

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

PRINTED: 08/31/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505185	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/18/2015
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NAME OF PROVIDER OR SUPPLIER CRESTWOOD HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1116 E LAURIDSEN BOULEVARD PORT ANGELES, WA 98362
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Crestwood Health & Rehabilitation Center on August 11 and 18, 2015. The sample included 13 current residents from a census of 91 and the records of 4 discharged residents.</p> <p>The following complaints were investigated:</p> <table border="0"> <tr> <td>3125100</td> <td>3127445</td> <td>3131008</td> </tr> <tr> <td>3126486</td> <td>3125713</td> <td>3132427</td> </tr> <tr> <td>3130605</td> <td>3135522</td> <td>3135384</td> </tr> <tr> <td>3130822</td> <td>3135384</td> <td>3135394</td> </tr> <tr> <td>3132446</td> <td>3155799</td> <td>3135133</td> </tr> <tr> <td>3135975</td> <td></td> <td></td> </tr> </table> <p>The survey was conducted by:</p> <p>Phan Pham, RN, BSN Candice Mohar, PhD, RN, MSN</p> <p>The survey team is from: Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services, District 3, Unit C & D, P.O. Box 45819 Tumwater, Washington 98504-5819</p> <p>Telephone: 360.664.8429 Fax: 360.664.8451</p> <p><i>Sinda Penco</i> 8-31-15 Residential Care Services Date</p>	3125100	3127445	3131008	3126486	3125713	3132427	3130605	3135522	3135384	3130822	3135384	3135394	3132446	3155799	3135133	3135975			F 000	<p>"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report."</p>	10/6/15
3125100	3127445	3131008																				
3126486	3125713	3132427																				
3130605	3135522	3135384																				
3130822	3135384	3135394																				
3132446	3155799	3135133																				
3135975																						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Michael L. Brown</i>	TITLE Executive Director	(X6) DATE 9/15/15
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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 272 SS=D	<p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p>	F 272	<p>1) Correction/s as it relates to the resident/s: Resident number 1 has an updated care plan, which includes diagnoses including dementia, difficulty speaking, stroke, generalized weakness, osteoporosis, impaired decision making ability and had pain in shoulders with limited range of motion..</p> <p>2) Action/s taken to protect residents in similar situations: Care plans for last 30 day admits have been assessed for accuracy.</p> <p>3) Measures taken or systems altered to ensure that solutions are sustained: will audit the 24-48 hour new and readmission audit tool. : New admits/ readmission will have a 24-48 hour audit to ensure pertinent history is encompassed in the plan of care with the IDT. Licensed nurses and management team will be re educated with communication of new information received to ensure care plans meet the patients' needs.</p>		

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F 272	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to conduct an accurate initial comprehensive assessment of each resident when a resident had a history of multiple shoulder dislocations that was not identified by the facility for 1 of 7 current sampled residents (# 1) reviewed for resident assessment. Failure to identify residents' functional health status placed all residents at risk of not receiving necessary care and services to prevent avoidable injuries.</p> <p>Findings include:</p> <p>Resident #1 re-admitted to the facility on [REDACTED] 15 with diagnoses including [REDACTED] and had pain in shoulders with limited range of motion. The resident was dependent on staff for assistance with activities of daily living, bed mobility and transfers. The Department of Social and Health Services assessment dated 4/27/15 indicated the resident had limited range of motion and history of multiple [REDACTED]</p> <p>On 8/11/15 the resident was observed sitting in her wheelchair in her room with her [REDACTED] in a [REDACTED]. The resident was not able to provide information related to her [REDACTED].</p> <p>Review of the event report revealed on 8/1/15, an unqualified staff member helped the resident up from her wheelchair by "pulling resident up by hands." The resident was assisted to the dining room for lunch. The resident complained of pain</p>	F 272	<p>4) Plans to monitor performance to ensure solutions are sustained and person responsible: Re The director of nursing will review and address issue the day of the audit then bring the audit tools to QAPI meeting monthly. Results of 24/48 check list will be presented in QAPI meeting monthly X 3 months. A request for Informal Dispute Resolution (IDR) has been submitted.</p> <p>Director of Nursing or designee is responsible to ensure compliance.</p>	10/6/15	

