

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

PRINTED: 12/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 506401	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/15/2014
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NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - PARKSIDE	STREET ADDRESS, CITY, STATE, ZIP CODE 308 WEST EMMA UNION GAP, WA 98903
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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-Parkside on 12/11/14 and 12/15/14. A sample of 7 residents were selected from a census of 88. The sample included 5 current residents and the records of 2 former and/or discharged residents.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#3056430 #3056706 #3057462 #3057603</p> <p>The survey was conducted by: Priscilla Becker, R.N.</p> <p>The survey team is from: Department of Social & Health Services Aging and Long-Term Support Administration Residential Care Services, District 1, Unit D 3611 River Road, Suite 200 Yakima, WA 98902</p> <p>Telephone: (509) 225-2800 Fax: (509) 574-8597</p> <p><i>[Signature]</i> Residential Care Services Date</p>	F 000		
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Received
Yakima RCS

DEC 31 2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator 12-29-14	(X6) DATE
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Any deficiency statement having 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 30 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 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 observation, record review, and interview, the facility failed to ensure 1 of 3 sampled residents (#1) involved in accidents had their environments as free of accident hazards as possible. Resident #1 placed a hot pack, heated by a staff member, and sustained a large burn on his arm. Findings include:</p> <p>Resident #1: Review of the medical record revealed the resident was admitted to the facility on [REDACTED] with multiple diagnoses including stroke with paralysis on his [REDACTED]. The resident's plan of care noted he was at risk for skin impairment due to having decreased sensation on his paralyzed [REDACTED]. The resident required staff assistance for all his activities of daily living.</p> <p>An 11/27/14 nursing entry noted the resident was complaining of left shoulder pain. Staff Member A, a Licensed Nurse (LN), documented a warm pack was applied and it offered some relief.</p> <p>When interviewed on 12/11/14 at approximately 4:00 p.m., Staff Member A stated Resident #1 had experienced some left shoulder pain. She</p>	F 323	<p>F000</p> <p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Prestige Care and Rehabilitation- Parkside 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>F 323</p> <p>It is the policy of this Skilled Nursing Facility that all staff members must operate within their occupational scope of practice for safety.</p> <p>Staff member C has been disciplined according to facility policy and procedure.</p>		

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F 323	<p>Continued From page 2</p> <p>had applied a warm, moist towel wrapped in plastic and another towel to his shoulder and it was helpful in reducing the pain.</p> <p>Review of a 12/01/14 nursing entry by Staff Member B, a LN, revealed the resident was noted to have "what appears to be a burn to left upper arm. two (sic) blisters noted, one popped the other is still fluid filled, surrounding skin is red in color. total (sic) measurement is approx (approximately) 11.5 cm (centimeters) by 5 cm (approximately 4 1/2 inches by 2 inches)." A physician's order was obtained for a medicated cream and a dressing to cover the burn area.</p> <p>Staff Member B was interviewed on 12/11/14 at approximately 1:00 p.m. and stated that on 12/01/14 in the morning a Nursing Assistant (NA) was assisting the resident with dressing. The NA noted the skin on the resident's left upper arm was bright pink. There was also a popped blister and an intact blister present. The LN asked the resident about the cause of the burn. Resident #1 stated the burn was caused by a hot pack that Staff Member C, a NA, had brought in on Saturday (11/29/14).</p> <p>According to the 12/01/14 facility investigation, Resident #1 stated he had requested that Staff Member C get a "hot pack" for his arm. He reported that the warmth helped his pain. Resident #1 stated he awoke the evening of 11/29/14 and saw the pack on his bedside stand. He rolled the pack up in the sleeve of his gown and placed it on his arm. He didn't feel it burning. No further heat was applied to the area after that occasion. Staff Member C had brought the "hot pack" from home thinking it would work well for the resident. Staff Member C stated she was not</p>	F 323	<p>Alternate therapeutic interventions were given to Resident #1 to ensure safety.</p> <p>Facility residents were interviewed to identify any other care issues/concerns and investigations were completed as appropriate.</p> <p>Staff were re-educated on 12/1/14 regarding policies and procedures and scope of practice</p> <p>To ensure on- going compliance Administrator/DNS/designee will complete random resident and staff interviews for four weeks starting from compliance date. Issues identified by these interviews will be followed up to ensure all nursing care practices are being followed in accordance with documented policy and procedure and proper nursing scope of practice.</p> <p>Copy of interview(s) results with findings (negative outcomes/trends/patterns) will</p>		

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F 323	<p>Continued From page 3</p> <p>aware that she was not to apply heat to a resident. She heated the pack and took it to his room. He was asleep so she left it at his bedside.</p> <p>The facility investigation concluded that Staff Member C was administering treatment outside the scope of her practice. She took this action without the direction or knowledge of the Registered Nurse who was on shift. Staff Member C had made this hot pack out of rice. She brought the pack from home to give to the resident. Bringing objects for medical care from home to use for a resident was prohibited. On 12/01/14 the resident was noted to have a second degree burn on his left shoulder.</p> <p>Observations on 12/11/14 at approximately 10:50 a.m. revealed a rectangular dark green brocade pack with whitish stitching around the edges. The pack appeared to be approximately 8 inches by 5 1/2 inches (per observation).</p> <p>At approximately 2:40 p.m. on 12/11/14 the resident's left upper arm was observed. There was a large scabbed area at the top of the left arm with bright pink intact skin surrounding the scabbed area and extending below. The affected area appeared to be approximately 4 inches long and 1 1/2 inches wide.</p> <p>Staff Member C was interviewed via telephone on 12/13/14 at approximately 3:20 p.m. The NA stated she was aware that some residents had received warm towel packs in the past. She recalled that during the evening (on 11/29/14) the resident reported his left shoulder was hurting. He wanted a heat pack for his shoulder. Staff Member C stated she could get him one. She made home-made rice packs to use for her</p>	F 323	<p>be provided 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.</p> <p>Compliance date is 12/30/2014</p>		

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F 323	<p>Continued From page 4</p> <p>family. During her lunch break she went home and picked up the rice pack. She placed the rice pack in the microwave at the facility for approximately 55 seconds. She went to the resident's room. He appeared to be sleeping so she left the heated rice pack at his bedside. She stated she heard later he awoke and placed the hot pack.</p> <p>During interviews with alert Resident #1 on 12/11/14 at approximately 1:20 p.m. and on 12/15/14 at approximately 1:25 p.m., the resident stated his left shoulder kept hurting and the warmth seemed to help the pain. He had mentioned that the warm packs helped his shoulder to Staff Member C. She stated she had something at home that would help. That evening (on 11/29/14) she brought the pack in. He found the warmed pack and placed it on his left shoulder. He did not have a towel to use so he rolled it up in his gown. It felt warm so he layed on his left shoulder with the pack in place. The next morning he put his hand to his left shoulder, felt fluid, and identified a blister. He reported it to staff. The resident stated the (rice) pack was only used once. Resident #1 recalled Staff Member B looking at the burn later.</p> <p>Resident #1 experienced harm, a burn, as a result of the unauthorized heat pack provided to the resident. The resident's diminished sensation on his [REDACTED] placed him at increased risk for injury.</p>	F 323			