

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CRISTWOOD NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 19301 KINGS GARDEN DRIVE NORTH SEATTLE, WA 98133
---	--

(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 323 483.25(h) FREE OF ACCIDENT
SS=D HAZARDS/SUPERVISION/DEVICES

F 323

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.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to ensure that 1 of 4 residents (Resident #1) received safe and adequate use of an assistive device during a transfer. This failure resulted in an avoidable accident due to error operation of a mechanical lift which led to a fall with injury and pain.

Findings include:

According to record review of facility medical records on 03/06/13, Resident #1 resided in the facility for long term care due to weakness and medical conditions. Review of the Minimum Data Set (MDS) Assessment dated 01/21/13 for Resident #1, revealed this resident was totally dependent on staff for transfers, and Resident #1 had a BIMS score of 15/15.

In an interview with Resident #1 on 03/06/13, the resident was found to be oriented to person, place and time. Resident #1 stated she recently

IDR AMENDED

RECEIVED
JUN 14 2013
DSHS/ADSA/H-2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CRISTWOOD NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 19301 KINGS GARDEN DRIVE NORTH SEATTLE, WA 98133
---	--

(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 323 Continued From page 2
experienced a fall to the floor during a transfer: "I fell because they didn't have the hook on right. I saw it unhooked on the right side as they lifted me..it was a terrible experience. My neck still hurts on the right side and my low back hurts. I will never forget that hook not being hooked. I am sitting here quietly because my arm, back and neck hurt".

F 323

In an interview on 03/06/13 at 2:30 p.m., Staff A stated Resident #1 fell the week prior and sustained bruising.

Observation on 03/06/13 at 2:40 p.m., revealed two dark bruises on the right upper arm, one four inches by one inch, and one three inches by one inch, purple in color with brownish edges. Resident #1 stated they "hurt on a level 5 of 10" when the bruises were touched by Staff A while assisting in the observation.

According to record review on 03/06/13, the facility Interdisciplinary Progress Notes dated 02/26/13, noted an entry by the licensed nurse on duty at the time of the fall: Resident #1's sling came undone on the right side.

In an interview on 03/06/13 at 3:30 p.m., Staff B stated the right front hook came off during Resident #1's transfer and the resident fell onto the floor.

IDR AMENDED

In an interview on 03/06/13 at 4:00 p.m., Staff C

RECEIVED
JUN 7 2013
DCHS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CRISTWOOD NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 19301 KINGS GARDEN DRIVE NORTH SEATTLE, WA 98133
---	--

(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 323 Continued From page 3
stated the lift clasp came undone and the caregiver must not have attached the sling correctly so it was operator error with Resident #1's fall.

In an interview on 03/06/13 at 4:15 p.m., Staff D, a supervisory nurse who investigated the fall, stated the connection to the lift slipped off and it was caregiver error, which was reviewed with the employee who performed the lift (one caregiver did the lift) after the fall.

Record review of facility Nursing Rehab Records on 03/06/13 revealed, Resident #1 declined restorative exercises the day after the fall that occurred on 02/26/13: the note dated 02/27/13 stated "resident declined upper body exercises and complained of soreness in arms and shoulders due to fall on 02/26/13, [licensed nurse notified". Further record review revealed Resident #1 also declined restorative nursing on 03/02/13 and noted "resident has pain on arm, [licensed nurse] notified".

Further record review on 03/06/13 of the Facility Incident report revealed Resident #1 had a fall during transfer on 02/26/13, sustained a scratch to the right lateral breast, and the fall was equipment related as well as preventable if error was made snapping on the sling [on the mechanical lift] for the transfer.

Further review revealed the facility incident report noted "discussion with NAC (caregiver) regarding importance of double checking straps of sling

F 323 For Resident #1, when the clip on sling by legs failed, it caused the resident to slip out feet first. She was assisted to the floor by the NAC. The NAC immediately got the nurse and they helped the resident back into bed. The resident indicated that she was OK. The Nurse assessed the resident for injury. No significant injury was found other than a slight abrasion. Later the resident was taken to Northwest ER for further assessment with no findings of injury on exam, so the hospital returned the resident to the facility. The abrasion became bruise due to Coumadin regime. The floor nurse immediately removed and tagged the lift until it could be inspected for proper functioning. An investigation was completed including interview of the resident who repeated that she was fine. The incident does not meet criteria to report to DSHS, however was logged per guidelines.

To ensure that our procedures and preventative measures are effective in providing safe equipment for other residents requiring a lift, all lifts and slings including the lift used in this incident, were inspected by the Physical Therapy supervisor.

2/26/13

2/28/13

IDR AMENDED

RECEIVED
JUN 14 2013
DSHS/ADSA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505069	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CRISTWOOD NURSING AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 19301 KINGS GARDEN DRIVE NORTH SEATTLE, WA 98133
---	--

(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 323 Continued From page 4
before use". The facility incident report noted the resident was being taken to the toilet using the mechanical lift and the right strap of the sling became undone. The report also noted Resident #1 was at high risk because of being on a blood thinning medication.

Additional record review of the facility investigation on 03/06/13 noted an entry by the nurse supervisor who investigated the incident and stated the incident was an accident and resulted in a substantial injury. The report stated the caregiver who was operating the mechanical lift at the time of the fall (Staff B), had the process of using the mechanical lift reviewed with Staff B by the supervisor, including the importance of checking straps when using the lift.

Observation of the facility mechanical lift equipment on 03/06/13 at 3:30 p.m. revealed, a lift with a sling that hooks onto the lift at 4 places around the resident. The hooks must be "locked" into place when they are attached onto the lift. There are 2 hooks in front and 2 hooks in back of the resident when they are placed into the sling.

Failure of the facility staff to ensure the mechanical lift device had a sling fastened securely, led to Resident #1's fall to the floor during a transfer that resulted in injury and pain.

F 323 To ensure systems addressing future lift safety are in place, we will continue our monthly lift and sling preventative maintenance inspection and documentation by Environmental Services on all lifts and slings. We will continue our annual and on request inspection, maintenance and documentation by the lift manufacturer certified technician. We will continue the staff training annually on use of lifts. We will continue to annually review the Safety checklist with nursing staff which includes the review of use of lifts.

The Environmental Services Manager will monitor to ensure Preventative Maintenance is done per schedule. The DNS will ensure the annual lift and transfer training is completed annually and the annual Safety checklist is completed for each staff member for oversight.

On-going

3/27/13

On-going

On-going

IDR AMENDED

RECEIVED
JUN 14 2013
DSHS/AS...