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F 272	Continued From page 3 to her [REDACTED] after lunch and cried out in pain when staff attempted to move the resident's [REDACTED]. The resident was transported to the hospital for evaluation and was diagnosed with a [REDACTED] and [REDACTED] as noted on the 8/1/15 x-ray. The resident's record failed to indicate an initial evaluation of the resident's [REDACTED] and no care plan was developed directing staff how to assist the Resident to minimize risk of injury/repeated [REDACTED]. Resident Care Manager (RCM) B said the facility was not aware the resident had a history of [REDACTED] until after the injury. Refer to F 499.	F 272		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure professional standards and practice were followed related to complete and accurately documented records for 4 of 4 current residents (#1, 2, 8 & 9) and 1 of 1 discharged residents (#14). This failure resulted in the inability to identify qualified persons who assessed, monitored and evaluated residents' medical conditions/treatments and medications and what	F 281		

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F 281	<p>Continued From page 4 their qualifications were to do so.</p> <p>Findings include:</p> <p>On 8/18/15 during interviews and review of Residents' records (#1, 2, 8, 9 and #14), it was found that the Medication Administration Records (MAR) did not contain complete documentation to indicate times and who administered medications to residents or what their qualifications were to do so. The MARs in the residents' records did not have signatures or titles (qualifications) of those who assessed, monitored and evaluated residents for safe medication administration/management/treatments.</p> <p>During observations of medication administration and interview with Licensed Nurse (LN) G at 4:30 p.m., s/he stated the facility utilized a master signature log for nurses to sign rather than documenting signatures and titles on the MAR and said the facility did not require nurses to sign the MAR. The Director of Nursing Services (DNS) stated she was aware of facility staff members who said they were educated to put full signatures and titles on each MAR to correlate with their initials and, during a recent facility training, the nurses were informed of the process for safe medication administration to include legible signatures and titles on the MAR.</p> <p>According to Centers for Medicare and Medicaid Services [CMS], errors related to signature requirements impact the payment claims process. "Signatures are handwritten or electronic [stamped signatures are not acceptable] and signatures are legible. Signature logs may be used to support the identity of the illegible signature provider. A signature log is a typed</p>	F 281	<ol style="list-style-type: none"> 1) Correction/s as it relates to the resident/s: Resident #1, #2, #9, MARs reviewed, LNs legible signatures with titles are present. Resident #8, #14 no longer resides in the facility. 2) Action/s taken to protect residents in similar situations: MARs were audited and corrected as necessary to ensure LNs have been re educated with following through with signing each MAR legibly. A master signature log has been updated and will be updated with each new hire and new providers. LNs educated to complete MAR review with change of shift report to include signatures. 3) Measures taken or systems altered to ensure that solutions are sustained: MAR audits completed daily x4 weeks with improvement will audit 3 days weekly x4 weeks and with continued improvement will audit weekly x4 weeks then monthly. RCMs/DON/ETD will complete weekly audits to ensure LNs are following thru with the change of shift MAR check during their change of shift report 4) Plans to monitor performance to ensure solutions are sustained and person responsible: IDT will monitor our daily/weekly audits. Report will be brought to QAPI monthly. Director of Nursing or designee is responsible to ensure compliance. 	10/6/15

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F 281	Continued From page 5 listing of the providers(s) identifying their name with a corresponding hand signature...and may be used to establish signature identify and credentials [e.g. MD, RN] of the signator as needed throughout the medical record documentation..." [Department of Health and Human Services Center for Medicare and Medicaid Services-CMS Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4, revised October 2013]. Failure to ensure nurses practiced according to accepted professional standards prevented the facility, residents and other providers from knowing who was accountable for the care and services to residents. Refer to F 329; F 333	F 281			
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition	F 329			

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F 329	<p>Continued From page 6</p> <p>as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure residents who received antibiotics had indications for use for 1 of 1 discharged residents (#14) reviewed for unnecessary medications. This failure placed all residents at risk of negative outcomes related to receiving unnecessary medication.</p> <p>Findings include:</p> <p>Discharged Resident #14 was admitted to the facility on [redacted] 15 with multiple medical conditions. On 7/23/15, the Physician's Assistant (PA) ordered the resident be given [redacted] (antibiotic) to treat a possible urinary tract infection (UTI) after collection of the urine analysis (UA) and culture and sensitivity (C&S) if needed.</p> <p>The UA report dated 7/23/15 at 8:00 p.m. indicated there was no UTI and no need to do a C&S.</p> <p>Review of the MAR indicated the resident received 10 days of the antibiotic beginning on [redacted] 15 without an indication for use. The records</p>	F 329	<ol style="list-style-type: none"> 1) Correction/s as it relates to the resident/s: Resident #14 no longer resides in this facility 2) Action/s taken to protect residents in similar situations: Review antibiotic orders prescribed in last 30 days for appropriate indication to ensure residents are not receiving unnecessary drugs. 3) Measures taken or systems altered to ensure that solutions are sustained: LNs educated on receiving diagnosis for medications. Audits will be completed x4 weeks daily, then x3 days weekly following weekly with improvement 4) Plans to monitor performance to ensure solutions are sustained and person responsible: Trends and audits to be forwarded to the QAPI committee monthly x3 months for opportunity of continued quality improvement <p>Director of Nursing or designee is responsible to ensure compliance.</p>	10/6/15	

