUPPLIER SULLIVAN PARK CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 14820 EAST FOURTH SPOKANE, WA 99216	

(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 and partial extended survey conducted at Sullivan Park Care Center on 8/11/14 and 8/12/14. A sample of 4 residents was selected from a census of 117.</p> <p>The following complaint was investigated as part of this survey</p> <p>#3030926</p> <p>On 8/12/14 an immediate jeopardy was identified related to F323-accidents and supervision.</p> <p>Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, District 1, Unit B Rock Pointe Tower 316 W. Boone Avenue, Suite 170 Spokane, Washington 99201-2351</p> <p>Telephone: (509) 323-7302 Fax: (509) 329-3993</p> <p><i>Ron Heine 8/13/14</i></p>	F 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">AUG 18 2014</p> <p style="text-align: center;">DSHS ADSA RCS SPOKANE WA</p>	<p style="text-align: right;">10</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8/15/14</i>
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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 000 F 176 SS=D	<p>Continued From page 1 Residential Care Services 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure 1 of 1 (#3) residents observed with medications unattended at the bedside was assessed to be safe to self administer medications. This failure placed the resident at risk for medication errors. Findings include:</p> <p>Resident #3 was admitted to the facility with diagnoses including [REDACTED]. She was alert and oriented and able to make her needs known. Per review of the facility medication pass policy dated July 1999, it stated to never leave medications at the bedside or unattended. Per record review of the self administration assessment dated 6/6/14, Resident #3 preferred to receive her daily medication from a licensed nurse. During an observation on 8/11/14 at 11:15 a.m., a medication cup full of a variety of pills was on Resident #3's bedside table. Resident #3 had been out of the room and just returned from a bath. When asked about the pills, she stated they must be her morning medications, but she wasn't</p>	F 000 F 176	<p>F-176- Resident #3 meds were given by LN when she returned to her room. Staff member was re-educated on safe medication administration.</p> <p>The LN staff was re-educated on the policy for safe medication administration. The written policy was also given to each LN.</p> <p>An audit tool was obtained from the pharmacy consultant Nurse to use as a tool to monitor/audit LN medications pass a minimum of once per week.</p>	

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F 176	Continued From page 2 . . . sure. In an interview on 8/11/14 at 11:16 a.m., Staff #1 stated she had remembered giving Resident #3 her morning medications but could not recall if resident had taken the medication. Staff #1 stated in the past she had left medications with the resident to take if the resident wasn't ready or eating. Failure to have an assessment to determine the resident could safely self administer medications left her at risk for medication errors.	F 176	The RCM's, DNS, ADNS will do weekly random audits to ensure compliance. The facility will be in compliance 8/21/2014. The Administrator, DNS and RCM's will ensure compliance.		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure safety interventions and adequate supervision was implemented for 1 of 4 residents (#1) related to transfers that involved the use of a mechanical lift. Resident #1 experienced actual harm as of result of a fall when care plan interventions were not followed. In addition, after the fall, the facility failed to reevaluate and develop targeted interventions for Resident #1 to ensure proper supervision, technique, and safety	F 323	F323- Resident #1 had a care plan adjusted to give instruction to the staff to prevent the resident from falling/sliding out of the mechanical Hoyer sling. The facility did re-evaluate, re-educate safe Hoyer transfer, requiring staff to		

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F 323 Continued From page 3
precautions were thoroughly understood and implemented by staff who transferred the resident. This failure allowed the resident to be at continued risk of fall and injury during transfers. This was determined to be an Immediate Jeopardy on 8/12/14.

Findings include:

Resident #1 had diagnoses including a progressive [redacted] that caused the resident to experience [redacted]. Per record review, Resident #1 was alert and oriented and able to make her needs known. She required extensive assist with transfers.

The resident's care plan identified the resident was at risk for falls related to total body [redacted] and [redacted]. The care plan directed staff to use a Hoyer (a mechanical lift) with 2 person assist when transferring. A mechanical lift is used by placing the resident in a sling which is then lifted in the air by hydraulic power. This allows the resident to be transferred between areas like a bed to a chair. There was no safety assessment found for the use of the mechanical lift to be used for this resident with [redacted].

In addition the care plan identified the resident's need for an upper body harness and seatbelt while in wheelchair to maintain position and safety related to inability to control body movements.

According to the resident's record, on 7/24/14 while suspended in the Hoyer lift, the resident fell forward, face first and hit her forehead on the floor. There was only one staff member

F 323 perform return demonstration.

The care givers for resident #2 were re-educated as well on proper technique using a Hoyer lift to transfer residents. On 7/25/2014 the day after the resident slid out of the Hoyer sling re-education was done on safe Hoyer transfers. This was done with the NAC and LN on duty at the time of the incident. In addition an in-service was done with an additional 45 employees. On 8/6/2014 a licensed Nurse meeting also included guidelines for safe

