

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

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FORM APPROVED
OMB NO. 0936-0391

File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ JAN 02 2015 B. WING _____	(X3) DATE SURVEY COMPLETED C 11/03/2014
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NAME OF PROVIDER OR SUPPLIER NEWPORT COMMUNITY HOSPITAL LTC	STREET ADDRESS, CITY, STATE, ZIP CODE 714 WEST PINE STREET NEWPORT, WA 98156
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Newport Community Hospital - LTC Unit on 11/3/14. A sample of 5 residents was selected from a census of 45. The sample included 5 current residents.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#3049173</p> <p>The survey was conducted by:</p> <p>Linda Loffredo, R.N., B.S.N.</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Long-Term Support Administration Residential Care Services, District 1, Unit A 318 West Boone Avenue, Suite 170 Spokane, Washington 99201</p> <p>Telephone: (509) 323-7302 Fax: (509) 328-3993</p> <p><i>Cindy CoVilles</i> 11/18/14 Residential Care Services Date</p>	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Tom Wilson</i>	TITLE CEO/Superintendent	(X6) DATE 12/18/2014
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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=0	<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 record review and interview, it was determined the facility failed to ensure adequate supervision and protective devices were consistently provided to prevent accidents for 1 of 5 residents (#1) reviewed. This resulted in actual harm to Resident #1, who fell while riding in the facility van, and received a fracture. Findings include:</p> <p>Resident #1 had diagnoses that included dementia and a stroke. Review of the resident's plan of care revealed she was at risk for falls, but had no recent falls. She required extensive assistance with activities of daily living.</p> <p>Review of the resident's medical record and facility investigation report revealed that on 10/30/14 at 2:40 p.m., the resident was being transported in her wheelchair on an outing in the facility van. The resident's wheelchair was secured with wheel tie-downs prior to transport, however there was no protective device (waist and shoulder straps) utilized to keep her secure in the wheelchair. During a slowdown, approaching a slight curve in the road, the resident fell forward out of her wheelchair onto the floor of the van. X-rays obtained on 10/30/14</p>	F 323	See attached Plan of Correction	

FW

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F 323	<p>Continued From page 2</p> <p>noted the resident had fractured her right arm due to the fall.</p> <p>During an interview on 11/3/14 at 1:25 p.m., Staff #A, the activity director, stated the facility van had a shoulder/waist harness to use for one resident in a wheelchair. She stated both she and Staff #B, (the activity staff driving the van on 10/30/14), had never been trained to consistently utilize the harness for residents in wheelchairs during transport in the van. Review of the owner's manual, related to the use the van, had instructions for the wheelchair tie-downs, and the use of the seatbelt/harness. Review of the facility policy for resident transportation did not include directions for securing resident wheelchairs in the van.</p> <p>During a telephone interview on 11/14/14, Staff #B stated she was slowing down as she approached a curve in the road, when she heard a noise and saw the resident had fallen. The resident fell before she reached the curve in the road. Staff #B stated the harness/seatbelt was available for use if a resident needed it. She stated Resident #1 had never needed the harness.</p> <p>Despite the need for residents in wheelchairs to be protected from injury during transport in a motorized vehicle, staff failed to recognize the need for protective devices to prevent accidents. As a result, Resident #1 had a fall resulting in a fracture.</p>	F 323		

TRC