

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

PRINTED: 01/09/2014
FORM APPROVED
OMB NO. 0938-0391

1459

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505204	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/02/2014
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NAME OF PROVIDER OR SUPPLIER QUEEN ANNE HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 2717 DEXTER AVENUE NORTH SEATTLE, WA 98109
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Queen Ann Healthcare in Seattle on 01/02/14. A sample of 3 residents was selected from a census of 103. The sample included 3 current residents and records of 1 former/discharged residents.</p> <p>The following complaint was investigated: 2927571</p> <p>The survey was conducted by: [REDACTED] MS, RN-BC [REDACTED] BSN, RN</p> <p>The survey team is from: Department of Social & Health Services Aging and Long Term Services Agency Residential Care Services, District 2, Unit B 3906 172nd St. NE Suite 100 Arlington, WA 98223 Telephone (360) 651-6850 Fax (360) 651-6840</p> <p><i>[Signature]</i> 1-9-2014 Residential Care Services Date</p>	F 000	<p style="text-align: center;">RECEIVED JAN 24 2013 DSHS/ADS/ARCS</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE ADMINISTRATOR	(X6) DATE 1-23-2014
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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 323 SS=D	<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, the facility failed to prevent an accident for one of four residents (Resident 2) who required supervision with transfer. Failure to consistently implement specialized training for transfer of Resident 2 with his attached medical equipment contributed to unanticipated pressure on his halo traction brace and placed him at risk of injury/full displacement of the equipment.</p> <p>Findings include:</p> <p>Resident 2 was re-admitted in [REDACTED] 2013 with multiple diagnoses including recent [REDACTED] for a [REDACTED]. He wore a halo traction brace, a metal "halo" shaped ring secured to the skull with pins and metal rods attached to the halo that fit into a plastic jacket that sits on the shoulders and chest of the person.</p> <p>On 10/20/13, all staff, who were assigned to work with Resident 2, received training on transfer and care of Resident 2 and his halo traction brace. The training manual, titled "Patient Care Guide for the Halo Traction Surgery Services," included avoiding "situations where you might be shoved."</p>	F 323	<p>F- 323 Free of accident hazard / supervision / devices.</p> <p>Facility does ensure that Resident environment remains as free of accident hazards as is possible.</p> <p>Resident was immediately assessed for injuries, first aide was initiated. Cervical neck/spine was stabilized. Resident transported to hospital for evaluation and treatment. Hospital evaluation revealed resident with zero [REDACTED] fracture, zero displacement of healing [REDACTED] of [REDACTED], Neurologist determined HALO to be removed at this time. HALO removed at hospital and resident returned to facility with orders to follow up with Neurologist in 1 week.</p> <p>Staff was in-serviced on care procedure for halo. Staff was in-service on plan of care update There are no other Residents with a halo currently residing in facility</p> <p>Director of Nurses and Staff Development Coordinator will monitor to ensure on-going correction.</p>	<p>12-10-13 no ongoing</p> <p>1/24/14</p> <p>Spoke with [REDACTED]</p> <p>2/17/14</p>

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F 323	<p>Continued From page 2</p> <p>Additionally, the manual noted written guidance to use care when moving as the "rods protruding out front can be bumped very easily and cause discomfort." Additionally the manual instructed to "never pull on any part of the halo traction."</p> <p>On [REDACTED]/13, Staff B and Staff C entered the room of Resident 2 to assist him from bed to the wheelchair. As they initiated raising the head of the bed, a small pillow caught in the halo traction brace and tilted his head, placing pressure on the pins in his skull and shifting their position as well as tilting halo traction brace. Resident 2 alerted the staff "something is wrong." Staff B and C halted the bed movement and observed small amounts of blood oozing from the two pins in Resident 2's forehead. Resident 2 complained of pain at these sites. Resident 2 reached up and moved the halo traction brace, fully dislodging the pins from his skull. Staff remained with Resident 2 until he transferred to the hospital for evaluation and treatment.</p> <p>Review of Resident 2's most recent Minimum Data Set assessment, dated 12/18/13, identified his memory and recall were fairly intact (13/15/ points on the memory assessment tool).</p> <p>On 01/02/14 at 9:35 a.m., Resident 2 reported he remembered the incident in December. The halo traction brace caught on the pillow and pins sticking out of his head began to bleed. There was "lots of pain." He went to the hospital and the physician told him the fracture was healing; he no longer needed the halo traction brace. The physician removed the brace. Now he used a cervical collar/brace, a device that fits snugly around a person's neck. He wore this collar at all times. He did not think the staff had proper</p>	F 323	See page 3 of 4	

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F 323	<p>Continued From page 3 training when the incident occurred.</p> <p>At 1:20 p.m., the Director of Nursing Services (DNS) and Staff A reported all staff, including Staff B and C, were trained how to assist and transfer Resident 2 in October 2013. The DNS stated staff should make certain all pillows are out of the way and protect the resident's head when transferring to and from bed. Staff A explained the halo traction brace can impact balance for an individual. Staff were trained to remove all items from the area before transfer. Both the DNs and Staff A stated Staff B and Staff C should have identified and removed the pillow from the head of the bed prior to initiation of raising the head of the bed.</p> <p>Review of the facility investigation revealed Staff B and Staff C failed to follow the training and the halo traction brace "became dislodged" as staff assisted him with raising the head of the bed. Staff should have identified and removed the small pillow prior to raising the head of the bed.</p>	F 323	See page 2 of 4	
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