

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

PRINTED: 03/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505354</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/21/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PROVIDENCE ST JOSEPH HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 EAST WEBSTER CHEWELAH, WA 99109</b>
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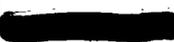
F 000

INITIAL COMMENTS

F 000

This report is the result of an unannounced Abbreviated Survey conducted at Providence St. Joseph Hospital Chewelah on 2/20-21/13. A sample of 4 residents was selected from a census of 36. The sample included 3 current and 1 discharged resident.

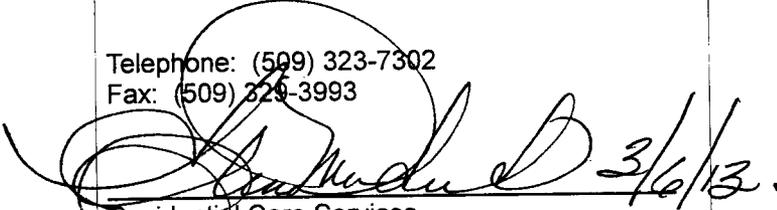
The survey was conducted by:

 RN, BSN

The survey team is from:

Department of Social & Health Services  
Aging & Disability Services Administration  
Residential Care Services, District 1, Unit A  
316 West Boone Ave., Suite 170  
Spokane, WA 99201-2351

Telephone: (509) 323-7302  
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 3/6/13

Residential Care Services  
F 323 483.25(h) FREE OF ACCIDENT  
SS=D HAZARDS/SUPERVISION/DEVICES

F 323

F 323 (starts on page 2)

RECEIVED  
MAR 10 2013  
DSHS ASDA RCS  
SPOKANE WA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE 	(X6) DATE <b>3/14/13</b>
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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	<p>Continued From page 1</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 fully assess causal factors for falls, follow the care plan interventions for injury prevention, or modify the care plan to prevent additional falls for 2 of 4 sample residents (#1, 2) in a census of 36. Findings include:</p> <p>1. Resident #1 had diagnoses of [REDACTED] and [REDACTED]. Per the record, she was alert and oriented, and able to make her own decisions (although some of her decisions were potentially detrimental to her health).</p> <p>On 12/5/12 at 9:15 p.m., the resident fell out of her wheelchair in her room. The resident stated she had fallen asleep and fell. A licensed nurse (LN) note on that shift documented the "resident has been observed sleeping in her w/c (wheelchair), leaning to the rt. (right) frequently on all shifts." She complained of back and right rib pain. LN progress notes on 12/6-12/7/12 (the 2 days after the fall) indicated that because of the pain, the resident was requiring several doses of narcotic medication. In addition, documentation during that time indicated the resident was spending more time in her wheelchair (because of the pain with transfers to her recliner), was</p>	F 323	<p><b>F 323</b></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><b>How the facility will correct the deficiency as it relates to the resident:</b></p> <ul style="list-style-type: none"> <li>• The care plan for resident #1 has been updated to conduct a trial of a lap tray on the wheel chair to prevent the resident from leaning to the right. This will reduce the risk for falling out of the wheel chair. The resident has a history of refusing to follow her care plan. If this occurs, nursing will document the results of the trial and update the informed consent that is currently in the chart from January of this year.</li> <li>• The physician will order a mental health evaluation that will assess the resident's need for spending numerous hours continuously cleaning her colostomy. The facility will follow the recommendations of this evaluation and implement specific interventions to address the resident's obsessive/compulsive behaviors.</li> <li>• The care plan for resident #1 has been updated to remind the resident to get out of the wheel chair and into her recliner for better positioning and safety.</li> <li>• The care plan for resident #2 has been updated to give the resident a reacher as an assistive device to help her reach objects to help reduce the risk of falling when she is reaching for objects out of her reach. The resident will be trained by nursing staff. She is currently independent with all</li> </ul>	
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F 323

Continued From page 2  
very sleepy, and continued to fall asleep in her wheelchair frequently. Despite the fact the resident had fallen asleep while in her wheelchair, was taking [REDACTED] medication which made her more drowsy, and was refusing to transfer out of the chair secondary to pain, no new interventions were put in place to prevent additional falls.

On 12/8/12 at 3:40 a.m., the resident again fell asleep in her wheelchair and fell out. The facility investigation for that incident documented the resident had been in the bathroom all night for 2 nights, fell asleep while in the bathroom, and fell out of her wheelchair. The resident had no new apparent injuries, but was still having pain from the fall on 12/5/12. Multiple LN notes documented that the resident was spending multiple hours in the bathroom (cleaning her ostomy bag - an appliance used to collect stool) and falling asleep. The resident was changed from independent with transfers to a 2-person assist; no other modifications were made in the care plan. When reviewed on 2/20/13 (over 2 months since the first fall), the care plan did not identify the fact she was falling asleep frequently in her wheelchair. In addition, the facility failed to assess if there were additional interventions that could decrease the resident's need to continuously clean her ostomy bag.