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F 329	Continued From page 7 failed to indicate facility staff questioned the PA order and why the unnecessary antibiotic was administered. Review of facility event reporting documents dated 8/6/15 indicated: "Of note, resident did not actually need the [redacted] due to being negative for UIT... noted by the PA on 7/24/15, the day after the [redacted] started... unclear as to why the [redacted] was not discontinued at that time." On 8/18/15 at 4:30 p.m., the Director of Nursing Services (DNS) said she had reviewed the event report and said the facility's practice was not to give antibiotics to residents when a need was not indicated. Receiving unnecessary antibiotics placed the resident at risk of harm. Refer to F 281; F 333	F 329		
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure 3 of 4 sampled residents (#'s 2, 8 & 9) and 1 of 1 discharged residents (#14) were free of significant medication errors when the facility failed to correctly transcribe orders and/or failed to administer [redacted] as ordered to Resident #2;	F 333		

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F 333	<p>Continued From page 8</p> <p>██████████ to Resident #8; antibiotics to Resident #9 and discharged Resident #14. The avoidable failed professional practice to ensure orders were transcribed correctly and medications were administered and documented as ordered placed these and other residents at risk of not receiving adequate care and therapeutic benefit of medications and created the potential for worsening of their health conditions.</p> <p>Findings include:</p> <p>According to nursing literature, "Safety is the main concern in medication administration ...preparing medications carefully and recording their administration. Use of the Medication Administration Record (MAR) ensures timely and safe medication administration ...Regardless of the type, all MARs provide a space for documenting when a drug is given, along with a place for the signature, title and initials of each nurse who administers a medication" (Fundamentals Nursing Skills and Concepts, 9th Ed. (2009) Lippincott, Williams and Wilkens, Chapter 32, page 771).</p> <p>Lippincott's 8 rights of medication administration includes: "Right Time--Check the frequency of the ordered medication; Double-check that you are giving the ordered dose at the correct time and confirm when the last dose was given." The "Right Documentation" includes "documenting administration AFTER giving the ordered medication, chart the time, route and other specific information including site of injections, laboratory values or vital signs before giving the drug" and "Right Response" to "make sure the</p>	F 333	<ol style="list-style-type: none"> 1) Correction/s as it relates to the resident/s: Residents #2, #9 MARs verified and updated with physician orders and are correct. Resident #8, #14 no longer resides in facility. 2) Action/s taken to protect residents in similar situations: Per system review resident on ██████████ verified to have ██████████ log in place and accurate. Audit MARs to ensure clarity of order, accuracy and legibility of transcription for prescription medications including ██████████ Episodic documentation will be monitored through clinical meeting process. 3) Measures taken or systems altered to ensure that solutions are sustained: Audits of MARS to be completed daily x4weeks then weekly.x3days for 4weeks with shown improvement will complete weekly x4weeks then monthly. : Licensed staff educated to policy and procedure for medication administration 4) Plans to monitor performance to ensure solutions are sustained and person responsible: Facility shall monitor for ongoing compliance utilizing our pharmacy consultants as well as end of month recaps done with resident care manager. Trends and will be brought to QAPI monthly. <p>Director of Nursing or designee is responsible to ensure compliance.</p>	10/6/15

