

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

receipt
2/18/16

PRINTED: 02/12/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505512	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/10/2016
NAME OF PROVIDER OR SUPPLIER GARDEN TERRACE HEALTHCARE CENTER OF FEDERAL WAY			STREET ADDRESS, CITY, STATE, ZIP CODE 491 SOUTH 338TH STREET FEDERAL WAY, WA 98003		
(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 Survey conducted at Garden Terrace Alzheimer's Center of Excellence on 02/9/2016 and 02/10/2016. A sample of two residents was selected from a census of 58 and included the closed records of one discharged resident.</p> <p>This survey included investigation of the following complaints: #3188222</p> <p>Survey team members included: Susan Loewen MSN. RN., Complaint Investigator</p> <p>The survey team is from: Department of Social and Health Services Aging and Adult Services Administration Residential Care Facilities District 2, Unit F 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388</p> <p>Telephone: (253) 234-6000 Fax: (253) 395-5070</p> <p><i>Mike Asberry</i> 02-12-16 Residential Care Services Date</p>	F 000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

M. Asberry *Executive Director* *2/22/16*

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=D	<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 observation, interview and record review the facility failed to ensure adequate supervision for one of two sampled residents (Resident #1) who required mechanical lift transfers. Failure to provide adequate supervision prevented direct-care staff from transferring Resident #1 correctly which caused the mechanical lift to tip and strike Resident #1 and staff. Such a failure had the potential to cause major neurological and other bodily trauma.</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility with diagnoses of [REDACTED] [REDACTED] difficulty walking and muscle weakness according to the 01/28/16 Minimum Data Set. Staff documented on this assessment Resident #1 was able to make his own decision, required extensive two-person physical assistance with transfers and weighed [REDACTED] pounds. Resident #1 was not available for interview.</p> <p>A 01/23/16 Physical Therapy (PT) assessment,</p>	F 323	<p><i>"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."</i></p> <p>F- 323</p> <p><u>Individual Residents</u> Resident #1 no longer resides at the facility.</p> <p><u>Residents in similar situations</u> Residents being transferred with Hoyer mechanical lifts were re-assessed for appropriate use and technique. Care plans and care directives were reviewed for accuracy and updated if indicated for residents receiving Hoyer lift transfers.</p> <p><u>Measures to prevent reoccurrence</u> Licensed nurses and NACs were re-educated on correct Hoyer lift transfers. They demonstrated proper technique by return demonstration. Nursing personal will receive transfer training upon hire, annually and as indicated.</p>	

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F 323	<p>Continued From page 2</p> <p>plan and treatment record indicated "The patient will safely transfer from bed (to/from) wheelchair increasing to moderate assistance (two times per day with two people) with slide board transfer. A 02/08/16 PT note indicated Resident #1 experienced a change in condition around 02/05/16 that included anxiety, activity intolerance, and poor sitting balance that made slide board transfer obsolete. Staff indicated a mechanical lift was to be used for transfers.</p> <p>According to the 01/22/16 Care Plan Resident #1 included no instruction to staff on how to transfer the resident. There were no updates to this care plan with this information. The updated 02/05/16 Care Directives (CD) instructed direct-care staff to use a "Hoyer" mechanical lift to perform two-person transfers.</p> <p>A Hoyer mechanical lift is an alternative to manual transfers where staff use physical strength to assist and transfer residents from one surface to another. According to the undated Liko manufacture's instructions a mechanical lift with a sling is a "...versatile mobile lift...aids for daily transfers of adults...lifting to and from wheelchair to bed..." The instructions came with a warning that included, " Certain environmental conditions can limit the correct use of the mobile lifts, including...various obstacle...(that) can cause ...possible imbalance..."</p> <p>The facility provided instructions on the use of a mechanical lift to staff on 06/30/15 that included, "2. 2-person transfer - every time. 4. Have lift (base)legs open wide when lifting, for better stability. and 5. For transferring and maneuvering thru narrow passages, have (base) legs in closed/narrow position." Additional</p>	F 323	<p><u>On-going Monitoring</u></p> <p>Audits of care plans and care directives will be conducted to confirm accuracy, and therapy's recommendations, will be conducted weekly x 4 weeks and then monthly for 2 months. Audits will be presented to the DON. Negative findings of the audits will be presented to the monthly QAPI committee x3 months for further education and training opportunities</p> <p><u>Individual to Ensure Compliance</u></p> <p>Director of Nursing or Designee will ensure compliance.</p> <p>Date of Compliance: 02/25/2016</p>		

