

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

PRINTED: 10/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/09/2014
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NAME OF PROVIDER OR SUPPLIER  TOPPENISH NURSING & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 802 WEST THIRD STREET TOPPENISH, WA 98948
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Toppenish Nursing &amp; Rehab Center on October 9, 2014. A sample of 3 residents was selected from a census of 64 residents. The sample included 2 current residents and the records of 1 discharged and/or former resident.</p> <p>The following was a complaint investigated as part of this survey:</p> <p>#3043348</p> <p>The survey was conducted by: Patti Zimmer, R.N.</p> <p>The survey team is from: Department of Social &amp; Health Services Aging &amp; Long Term Support Administration Residential Care Services, District 1, Unit C 3611 River Road, Suite 200 Yakima, Washington 98902</p> <p>Telephone (509) 225-2800 Fax: (509) 574-5597</p> <p><i>Patti Zimmer</i> 10/21/14</p> <p>Residential Care Services Date 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment</p>	F 000	<p><b>F000</b></p> <p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Toppenish Nursing &amp; Rehab Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>Received Yakima RCS NOV - 8 2014</p>	
F 225 SS=D		F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>ABD</i>	TITLE <i>Admin</i>	(X6) DATE <i>11/3/2014</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 225	<p>Continued From page 1</p> <p>of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to perform a thorough investigation in accordance with CFR 483.15(c)(3) for 1 of 3 sampled residents (#1) reviewed for incidents resulting in injury. Failure to perform thorough investigations disallowed an opportunity to gather</p>	F 225	<p><b>F 225</b></p> <p><b>Resident #1 no longer resides at the facility.</b></p> <p><b>Residents with history of /or actual falls have the potential to be affected. In- house residents were reviewed to ensure potential or actual fall risk issues have all been appropriately care planned.</b></p>		

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F 225	<p>Continued From page 2</p> <p>data to determine the etiology of the injury, and to implement protective interventions to prevent recurrence. Findings include:</p> <p>Resident #1: Admitted to the facility on [REDACTED] from the hospital with diagnoses which included [REDACTED]</p> <p>Review of Progress Notes dated 9/23/14 at 1:27 p.m. revealed the resident's family informed staff the resident was a high fall risk with multiple attempts to fall forward out of her wheelchair. Later that day at 10:13 p.m. documentation stated the resident made numerous attempts to get out of her bed and wheelchair. On 9/24/14 at 8:12 p.m. the resident was observed seated on her buttocks on the floor. No injuries were assessed at that time, however the following day (9/25/14) at 10:39 a.m. the resident's right wrist was noted to be swollen. The physician was notified on 9/25/14 with orders obtained for x-rays to be done. X-ray results revealed a fracture and dislocation of the resident's right arm. Following the results of the x-ray the physician ordered to transport the resident to the hospital for a further evaluation. The resident returned to the facility from the hospital on [REDACTED] with a long-arm cast to the right arm.</p> <p>Review of the facility investigation report and interviews with Staff A (Administrative Licensed Nurse) on 10/9/14 at 3:00 p.m. revealed a family member was with the resident in her room after she returned from her medical procedure at approximately 6:45-7:00 p.m. on 9/24/14. The family member was advised at that time by Staff A to notify a staff member when she was ready to leave the facility due to the resident's high fall risk. The resident was found by staff on the floor</p>	F 225	<p><b>Resident Care Managers were re-educated by Director of Nursing Services regarding completion of fall investigations to include witness statements and review of fall history.</b></p> <p><b>Licensed Staff were re-educated by Director of Nursing Services regarding completion of fall risk scale and implementation of care planning interventions to reduce risk of falls.</b></p> <p><b>To ensure on-going compliance DNS/designee to complete weekly audits to ensure new admissions have had fall risk assessment completed and appropriate interventions have been care planned. DNS/designee will also complete weekly audits to ensure fall incidents have been thoroughly investigated and care plan interventions are up to date. Audits to continue weekly for four weeks, then monthly for two months. Copy of audit(s) with findings (negative outcomes/trends/patterns) will</b></p>	

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F 225	Continued From page 3 of her room at 8:12 p.m. on 9/24/14. Documentation stated staff had been unable to reach the resident's family member to determine if she notified a staff member prior to her leaving the facility.  Review of the investigation report revealed the investigation was not thorough as evidenced by no interviews conducted to determine the etiology of the resident's fall and her past history of falls. Despite the significant injury to the resident due to a fall and her history of falls, staff had not developed preventative measures to prevent recurrence of falls.	F 225	<p><b>be provided to the Administrator for review and follow-up as necessary. Issue will be reviewed during monthly Performance Improvement Meeting for 3 months or until resolved to ensure continued compliance.</b></p> <p><b>Our date of compliance is October 31, 2014.</b></p>	