

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

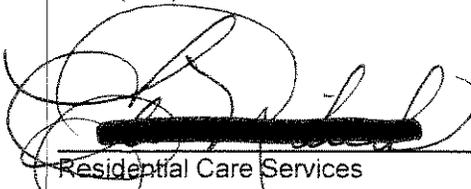
PRINTED: 03/06/2014
FORM APPROVED
OMB NO. 0938-0391

1416

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2014
--	--	--	--

NAME OF PROVIDER OR SUPPLIER HARMONY HOUSE HEALTH CARE CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 100 RIVER PLAZA BREWSTER, WA 98812
---	--

(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 Quality Indicator Survey conducted at Harmony House Health Care Center on 2/3/14, 2/4/14, 2/5/14, 2/6/14, 2/10/14, and 2/11/14. A sample of 30 residents was selected from a census of 51. The sample included 27 current residents, and the records of 3 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████, R.N., B.S.N. ██████████, R.N., B.S.N. ██████████, R.N., B.S.N.</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging and Long-Term Support Administration (AL TSA) Division of Residential Care Services, District 1, Unit A 316 West Boone Ave., Suite 170 Spokane, Washington 99201-2351</p> <p>Telephone: (509) 323-7300 Fax: (509) 329-3993</p> <p> Residential Care Services</p>	F 000	<p style="text-align: center;">RECEIVED</p> <p style="text-align: center;">MAR 17 2014</p> <p style="text-align: center;">DSHS ADSA RCS SPOKANE WA</p>	
-------	--	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE owner/admin	(X6) DATE 3-12-14
--	----------------------	----------------------

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: 505430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2014
NAME OF PROVIDER OR SUPPLIER HARMONY HOUSE HEALTH CARE CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 100 RIVER PLAZA BREWSTER, WA 98812		
(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 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to implement interventions for specific conditions related to skin care in 1 of 3 (# 53) residents reviewed for skin integrity in a sample of 30. Findings include:</p> <p>Resident #53 was admitted to the facility in [REDACTED] 2013. The resident's diagnoses included long term [REDACTED] therapy (use of medication that [REDACTED]). The facility assessment of activities of daily living (ADL's) included the assistance from staff for bathing and shaving.</p> <p>Per record review, Resident #53 received two daily blood thinners and routine laboratory studies to determine blood viscosity. Record review of the resident's care plan included an update on 02/05/14 for staff to use an electric razor, after the resident had incidents from shaving nicks to his chin.</p> <p>The treatment record for the resident dated 12/06/13 revealed the need for dressing changes/care for chin cuts. Nurse progress notes for 01/16/14 included " resident chin was bleeding</p>	F 309	<p>F-TAG 309</p> <p>This resident sustained nicks from a razor and had 2 episodes of reopening of the nicks. Although the electric razor was ordered and present in the building the specific aide that was providing care for the resident opted to use a regular disposable razor vs. the electric since it was not in the residents room at the time of am cares. The facility has changed this resident's care plan to include "use electric razor only, do not use disposable razors". This identifies that there is no option and shaving is exclusive to the use of electric razor only. This resident's skin contour is irregular and has scar tissue present, increasing the risk for nicks and cuts.</p> <p>Upon admission, and for current residents, the facility will assess and support use of electric razors for residents that are on anticoagulants as appropriate. Also, the standing treatment orders for all residents on anticoagulants will include, "assess for signs and symptoms of bleeding".</p> <p>Quality Assurance will monitor monthly x3 then quarterly. Correction action will be completed by 3-21-14.</p> <p>DNS will ensure compliance of correction.</p>	03-21-14