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F 333	<p>Continued From page 9 drug led to the desired effect."</p> <p>Review of the facility's "Flexible Med Pass Policy" revealed the following administration periods: "AM-between 6:00 a.m. and 10:00 a.m.; Midday - between 10:00 a.m. and 2:00 p.m., PM-between 4:00 p.m. and 8:00 p.m." and "HS (hour of sleep) between 8:00 p.m. and 10:00 p.m."</p> <p>1) Resident #2 was admitted to the facility on [redacted] 15 with diagnoses including [redacted] that required close monitoring.</p> <p>On 8/11/15 the resident stated his [redacted] fluctuated and staff had a difficult time getting his [redacted] under control. The resident stated he received [redacted] at meal times and would not know if an error had been made.</p> <p>Review of the record revealed on 7/12/15, the resident's physician ordered staff to check the resident's [redacted] before meals and at bedtime. The resident's physician also ordered [redacted] to be administered with meals and the amount would be based on the [redacted] test results. The orders were transcribed onto the MAR with times of 7:00 a.m., 12:00 p.m., 5:00 p.m., and 9:00 p.m.</p> <p>Review of the MAR from 7/12/15 to 7/28/15 revealed the resident was given 8 doses of [redacted] for which no order was given for the 9:00 p.m. hour.</p> <p>According to Licensed Nurse (LN) C, the LN who received the orders transcribed the orders onto the MAR and alerted a second LN to verify the orders to ensure the orders were correctly transcribed. LN C stated she would go through</p>	F 333	

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F 333	<p>Continued From page 10 the resident's record and verify the order if the order was not clear.</p> <p>Resident Care Manager (RCM) A stated the resident had orders for [REDACTED] to be administered with meals and not at bedtime. According to RCM A, the orders transcribed onto the MAR were not clearly written and the evening shift LN administered the additional [REDACTED] RCM A said the management staff reviewed MARs weekly to ensure orders were correctly transcribed.</p> <p>Review of the medication event report was signed by the Medical Director on 8/13/15 with this notation: "Discussed need for clear medication lists...cramming too many things on MAR led to error and unclear instructions."</p> <p>2) The Institute for Safe Medication Practices (ISMP) includes [REDACTED] among its list of drugs which "have a heightened risk of causing significant patient harm when used in error" (Geriatric Dosage Handbook, 12th edition, p. 1646).</p> <p>Resident #8 was admitted to the facility from the hospital on [REDACTED] 15 following extensive and complicated surgery to [REDACTED]. Hospital records indicated she was at high risk for repeated [REDACTED].</p> <p>On admission to the facility, the physician ordered two [REDACTED] medications dally to prevent [REDACTED] with [REDACTED] parameters for management to include [REDACTED] blood levels drawn regularly and results to be reported to ensure a therapeutic Internationalized Ratio (INR) of 2-3 was</p>	F 333		

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NAME OF PROVIDER OR SUPPLIER CRESTWOOD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1116 E LAURIDSEN BOULEVARD PORT ANGELES, WA 98362		
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F 333	<p>Continued From page 11 maintained.</p> <p>On 7/22/15, the INR was within the goal range at 2.56. The INR was to be rechecked on 7/27/15 and no documentation was found to indicate the INR was drawn. The next INR report on 7/29/15 was below therapeutic level at 1.17.</p> <p>Review of the MAR dated 8/3/15 indicated the [redacted] Log form was to be sent to the physician's office "after each INR was drawn." The INR on 8/3/15 was below therapeutic level at 1.2. The MAR for this date indicated "no [redacted] Log] form found" despite nurses' initialing the MAR daily to indicate "I have reviewed the [redacted] Log." The MAR failed to indicate nurses sent the log to the physician's office on 8/3 or 8/10/15. There was no INR report found in the record for 8/10/15.</p> <p>On 8/18/15 at 4:00 p.m., at the surveyor's request, LNE called the hospital laboratory and requested a copy of the INR for 8/10/15 be faxed to the facility. The INR was 1.78.</p> <p>The MAR/records indicated the resident did not receive 5 daily doses of [redacted] between 8/11/15 and 8/15/15.</p> <p>The INR on 8/17/15 was 1.07. The resident thought the medication had been discontinued and she was not informed of the INRs which caused her concern as well as continued pain in [redacted]</p> <p>Review of the facility's alert charting guidelines log failed to identify Resident #8's need to be monitored related to the omission of [redacted] and the sub-therapeutic INRs/reporting to the</p>	F 333			

