STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505511	A. BUILDING ______ B. WING ______	C 08/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARAMOUNT REHABILITATION AND NURSING	**2611 SOUTH DEARBORN SEATTLE, WA 98144**

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F 689	Continued From page 1 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, and record review the facility failed to ensure resident supervision, and a thorough accident investigation occurred, to determine the circumstances of a fall for one (#1) of two sampled residents. The facility failed to provide care the resident was assessed to require for one (#1) of two residents reviewed for falls, resulting in right femur fracture, left femur fracture, left humerus fracture, pain and hospitalization. In addition, the facility failed to provide emergent post fall treatment which contributed to unrelieved pain and delayed medical treatment. Findings included... According to the 05/20/19 Quarterly Minimum Data Set (MDS - an assessment tool), Resident #1 required extensive two person physical assist with bed mobility. The 04/29/19 Care Plan (CP) showed the resident required total assistance by two staff to turn and reposition in bed and as necessary. The CP further identified the resident was at risk for falls and listed an intervention of, "The Resident needs prompt response to all requests for assistance." During an interview on 07/29/19 at 11:08 AM, Resident #2 stated that Resident #1 fell from the	F 689	1. Resident # 1 no longer resides in the facility 2. A thorough investigation will be completed for all accidents. Resident's with injury will be assessed to meet any emergent need 3. Staff C was provided with education and training on following a resident's plan of care Staff I was provided training on assessing injured residents and the expectation for alerting 911 Training will be conducted by the Director of Nursing (DNS) Staff providing direct care will be educated on following the resident's individual plan of care. LN staff will be educated on assessment of resident injury and providing for identified emergent care needs 4. DNS or designee will conduct random audits and direct observation on care being provided for residents identified as requiring two person assist weekly for 4 weeks. Continuation of the	

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F 689	Continued From page 2 bed while a CNA (Certified Nursing Assistant) was changing her. The CNA was not assisted by a second assistant. Review of a 07/15/19 Emergency Department (ED) Note showed Resident #1 stated that staff at the facility had her lying on her side to clean her. The resident told them she believed staff stepped away from the bed for a moment, at which time she rolled and was unable to stop herself from falling from the bed to the floor. Resident #1 stated she landed on her left hand and left leg. Review of the 07/15/19 facility Incident Report and investigation showed that at 10:30 AM, Resident #1 was assisted on the floor by a CNA as the resident rolled to her right side while waiting to be changed. The resident sustained fractures of the right and left femurs (thigh bone) and left humerus (arm bone). The facility investigation included an undated written statement that showed while Staff C, Certified Nursing Assistant (CNA), was gathering supplies to change Resident #1, "I saw the resident rolling out of bed, rushed in to hold her and lowered her on the ground". During an interview on 07/19/19 at 12:12 PM, Staff B stated that she found it "very hard to believe" the resident was lowered to the floor and sustained that many fractures. During an interview on 08/06/19 at 12:39 PM, Resident #3 stated that he had spoken to Staff C who said he was changing Resident #1, and she moved her leg and she fell. Resident #3 stated that Resident #1 liked her bed up higher, and when the CNAs changed Resident #1, the bed	F 689	audits frequency will be determined based on the review and evaluation of any findings during the facility QAPI committee meetings. Investigations will be reviewed by the IDT during the daily clinical meeting. A review of any resident sustaining injury will be conducted to ensure a delay in required care did not occur. 5. Administrator will ensure compliance	

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F 689	Continued From page 3	F 689		

was up high so the CNAs did not hurt their backs.

Review of the 07/15/19 Incident Report showed fall interventions in place prior to the incident included, low bed, two person assist for transfers and cares. At the time of the fall, Resident #1 was in bed in a supine (on back) position.

During an interview on 07/19/19 at 12:12 PM Staff B, Director of Nursing stated that she was not sure if the bed was in a raised position at the time of the resident's fall. The facility investigation failed to determine the height of the bed position at the time of the resident's fall.

