

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

PRINTED: 06/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505421	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/03/2014
NAME OF PROVIDER OR SUPPLIER WASHINGTON ODD FELLOWS HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 534 BOYER AVENUE WALLA WALLA, WA 99362		
(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 Washington Odd Fellows Home on June 3, 2014. A sample of 3 residents was selected from a census of 96 residents. The sample included 2 current residents and the records of 1 former and/or discharged resident.</p> <p>The following were complaints investigated as part of this survey: #3013408 #3011370</p> <p>The survey was conducted by: Patti Rose, R.N.</p> <p>The survey team is from: Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services, District 1, Unit C 3611 River Road, Suite 200 Yakima, Washington 98902</p> <p>Telephone (509) 225-2800 Fax (509) 574-5597</p> <p><i>[Signature]</i> Residential Care Services Date</p>	F 000			
F 323 SS=G	<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>	F 323			

Received
Yakima RCS
JUN 18 2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
Administrator

(X6) DATE

June 16, 2014

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	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to identify and provide adequate supervision to prevent falls for 2 of 3 sampled residents (#'s 1,2) reviewed for falls. This deficient practice resulted in Resident #1 being transferred to the Emergency Room (ER) due to complaints of hip pain where x-rays revealed a hip contusion (bruise). Findings include: Resident #1: Admitted to the facility with diagnoses which included Alzheimer's disease, dementia with behaviors, osteoporosis, and [REDACTED] Review of the resident's plan of care revealed she was at high risk for falls due to confusion, and gait/balance problems. A tag alarm system was utilized while she was in bed and in her wheelchair to alert staff to her needs and aid in fall prevention. She required extensive assistance with toileting. Review of a facility investigation report dated 2/12/14 revealed the resident fell to the floor when she attempted to self transfer from her bed to the wheelchair. The investigation noted the resident frequently attempted to self transfer without the use of her call light. Review of Progress Notes dated 3/9, 11, 16/2014 and 4/30/14 noted the resident made attempts to get out of bed on the night shift.	F 323	All residents have been assessed to determine the appropriateness of being left unattended while toileting. Residents who are both a high fall risk and are dependent on staff for toileting have had their Care Plans updated to not be left unattended while toileting. Nursing staff have been inserviced on the procedures to include the information on the Care Plan and to inform the caregivers of the plan. NAC staff have been inserviced regarding the necessity to monitor high risk residents while toileting. This will be monitored by the Resident Care Managers completed by July 3, 2014.	7/3/14	

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F 323	<p>Continued From page 2</p> <p>Review of a facility investigation report dated 5/9/14 at 2:15 a.m. noted staff found the resident lying on her left side on the bathroom floor. She had a large skin tear to her left arm. Staff A (Nursing Assistant) had heard her tag alarm and upon entering the resident's room noted she had self transferred into a wheelchair. The resident informed Staff A she needed to use the bathroom, thus was assisted onto the toilet. Staff A then left the resident unattended on the toilet while she proceeded to check on another resident. Staff A had just left the room when she heard the resident fall and hit the floor. The investigative report stated the incident was reasonably related to the resident's poor safety awareness and impulsive attempts.</p> <p>Later that afternoon at 5:30 p.m. the resident began complaining of left hip pain, thus was transferred to the ER. Review of ER records noted the resident's hip pain was "sharp and severe." X-rays revealed a hip contusion (bruise).</p> <p>A telephone interview on 6/4/14 at 5:38 a.m. with Staff A revealed the resident self transferred into her wheelchair frequently on the night shift and was very confused.</p> <p>Despite the resident's cognitive impairment, frequent attempts to self transfer, impulsive behavior, poor safety awareness, balance/gait problems, and recent fall on 2/12/14; staff failed to supervise the resident while seated on the toilet.</p> <p>Resident #2: Admitted to the facility with diagnoses which included Alzheimer's disease. Review of the resident's plan of care noted he</p>	F 323		

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F 323	Continued From page 3 required extensive assistance for toileting with transfers. He was at high risk for falls due to unaware of safety needs, confusion, and impaired gait and balance. He utilized a tag alarm system when in bed and the wheelchair to alert staff to his needs and aid in fall prevention. Review of the resident's medical record revealed he had fallen from his wheelchair on 2/17, 3/29, and 4/14/14 when he attempted to self transfer. Review of a facility investigation report revealed on 5/28/14 at 1:45 p.m. the resident was left unattended on the toilet in the shower room. Staff B (Nursing Assistant) had left him to obtain clean pants and when she returned to the shower room the resident was on the floor. He had attempted to self transfer off the toilet when he fell. He sustained a skin tear to his right elbow. An interview on 6/3/14 at 1:45 p.m. with Staff B revealed she was aware of the resident's history of attempts to self transfer. She stated she had instructed a student Nursing Assistant (NA) to stay with the resident until she returned from obtaining clean pants for him. When she returned she found the student NA outside the door of the shower room, unaware of the resident's activities. When she opened the door she observed the resident on the floor. Despite the resident's significant fall history with attempts to self transfer; confusion; impaired balance and gait; and unawareness of safety needs; staff failed to supervise the resident while seated on the toilet.	F 323		