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F 323	<p>Continued From page 3 instruction included "Make sure path is clear for transfer."</p> <p>Staff D and E said and demonstrated, in an interview with observation on 01/10/16 at 8:30 a.m., the transfer of Resident #1 from the bed to the wheelchair was made difficult because the wheelchair was against the wall and the space between the bed and the wheelchair was minimal, approximately four feet. These staff demonstrated how they lifted Resident #1 from the bed without widening the base legs and then inserted one base leg between the front and back wheels of Resident #1's wheelchair. This placed Staff D at the control panel that raised and lowered the lift, and Staff E at the sling bar opposite from the resident, allowing a gap between Resident #1 and the chair. Staff D and E continued, saying that Resident #1 was about six inches in height from the seat of the wheelchair when the lift began to tilt striking Staff E first then Resident #1 on the forehead.</p> <p>Staff D and E said during this interview/demonstration, they had used the same transfer technique repeatedly with success. This indicated that the resident was transferred incorrectly more than once.</p> <p>Interview with Staff F, on 01/10/16 at 9:15 a.m., revealed at least two options staff could have used to safely transfer Resident #1. Both options included repositioning the wheelchair so staff had more room than the four feet Staff D and E said existed and widening the base legs to increase stability. Neither option included placing one base legs between the front and back wheels of the wheelchair which limited staff access to the resident and created poor stabilization. Both</p>	F 323			

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F 323	Continued From page 4 options indicated one staff at the controls and one staff at the sling bar behind the resident. Staff C said, in an interview on 02/10/16 at 9:00 a.m., Resident #1 was observed to have a reddened are on the mid forehead after the incident. When documentation was requested from Staff A and B on 02/10/16 at 9:30 a.m. to support neurological assessment was performed to ensure there was no major trauma, none was provided. The facility failed to supervise direct-care staff who, contrary to the facility's instruction did not provide a clear path, ensure stability of the mechanical lift by widening the base of the device and did not position staff to ensure proper resident position when being lowered to the wheelchair. The facility did not ensure proper transfer of Resident #1 from the bed to the wheelchair.	F 323			

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AGING AND DISABILITY SERVICES ADMINISTRATION
Nursing Home Survey Report
STATE AND CORRESPONDING FEDERAL REQUIREMENTS

1. Page <u>1</u> of <u>1</u> Pages
2. DATES OF DATA COLLECTION 03/01/2016
5. TIME OF SURVEY <input checked="" type="checkbox"/> Day <input type="checkbox"/> Night <input type="checkbox"/> Weekend <input type="checkbox"/> Holiday
7. LICENSE NUMBER 1350

3. NAME OF FACILITY Garden Terrace Alzheimer's Center of Excellencer	4. TYPE OF SURVEY <input type="checkbox"/> Full <input checked="" type="checkbox"/> Post <input checked="" type="checkbox"/> Complaint <input type="checkbox"/> Other: specify _____
6. STREET ADDRESS 491 S. 338th	CITY STATE ZIP CODE Federal Way WA 98003

NOTE: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.

8.	9. WASHINGTON ADMINISTRATIVE CODES 388-97	10. CODE OF FEDERAL REGULATION 42 CFR 483.	11. FEDERAL DATA TAG NUMBER	12. REPEAT DEFICIENCY FROM SURVEY DATED	13. NEW CITATION ON POST SURVEY	14. LICENSEE'S PLANNED DATE OF CORRECTION
<input type="checkbox"/> The requirements of the following WAC's and corresponding CFR's were not met. The text of the statements of deficiencies and the licensee's plan of correction may be read on CMS form 2567, dated: <u>02/10/2016</u> . **Licensee must complete column 14. <input checked="" type="checkbox"/> The following deficiencies were determined to be corrected.	-1060(3)(g)	.25(h)(2)	F-323	7-23-14	<input type="checkbox"/>	02/25/16
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					<input type="checkbox"/>	

15. SURVEYOR'S SIGNATURE(S)

SIGNATURE	DATE <u>03/02/16</u>	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

16. LICENSEE OR AGENT

SIGNATURE OF LICENSEE (OR AGENT)	TITLE	DATE
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AGING AND DISABILITY SERVICES ADMINISTRATION
Nursing Home Survey Report
 STATE AND CORRESPONDING FEDERAL REQUIREMENTS

1. Page 1 of 1 Pages

2. DATES OF DATA COLLECTION
02/9 & 10/2016

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15. SURVEYOR'S SIGNATURE(S)

SIGNATURE <i>Austen Lee Lowen man</i>	DATE <i>2/10/16</i>	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE

16. LICENSEE OR AGENT

SIGNATURE OF LICENSEE (OR AGENT) <i>M. Bal</i>	TITLE <i>Executive Director</i>	DATE <i>2/22/16</i>
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15. SURVEYOR'S SIGNATURE(S)			
SIGNATURE <i>Susan Lee Lowen man</i>	DATE <i>2/10/16</i>	SIGNATURE	DATE
SIGNATURE	DATE	SIGNATURE	DATE
16. LICENSEE OR AGENT			
SIGNATURE OF LICENSEE (OR AGENT)	TITLE	DATE	