

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

PRINTED: 11/12/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505226	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/05/2014
NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - SUNNYSIDE			STREET ADDRESS, CITY, STATE, ZIP CODE 721 OTIS AVENUE SUNNYSIDE, WA 98944		
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Prestige Care & Rehabilitation - Sunnyside on October 31, 2014 and November 5, 2014. A sample of three residents was selected from a census of 75 residents. The sample included 3 current residents.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#3050031 #3049362</p> <p>The survey was conducted by: Patti Zimmer, R.N.</p> <p>The survey team is from: Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services, District 1, Unit A and C 3611 River Road, Suite 200 Yakima, Washington 98902</p> <p>Telephone (509) 225-2800 Fax: (509) 574-5597</p>	F 000	<p>F000 Initial Comments</p> <p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction Prestige Care Sunnyside 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 style="text-align: center;">Received Yakima RCS NOV 20 2014</p>		
F 225 SS=D	<p><i>Mary Arthur</i> 11/12/14 Residential Care Services 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have</p>	F 225			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Mary Arthur

Adm

11-17-14

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.

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F 225	<p>Continued From page 1</p> <p>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 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 have evidence of a thorough</p>	F 225 F225	<ol style="list-style-type: none"> 1) CRU hotline called and report of neglect given R/T this incident. 2) Allegations of abuse or neglect will be reported immediately to CRU and thorough investigation completed timely. 3) Staff have been re-educated on <u>Washington State Reporting Guidelines for Nursing Homes</u> with special focus on root cause analysis and identifying neglect during an investigation. 4) All incidents and investigations will be reviewed daily during the MACC (Managing Acute Condition Changes) meeting by RCM to ensure appropriate reporting and investigation is in process/ completed. To complete random weekly audits for four weeks to ensure issues 	

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F 225	<p>Continued From page 2</p> <p>investigation and reporting of a neglect incident to the State agency in a timely manner in accordance with 42 CFR 4783.13(c)(2-4) involving 1 of 1 resident (Resident #1) reviewed. Findings include:</p> <p>Resident #1: Review of a facility investigation report noted that on 10/23/14 at 1:10 p.m. the resident was being transported in her wheelchair in the large facility van to a physician's appointment. During a turn to the left the van hit a "pothole", and the van "jarred", causing the resident to fall forward out of her wheelchair onto the floor of the van.</p> <p>The investigation report indicated the owner's manual was reviewed, and it was determined Staff A (driver of the van) had appropriately followed the manufacturer's instructions for securing wheelchairs in the van. The investigation concluded the incident was an "accident" as it was an "unexpected and unintended" event.</p> <p>An interview on 11/5/14 at 10:30 a.m. with Staff A revealed the above referenced manufacturer's instructions for securing wheelchairs in the van was for the small facility passenger van, and not the large van utilized during the transport on 10/23/14. He stated the facility did not have manufacturer's instructions for the large facility van, nor was there a facility policy and procedure relative to securing residents in wheelchairs during transport. He stated the large van did not have shoulder/waist straps for residents in wheelchairs at the time of the incident on 10/23/14. The driver stated the van "jarred" when he hit the pothole which caused the tie-down straps to loosen, however the wheelchair</p>	F 225	<p>F 225 continued</p> <p>have been investigated timely and thoroughly to rule out abuse/neglect. Audit outcomes will be reviewed by DNS during the facility monthly QAPI meetings until compliance has been maintained.</p>	11-17-14	

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F 225	Continued From page 3 remained upright and did not tip over. He stated he recognized right away the need to seatbelt residents in wheelchairs as that was how the resident was injured. Despite the omission of a waist/shoulder strap during the transport of the resident, which caused her to fall forward from her wheelchair on 10/23/14, staff failed to recognize the incident as neglect, and did not report the incident to the State agency until 10/28/14 (five days later).	F 225	F 323 1) Resident #1 has recovered from her injury with no negative outcomes. Any future transport rides, this resident will have wheelchair straps as well as shoulder/waist restraints in place.		
F 323 SS=G	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 record review and interviews the facility failed to ensure adequate supervision and protective devices were provided to prevent accidents for 1 of 2 residents (#1) reviewed for falls. This deficient resulted in actual harm to Resident #1, who fell from her wheelchair in the facility van and sustained a [REDACTED] Findings include: Resident #1: Admitted to the facility on [REDACTED] 14 with diagnoses that included dementia and a recent hip fracture secondary to a fall on 8/17/14. Review of the resident's plan of care revealed she	F 323	2) Use of the van had been discontinued, immediately following the incident, until the shoulder/waist restraints arrived. When Van Commercial shoulder/waist restraints arrived, they were installed per manufacturer instructions. 3) All residents will be secured with proper protective equipment (shoulder/waist straps) during all van transports		

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F 323	<p>Continued From page 4</p> <p>was at high risk for falls due to her poor balance, unsteady gait, and neurological disorder. She required extensive assistance with activities of daily living.</p> <p>Review of the resident's medical record and facility investigation report revealed on 10/23/14 at 1:10 p.m., the resident was being transported in her wheelchair to a physician's appointment in the facility van. The resident's wheelchair was secured with tie-downs prior to transport, however there was no protective device (waist and shoulder straps) utilized to keep her secure in the wheelchair. During a turn to the left the van hit a "pothole" in the road. The van "jarred" causing the resident to fall forward out of her wheelchair onto the floor of the van. X-rays obtained on 10/24/14 noted the resident had fractured her nose due to the fall.</p> <p>During an interview on 11/5/14 at 10:30 a.m. with Staff A (van driver) he stated the large facility van did not have shoulder or waist straps to use for residents in wheelchairs. He stated he had never been trained to utilize them for residents in wheelchairs during transports in that van.</p> <p>Despite the need for residents in wheelchairs to be protected from injury during transport in a motorized vehicle staff failed to recognize the need for protective devices to prevent accidents.</p>	F 323	<p>F323 continued</p> <p>4) Van drivers have received training and return demonstration on the use and application of protective equipment to maintain patient safety during transport. Van drivers have reviewed training video from Q Straints on proper securing of passengers. Signs have been placed in van for step by step instructions for securing passengers in van.</p> <p>5) Condition and use of van equipment for securing devices will be reviewed during the QAPI monthly meeting. Plant operations Manager will complete random weekly audits to ensure equipment is in place and in use prior to or upon return of resident van trips. Plant Manager to review audit results monthly at QAPI meeting until facility has maintained compliance</p>	11-17-14	