The LN notes for several days after the second fall documented the resident was having increased pain, increased [REDACTED] and on 12/13 was placed on medication for [REDACTED] as needed, placing the resident additionally at risk for drowsiness and falls), and continued to spend multiple hours in the bathroom and multiple hours asleep in her wheelchair. The resident continued

F 323

**F 323 (cont'd)**

transfers and ambulation with front-wheel walker.

**How the nursing home will act to protect residents in similar situations:**

- The nursing staff will conduct a more thorough investigation after all falls that occur. An assessment will be conducted to evaluate any changes that need to be made to prevent falls from reoccurring. The care plan will be updated after each occurrence if necessary. This is to ensure that the facility is assessing that the environment remains free of accident hazards.

**Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:**

- There will be mandatory re-education at the Licensed Nurse's meeting on 3/12/13 regarding the investigation process and the importance of assessing and applying new interventions to prevent further falls. This will ensure that the residents receive adequate supervision and assistance devices to prevent accidents.
- There will be a line added to the Investigation Worksheet that states: Have you reviewed the care plan and made the necessary changes to the care plan?

**How the nursing home plans to monitor its performance to make sure that solutions are sustained:**

- The Director of Nursing (DNS) or the Nursing Supervisors (NS) will review each Investigation Worksheet and complete the

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F 323	<p>Continued From page 3</p> <p>to be hesitant to transfer from her wheelchair because of pain. On 12/14 she was found to have compression fractures in 2 places on her lower back.</p> <p>In reviewing the LN notes from the date of the last fall on 12/8/12, until the surveyor was in the facility on 2/20/13, there were at least 25 instances where the resident fell asleep in her wheelchair, sometimes leaning forward and/or to the right. A note on 1/1/13 at 12:30 a.m. documented that the resident was leaning so far forward and to the right that "if the rail and bin (handrail and laundry bin) were not there, Resident #1 would have been on the floor." Aside from therapy evaluations on 12/10 and 12/13, no additional interventions were put into place to prevent the resident from having additional falls out of her wheelchair. These factors placed her at continued risk for falls when asleep in her wheelchair.</p> <p>On 2/20/13 and approximately 1:00 p.m. and 2/21 at approximately 10:00 a.m., the resident was observed sitting in her wheelchair in her room. In both instances the resident was awake, and her upper torso was leaning to the right.</p> <p>The facility failed to modify the care plan to prevent the resident from having additional falls while falling asleep in her wheelchair. In addition, there was no recent assessment (or determination if additional measures could be put in place) related to the resident's need for spending numerous hours caring for her ostomy.</p> <p>2. Resident #2 had diagnoses of [REDACTED]</p>	F 323	<p><b>F 323 (cont'd)</b></p> <p>section of the summary of findings. The DNS or the NS will ensure that the care plan is accurate and has been updated if necessary.</p> <p><b>Date when corrective action will be completed: 4/5/2013</b></p> <p><b>The title of the person responsible to ensure correction: The Director of Nursing.</b></p>	
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F 323	<p>Continued From page 4</p> <p>██████████ and ██████████ Per the record, the resident had some ██████████ but was initially independent with transfers and ambulation.</p> <p>On 11/24/12, the resident fell when she leaned too far forward to reach for something on her bedside table. No modifications were made in her plan of care at that time. On 12/19/12, the resident had another fall when she was reaching for her cell phone. In this instance, the resident hit her head "hard" on the handle of a drawer. The investigation of this incident was minimal, with no assessment/evaluation of changes that could be made to prevent this from reoccurring. The care plan was not modified in any way to prevent falls when reaching for objects.</p> <p>In addition, a nurse's note on 12/22 indicated the resident was found in her room walking around with regular socks. The LN documented that the resident's care plan directed staff to ensure she had on either "good shoes or non-skid socks at all times to help prevent falls." On 1/1/13, the resident had a fall in her room when she got out of bed to use the bathroom. The resident stated she hit something when she fell, and was found to have a bloody lip, jaw pain, bruising to her right knee, a skin tear to her left thumb, bruising to her right wrist, and a scratch on her right forearm. A LN note documented the resident had regular socks on at the time of the fall.</p> <p>When interviewed on 2/21/13 at approximately 10:20 a.m., Staff A was unable to provide additional information to show that the facility had thoroughly evaluated the incidents when the resident fell reaching for items - the care plan</p>	F 323		
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F 323	Continued From page 5 was not modified after either incident to prevent its reoccurrence. In addition, she verified the facility staff was to ensure the resident had on non-skid socks or shoes at all times (as directed in the plan of care).	F 323		
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