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

1397

PRINTED: 04/16/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505483		C 04/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALASKA GARDENS HEALTH AND REHABILITATION	6220 SOUTH ALASKA STREET TACOMA, WA 98408

(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	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Standard Survey conducted onsite at Alaska Gardens Health & Rehab on 4/10/13. The sample included 4 residents out of a census of 99. The sample included 4 current residents. The following are complaints investigated as part of this survey: #2776795 The survey was conducted by: [redacted] R.N., BSN The Complaint Investigators were from: Department of Social & Health Services Aging & Long-Term Support Administration Division of Residential Care Services, District 3, Unit C P.O. Box 45819 Olympia, Washington 98504-5819 Telephone: 360.664.8420 Fax: 360.664.8451 Joan Price 4-16-13 Residential Care Services Date	F 000	*1. How corrective action accomplished for the identified residents?* *Resident #1 has his seatbelt in place* *2. How you will identify other residents with the potential of being affected by the same practice?* *Physician orders were audited to validate that any devices that maintenance had to apply are in place.* *3. Address what measures will be put in place to ensure deficient practice will not recur* *Maintenance has been reeducated on timely application of assistive devices.* *Maintenance to sign maintenance log when work order is completed and verbally inform DNS/RCM of completion of applying device.*	

RECEIVED
MAY 02 2013
DSHS - ADSA
RCS - REGION 5

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505483		C 04/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALASKA GARDENS HEALTH AND REHABILITATION	6220 SOUTH ALASKA STREET TACOMA, WA 98408

(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	Continued From page 1	F 000		
F 323 SS=D	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 the facility failed to implement the fall prevention measures for one (Resident #1) of four sampled residents with a history of prior falls in a timely manner. This failed practice resulted in the resident sustaining a "traumatic subdural hematoma" and a "laceration to his forehead" when he fell from his wheelchair. Findings include: Resident #1 was alert and well-groomed. He was able to respond to simple yes and no questions. His diagnosis included [redacted] and [redacted] from a prior [redacted] ([redacted]). The resident was observed to be able to self-propel himself in his wheelchair. He	F 323	*4. How will the plan be monitored to ensure the solutions are sustained?* *ED to complete weekly audits x 1 month and monthly x 2 months to validate devices are applied timley and process is followed for completion. Findings to be brought toCQI for further review.* *5. Person responsible to validate compliance* *ED is resonsible* *April 26, 2013*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	505483		C 04/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALASKA GARDENS HEALTH AND REHABILITATION	6220 SOUTH ALASKA STREET TACOMA, WA 98408

(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 323	Continued From page 2 was observed to have a seat belt on his wheelchair which had an alarm. The resident was observed to be able to self-release the seat belt which set off an alarm which alerted staff the resident was attempting to get up without staff assistance. The DNS (director of nursing services) was interviewed on 04/10/13 at 11:15 a.m. She stated the resident had history of frequent falls from his wheelchair when he tried to stand without staff assistance. The resident had used a self-releasing alarmed belt in the past to alert staff when he attempted to get up so staff could assist him. The alarmed belt was installed on 3/20/13 by maintenance but had been ordered on 3/11/13 to be installed (9 day delay). The director stated, since the incident, she was working with the maintenance department as well as nursing and the restorative program which assisted in the proper placement of equipment to wheelchairs to make sure orders were completed timely. Nurse A was interviewed on 04/10/13 at 12:30 p.m. She frequently worked with the resident. She said the resident could self-release his seatbelt and frequently did this. The alarm was helpful since it gave staff time to come help the resident when the alarm sounded. Nurse B was interviewed on 04/10/13 at 01:00 p.m. She also worked with the resident on a regular basis. She was working the day the resident fell. The resident could self-release his seat belt and frequently did this. The alarm was helpful since it provided staff a chance to come help the resident before he tried to get up by himself. At the time, the resident (on 3/20/13) did	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505483		C 04/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALASKA GARDENS HEALTH AND REHABILITATION	6220 SOUTH ALASKA STREET TACOMA, WA 98408

(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 323	Continued From page 3 not have his seat belt installed on his wheelchair. The seatbelt was installed after the resident fell on 03/20/13. The maintenance director was interviewed on 04/10/13 at 01:25 p.m. He said he installed the seatbelt on 03/20/13 to the resident's wheelchair. He said he did originally receive and order on 03/11/13 but it was not done until 3/20/13 when he received another order for the seatbelt. Due to the volume of requests he sometimes received staff was now going to call and leave messages for him as a way to help make sure requests were carried out timelier. The Administrator was interviewed on 04/10/13 at 02:00 p.m. The administrator said the maintenance staff worked in conjunction with the restorative program when equipment modifications were made to wheelchairs. As result of the delay in the resident receiving his seatbelt, the facility was working with staff to make a follow-up call to maintenance for service requests as well as forward a copy of the request to restorative services. Resident #1's record was reviewed. The resident had fallen on 03/20/13 from his wheelchair while sitting at the nurses' station when he attempted to stand and fell forward hitting his head. The resident sustained a laceration to his forehead. The facility did neurological checks after the fall. The resident was sent out to the local hospital on 3/21/13 when he began to show signs of right sided weakness and lethargy. The local hospital admission record was reviewed. The resident was sent to the hospital	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	505483		C 04/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALASKA GARDENS HEALTH AND REHABILITATION	6220 SOUTH ALASKA STREET TACOMA, WA 98408

(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 323	Continued From page 4 on 3/21/13 where Resident #1 was found to have a skin tear to his forehead and traumatic subdural hematoma. The resident was kept overnight and returned to the facility on [redacted]/13. Review of the physician orders showed the physician ordered reinstatement of the resident's alarmed seatbelt on 3/11/13. The maintenance log was reviewed and showed the alarmed seatbelt was installed on the resident's wheelchair on 3/20/13. The maintenance log showed the request for the seatbelt was made on 3/11/13 and again on 03/20/13 the day the resident fell.	F 323		