[Handwritten signature]
3/12/14

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

PRINTED: 03/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2014
NAME OF PROVIDER OR SUPPLIER HARMONY HOUSE HEALTH CARE CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 RIVER PLAZA BREWSTER, WA 98812		
(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 309	Continued From page 2 from multiple nicks from a razor in the shower. Charge nurse notified to attempt to change to a safer razor for resident." The facility took measures to order a cordless electric razor on 1/17/14. However, nurse progress notes dated 02/04/14 documented "resident had nicks on face related to shave earlier in day". Record review of treatment record indicated dressing changes for chin. On 02/04/14 at 10:45 a.m., the resident was observed asleep in his room. His chin was covered with a gauze dressing and tape. Observations at 3:45 p.m., the resident was sitting in his wheelchair in the hallway. The gauze dressing remained on his chin, speckles of blood were visible through the tape that covered the dressing. In an interview on 02/05/14 at 1:30 p.m., Staff #H stated the facility had been using regular disposable razors on the resident, and the resident was getting facial nicks and bleeding due to being on a blood thinner. According to Staff H, the resident received an electric razor that day (2/5/14) and staff were only to use it. In an interview on 2/10/14 at 4:15 p.m., Staff #E, verified she'd recently purchased an electric razor for Resident #53 as his razor wasn't good on his skin. The resident was admitted to the facility with a risk for [REDACTED] from long term [REDACTED] therapy. The facility failed to ensure timely measures were implemented to prevent skin cuts/nicks once the issue was identified.	F 309			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323			

[Handwritten Signature]
3/12/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2014
NAME OF PROVIDER OR SUPPLIER HARMONY HOUSE HEALTH CARE CTR		STREET ADDRESS, CITY, STATE, ZIP CODE 100 RIVER PLAZA BREWSTER, WA 98812	
(X4) ID PREFIX TAG F 323	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 323	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F-TAG 323 03-21-14
	<p>Continued From page 3 .</p> <p>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, it was determined the facility failed to ensure adequate supervision and assistant devices to prevent accidents in 1 of 8 (#53) residents reviewed for accidents in a sample of 30. Findings included:</p> <p>Resident #53 was admitted to the facility in [REDACTED] 2013 with diagnoses including [REDACTED] (a [REDACTED] disorder of the [REDACTED] system), [REDACTED] problems, [REDACTED] and long term [REDACTED] use (a medication that [REDACTED] the [REDACTED]).</p> <p>The facility assessment indicated the resident was at risk for falls, required assistance with transfers, mobility and activities of daily living (ADL's).</p> <p>Per the record review, the resident's care plan dated 01/21/14 and 02/5/14 revealed facility planned interventions for accident prevention which included the use of a lap buddy (a soft device placed on front of chair to remind resident not to self-transfer). Staff were to assist with the removal of the device every 1 ½ - 2 hours for the resident's toileting, repositioning, or assistance to lay down.</p> <p>Per the record, the resident would self-transfer without calling for staff assistance. The resident</p>		<p>This resident was care planned for a lap buddy to help increase safety while up in his chair. The resident was observed to not have his lap buddy on. Although his care plan is appropriate the NAC responsible for the placement of the lap buddy failed to ensure it was on him on that specific shift. After conducting an interview it was identified that a certain amount of staff miss understood the lap buddy to be PRN. This was not the case and nor did the care plan reflect it.</p> <p>On 2-12-14 the staff was re-educated on this residents specific care plan for placement of the lap buddy. The staff was also re-educated on safety measures in general to ensure compliance with care plan interventions and safety measures.</p> <p>The care plans will be formatted differently to highlight safety measures for fall prevention so they are more visible and stand out. These will be completed by 3-21-14.</p> <p>Quality Assurance will monitor effectiveness monthly and PRN.</p> <p>DNS will ensure compliance.</p> <p><i>[Handwritten Signature]</i> 3/21/14</p>

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

PRINTED: 03/06/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505430	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2014
NAME OF PROVIDER OR SUPPLIER HARMONY HOUSE HEALTH CARE CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 RIVER PLAZA BREWSTER, WA 98812		
(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	<p>Continued From page 4</p> <p>fell on 01/31/14 when he attempted to self-transfer from his chair to the bed.</p> <p>Observations were made of the resident up in his wheelchair with the lapbuddy in place on 2/5/14. On 02/10/14 at 4:00 p.m., the resident was observed in the dining room, sitting in his wheelchair for an activity. The lap buddy was not in place or observed nearby. The resident was again observed at 4:40 p.m., the resident was in his wheelchair without the lap buddy; he was self-propelling his wheelchair down the hall by the dining room. He stated, " I got to go lay down".</p> <p>In an interview on 02/11/14, Staff # C said, " the lap buddy was only used as needed if the resident was trying to get up. Staff C stated the staff would use the lap buddy only on days when the resident was real active self-transferring.</p> <p>During the exit conference on 02/11/14, Staff #A confirmed the resident's lap buddy was not used as outlined on the care plan.</p> <p>The facility failed to ensure interventions were implemented as planned to prevent falls/injuries.</p>	F 323			

[Handwritten Signature]
3/12/14