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F 323	<p>Continued From page 4 . . .</p> <p>completing the transfer at the time of the fall. The resident was sent to the hospital for required medical treatment of the head injury. The facility investigation of the incident determined the staff was not following the care plan when the fall occurred.</p> <p>Per review of the facility investigation, the facility provided a "mini" inservice to staff dated 7/25/14. The inservice stated that "all Hoyer transfers were to be done with 2 person total assist and while transferring with a Hoyer both staff members were to ensure the sling was placed correctly, surrounding areas are clear and the bed, wheelchair etc. are ready". Despite the knowledge of the resident's previous fall, no education specific to Resident #1 and risk of her falling forward was given to staff. The "mini" inservice was signed by only 6 staff members. No changes were made to Resident#1's care plan at that time. The safety of the Hoyer lift was still not evaluated. These failures placed the resident at risk for another significant injury.</p> <p>During an interview on 8/11/14 at 1:00 p.m., Resident # 1 was able to recall the fall, she pointed to her forehead where a scar was visible. She stated prior to her fall she had been transferred with only one staff member using the Hoyer lift.</p> <p>On 8/11/14 at 1:15 p.m., an observation was made of Resident #1 being transferred from her wheelchair to the toilet. Resident #1 was in her wheelchair seated in an upright position and her seat belt and safety harness were removed by staff. The resident was left slumped in her wheelchair with no safety devices in place, while both staff proceeded to gather supplies in the</p>	F 323	<p>Hoyer transfers and following the care plan. This meeting was attended by 29 licensed staff. A restorative referral was done on 7/25/2014 to evaluate the Hoyer lift, the sling and training on technique of the staff doing the Hoyer transfers. All residents in the facility requiring mechanical lifts for transfers were evaluated by the Therapy Department Manager and Restorative Manager to assess the need of a mechanical lift, sling size and staff performance for safe Hoyer transfer.</p>	<p style="text-align: right;">JD</p>

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F 323	<p>Continued From page 5</p> <p>resident's room and bathroom. Neither staff were facing the resident, nor were they in arms length of resident. Leaving the resident unattended after removing her safety harness and seatbelt placed the resident at risk to fall out of her wheelchair.</p> <p>Resident #1 was then placed in the Hoyer sling, and taken to bathroom. During that time Staff #A was controlling the Hoyer's lift mechanism and Staff# B was behind the resident and intermittently placed her hands on the resident's back. Neither staff members were positioned in front of the resident to prevent her from falling forward as she had in the fall less than a month prior. Upon return from the bathroom the resident experienced a muscle spasm causing her to jerk her body forward, at that time she was suspended over her bed still in the Hoyer sling. Staff #B who was observed by surveyor transferring the resident was not listed as receiving the inservice dated 7/24/14.</p> <p>In an interview following the transfer Staff #A stated staff use different slings. There were no specific instructions on which sling should be used for this resident. The slings observed were different sizes and would suspend the resident at different angles. No evaluation was completed to determine which sling was safest for this resident who was at high risk to fall forward.</p> <p>Resident #2 was observed being transferred using a Hoyer by 2 staff members from her bed to her wheelchair on 8/11/14 at 10:00 am. While in the Hoyer Resident #2 was suspended in the air and swinging back and forth and the fabric strap was hitting the resident's face. Staff #C commented to the resident about the strap hitting her, but made no attempts to keep it away from</p>	F 323	<p>Residents using a Hoyer Mechanical lift had a safety assessment.</p> <p>Modifications to specific instructions were added to the facility protocol in the form of competency training tool to verify they have been thoroughly trained on the use of mechanical lifts to transfer residents. Results of competency audits will be referred to the process improvement team for further follow-up.</p> <p>A minimum of one audit per week will be completed by the RCM's and one per</p>	<p style="text-align: right;">80</p>

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F 323	<p>Continued From page 6</p> <p>her face. Staff #C operated the Hoyer lift controls (elevation and decent) and Staff #D prepared and positioned the wheelchair, neither staff had their hands on the resident until she was lowered into the wheelchair. Per interview after the transfer was complete, Staff #C stated it was a normal transfer and the job of the second person during the transfer was to spot and help position the resident. In a follow up interview 8/11/14 at 5:07p.m., Staff #C stated Staff #D "should have been spotting the resident and could have stopped her from swinging by grabbing the sling". Neither Staff #C or #D were listed as receiving the inservice given on Hoyer transfers after the fall involving Resident #1.</p> <p>On 8/11/14 the facility was informed of the observations and the concern for resident safety related to transfers using the Hoyer. Staff# E, the Director of Nursing immediately provided re-education to current staff on duty which included to read the care plan in the resident's closet that provided direction on how to transfer the resident to ensure safety. Per review of the care plan, the last update/revision was dated 6/4/13. No updates were made to the resident's care plan related to Hoyer transfers or to be aware of her risk to fall forward. The inservice directed the staff to follow the resident's care plan but the facility failed to update the resident's care plan. This again placed the resident at risk for significant injury.</p> <p>Per interview with physical therapy department on 8/12/14 Staff #F stated they perform safety assessments on residents if they were notified to do so. Per Staff #G, Director of Rehabilitation, the last assessment completed on Resident #1 was dated April 2014 and was related to a wheelchair assessment.</p>	F 323	<p>week by the restorative manager using the competency tool for mechanical lifts.</p> <p>The facility will be in compliance 8/21/2014.</p> <p>The Administrator, DNS, RCM's and Restorative department will ensure compliance.</p>	

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F 323	<p>Continued From page 7 . . .</p> <p>On 8/12/14 Staff #H stated he had reviewed the mini inservice with staff that morning and was planning to watch them complete a transfer later that morning. Staff were allowed to continue transfers with the resident before being evaluated on their transfer methods despite prior knowledge unsafe transfers had occurred with Resident #1 the day before. The lack of supervision of staff performing transfers again placed Resident #1 at risk for another injury.</p> <p>The facility failed to ensure safety interventions and adequate supervision was implemented and despite a resident experiencing a fall with a head injury requiring medical treatment no thorough reevaluation of safety was completed. No targeted interventions to ensure proper supervision, technique, and safety precautions were developed to ensure safe transfers for the resident. These failures resulted in continued risk of significant injury to Resident #1 and others residents using a Hoyer lift.</p>	F 323			

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