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F 333	<p>Continued From page 12</p> <p>physician that on 8/18/15 at 4:30 p.m., the Director of Nursing Services (DNS) said should have been done.</p> <p>The facility's policy and procedure for monitoring [redacted] (revised in March 2015) indicated to initiate the Anticoagulant Care Plan.</p> <p>Review of the resident's Anticoagulant Care Plan indicated: "Initiate [redacted] Log and place in front of the resident's MAR."</p> <p>On 8/18/15 at 4:00 p.m., the [redacted] Log could not be located in the MAR or any records. During interview, LN E said she gave the resident [redacted] on 8/17/15 but "I honestly can't remember if the log was there or not."</p> <p>The LNs were asked at what time the [redacted] was administered since the MAR indicated "PM." Responses varied from 4:00 p.m., 5:00 p.m. and/or 7:00 p.m. According to Lippincott Drug Handbook, "give drug at same time each day." No acutal times of administration had been documented and no nursing signatures or titles of the nurses were found on the MAR to correlate with the initials of the person giving the medication and monitoring the effects.</p> <p>#3) Resident #9 was admitted to the facility on [redacted] 15 with multiple medical conditions. On 7/22/15 the resident was ordered 2 medications to treat a [redacted]</p> <p>Review of the MAR indicated the resident did not receive 4 doses of [redacted] due to the medication not being transcribed from the July</p>	F 333		
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F 333	Continued From page 13 MAR to the August MAR. #4) Discharged Resident #14 was admitted to the facility on [REDACTED] with multiple medical conditions. On 7/23/15, the physician's assistant (PA) ordered [REDACTED] (antibiotic) twice daily for 14 days to treat a possible urinary tract infection (UTI). Review of the MAR indicated the resident did not receive 4 days (8 doses) of the medication due to the order not being transcribed from the July MAR to the August MAR. At 4:30 p.m., the DNS stated the nurses had recently received education related to safe, professional practice for medication administration and documentation. Refer to F 281; 329	F 333		
F 499 SS=G	483.75(g) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure qualified Professional staff (licensed, certified, or registered in accordance with	F 499		

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F 499	<p>Continued From page 14</p> <p>applicable State laws) provided care to 1 of 4 sampled residents (#1) during transfer assist. This failure placed all residents at risk for injuries when services were provided by unqualified staff and caused harm to Resident # 1 when an unqualified staff member assisted the resident to transfer and shortly after, the resident was found to have a [redacted] and [redacted] of the resident [redacted].</p> <p>Findings include:</p> <p>Resident #1 was admitted to the facility on [redacted] 15 with diagnoses including [redacted]. [redacted] The Department of Social and Health Services assessment dated 4/27/15 documented the resident had a history of multiple [redacted] and had limited range of motion.</p> <p>The resident's initial assessment dated 6/27/15 documented the resident had memory problems, impaired decision making-ability and had pain in [redacted] with limited range of motion. The resident was dependent on staff for assistance with activities of daily living, bed mobility and transfers.</p> <p>On 8/11/15 the resident was observed sitting in her wheelchair, in her room. The resident's [redacted] was in a [redacted]. The resident was not able to provide additional information related to the incident.</p> <p>Review of an event report revealed on 8/1/15 an unqualified staff member helped the resident up from the wheelchair by "pulling resident up by [resident's] hands," [without a gait belt] and</p>	F 499	<ol style="list-style-type: none"> 1) Correction/s as it relates to the resident/s: Resident #1 will receive care from licensed qualified staff. 2) Action/s taken to protect residents in similar situation: No other residents have been identified. 3) Measures taken or systems altered to ensure that solutions are sustained: Education will be provided in orientation to ensure all staff are aware of scope of practice. Random audit performed to ensure staff operating within scope of practice. 4) Plans to monitor performance to ensure solutions are sustained and person responsible: Ongoing education with orientation and quarterly and adding scope of practice. Informal Dispute Resolution (IDR) meeting requested. <p>Director of Nursing or designee is responsible to ensure compliance:</p>	10/6/15

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F 499	<p>Continued From page 15 transferred the resident to the wheelchair and taken to lunch.</p> <p>After lunch, the resident complained of pain to her [redacted] and cried out in pain when staff attempted to move the resident's [redacted]. The resident was transported to the hospital for evaluation and was diagnosed with a [redacted] and [redacted] as noted on the hospital X-ray dated 8/1/15.</p> <p>According to the physical therapy treatment note dated 7/30/15, the resident was trained to perform sit to stand and stand-pivot transfer with standby assist. The resident was able to perform the transfer with no upper extremity support.</p> <p>On 8/11/15 the Activity Director (AD) stated she assisted the resident to transfer from the resident's bed to the resident's wheelchair on 8/1/15. The AD said she held the resident's hands and the resident stood up and pivoted to the wheelchair.</p> <p>The facility could not provide evidence the AD was registered, certified, licensed or had training to perform transfers of residents with limited mobility. Resident Care Manager (RCM) A said the AD was not a qualified professional who could assist residents with transfers.</p> <p>The Director of Nursing Services (DNS) said the resident could stand independently and required one staff standby assist to provide verbal guidance during a transfer.</p>	F 499			