

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

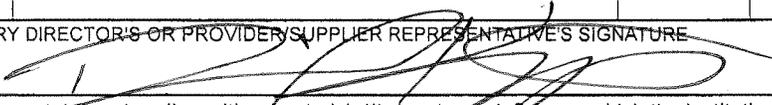
PRINTED: 10/29/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/16/2014
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NAME OF PROVIDER OR SUPPLIER  PRESTIGE CARE & REHABILITATION - CLARKSTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1242 ELEVENTH STREET CLARKSTON, WA 99403
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(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
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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 &amp; Rehabilitation Clarkston on 10/16/14. A sample of 3 residents was selected from a census of 79.</p> <p>The following complaint was investigated as a part of this survey:</p> <p>#3044178</p> <p>This survey was conducted by:</p> <p>Jessica Wolfrum, R.N.</p> <p>The survey team is from:</p> <p>Department of Social &amp; Health Services Aging and Long Term Support Administration Residential Care Services, District 1, Unit B Rock Pointe Tower 316 W. Boone Avenue, Suite 170 Spokane, Washington 99201-2351</p> <p>Telephone: (509) 323-7302 Fax: (509) 329-3993</p>	F 000	<p style="text-align: center;"><b>RECEIVED</b></p> <p style="text-align: center;">NOV 13 2014</p> <p style="text-align: center;"><b>DSHS ADSA RCS SPOKANE WA</b></p> <p>"This plan of correction is prepared and submitted as required by law. By submitting this plan of correction Prestige Care &amp; Rehabilitation-Clarkston does not admit that the deficiency listed on this for exist, nor does the Center admit to any statements, findings, facts or conclusions the form the basis for the alleged deficiencies. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiencies, statements, facts and conclusions that form the basis for the deficiencies."</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 11/11/14
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A 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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NAME OF PROVIDER OR SUPPLIER  <b>PRESTIGE CARE &amp; REHABILITATION - CLARKSTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1242 ELEVENTH STREET CLARKSTON, WA 99403</b>		
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F 323 SS=G	<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 interview and record review, it was determined the facility failed to consistently implement planned interventions to promote safety, and to prevent injury for 1 of 3 residents (#1). This failure resulted in actual harm to Resident #1, who received an injury to the leg requiring stitches. Findings include:</p> <p>Resident #1 was admitted the facility in [REDACTED] with diagnoses including [REDACTED]. According to the facility's most recent assessment, Resident #1 was alert only to self, unable to make her needs known, and required extensive assistance with all activities of daily living.</p> <p>Per review of the in-room care plan dated 4/28/14 for Resident #1, she required 2-person extensive assistance for all transfers.</p> <p>On [REDACTED] Resident #1 was transferred from her bed to her wheelchair by one staff person. Resident #1 sustained a laceration, which required her to be transported to the hospital, where she received stitches on her right lower leg.</p> <p>Per review of the facility investigation, Staff #A did not follow the care plan for Resident #1 during</p>	F 323	<p>F 323</p> <ol style="list-style-type: none"> <li>1) Resident 1's wound is healing without complications.</li> <li>2) Staff 1 was terminated. The incident log was reviewed to determine if other residents received injuries as a result of not following care planned safety interventions and no other issues were identified. The Maintenance Director checked beds and wheelchairs in resident rooms to ensure there were no sharp edges that could cause injuries.</li> <li>3) Re-education was completed on updating in-room care guides, checking in-room care guides prior to providing care, checking equipment for sharp edges, use of appropriate footwear &amp; safety interventions related to safe transfers.</li> <li>4) Resident Care Managers will conduct visual observations of resident care to ensure safety interventions are implemented by direct care staff. These observations will be done randomly each week for 4 weeks then monthly for 2 months. Issues of non-compliance will be immediately forwarded to the Director of Nursing for follow-up.</li> </ol>	11/27/14	

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F 323	Continued From page 2 a transfer, resulting in a substantial injury. Per interview with Staff #B on 10/16/14 at 1:30 p.m. the investigation resulted in termination of Staff#A. The facility failed to implement planned interventions to prevent injury for Resident #1, which resulted in a substantial injury requiring transport to, and treatment from, a local hospital.	F 323	The Director of Nursing will present results of the audits to the monthly Quality Assurance Performance Improvement committee meeting for 3 months to ensure on-going compliance.		