During an interview on 07/19/19 at 11:25 AM, Staff C, stated that he was in Resident #1's room, preparing supplies. Resident #1 was lying on her back, when she tried to turn and be comfortable. Staff C stated that Resident #1 called out, he turned and assisted her down ...put her on the floor. Upon further questioning, Staff C stated that Resident #1 was on the edge of the bed, turned on her right side, with a pillow behind her back. The resident lifted her left leg over her right leg, the weight of which caused her to fall off the bed. When asked to demonstrate the bed position, Staff C, stated that the bed was in the lowest position, but then lowered it only midway.

Staff C, stated that Resident #1 required assistance of two to be changed and added, "my partner was coming."

Review of the facility incident investigation showed no other CNA was identified or interviewed to verify if they had been asked to assist with Resident #1's care. In addition, according to the facility investigation, Staff C

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F 689	Continued From page 4 changed the resident's brief earlier that morning, at 8:30 AM. The investigation failed to investigate further to determine if two staff assisted at that time as care planned. During an interview on 07/26/19 at 11:42 AM, Resident #1's representative stated that Resident #1 told her one person was trying to change her and they're supposed to be two, and she fell out of bed. Resident #1's representative stated, "She shouldn't have been that close to the side (of the bed) to begin with.", "If she was on her side, he shouldn't have taken his eyes off of her." Resident #1's representative also stated, "She can't lift her leg up that far." Resident #1's representative stated that normally, Resident #1 stayed on her back, and had only been seen on her side when staff rolled her over to change her incontinent briefs. During an interview on 07/29/19 at 10:40 AM Staff F, CNA, stated that Resident #1 was unable to turn to the right by herself. According to Staff F, Resident #1 was usually in bed, on her back, with the head of the bed elevated. During an interview on 07/29/19 at 2:00 PM Staff G, CNA, stated that Resident #1 was only ever seen in bed, straight on her back with the head of the bed up. During an interview on 07/29/19 a 2:05 PM Staff J, Licensed Practical Nurse (LPN), stated that Resident #1 was usually on her back, sitting up. When asked if the resident could lay on her side, Staff J replied, "Not that I know of." During an interview on 07/29/19 at 1:56 PM Staff H, LPN, stated that the resident was always sitting up in bed. Staff H stated, "I don't think she liked to be laid down, hard time breathing." Review of Resident #1's 07/15/19 11:17 AM	F 689		

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F 689	Continued From page 5 progress note showed, the CNA summoned the nurse who was nearby came and assessed the resident. According to the nurse the resident seemed at baseline except for her pain level. Resident #1 complained of pain to her right lower extremity, on a scale of 0-10, resident rated her pain at 1,000. Resident #1 was transferred back into bed with a Hoyer lift. A 07/15/19 12:51 PM progress note showed Resident #1 complained of unbearable pain to bilateral knees, left shoulder, and spine. The physician was notified and ordered x-rays. The resident requested to be transferred to Emergency Room (ER). An order to transfer was obtained, and AMR (Medical Transportation) was called with an estimated arrival in 30 minutes. A 07/15/19 1:04 PM Progress Note showed the physician ordered x-rays, but the resident insisted that she needed to be transferred to the Emergency Department (ED). Review of the 07/15/19 ED Note showed Resident #1 stated that when she was helped up, she heard three popping noises and experienced back pain. Review of 07/16/19 hospital records showed that Resident #1 was endorsing pain everywhere, including her neck and had arrived without a c-collar. During an interview on 07/29/19 at 10:08 AM Staff I, Licensed Nurse (LPN), stated that Resident #1 was assessed while on the floor at the facility, and complained of pain to her knees, back, and her left shoulder was tender to touch. The resident was transferred back into bed with a mechanical lift. Staff I called the physician who ordered X-rays if Staff I "thought they were needed". Resident #1 put the call light on and	F 689		

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F 689	Continued From page 6 said I think you need to send me to the hospital. After receiving physician clearance, Staff I stated that he canceled the X-ray and sent the resident out by ambulance. During an interview on 07/29/19 at 2:05 PM, when asked if a resident fell and upon assessment complained of pain in knees, shoulder, and back, Staff J (LPN) stated that the expectation was that the resident would not be moved from the floor, and 911 would be called. During an interview on 07/29/19 at 3:30 PM Staff A, Administrator, stated that based on the nurse's assessment, the expectation would have been for the nurse to leave the resident on the floor and call 911 for emergency transport to a hospital. REFERENCE: WAC 388-97-1060 (3)(g) .	F 689		

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