

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

FORM
OMB NO.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE COMPLETED C 08/11/14
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NAME OF PROVIDER OR SUPPLIER ROCKWOOD SOUTH HILL	STREET ADDRESS, CITY, STATE, ZIP CODE EAST 2903 25TH AVENUE SPOKANE, WA 99223
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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
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INITIAL COMMENTS

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This report is the result of an unannounced Abbreviated Survey conducted at Rockwood South Hill on 8/11/14. A sample of 4 was selected from a census of 35. The sample included 3 current residents and the records of 1 former and/or discharged resident.

The following complaint was investigated as part of this survey:

3030174

The survey was conducted by:

Susan R. Bergeron, R.N.

The survey team is from:

Department of Social & Health Services
Aging & Long Term Support Administration
Residential Care Services, District 1, Unit B
Rock Pointe Tower
316 W. Boone Avenue, Suite 170
Spokane, Washington 99201-2351

Telephone: (509) 323-7303
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Susan R. Bergeron 8/14/14
Residential Care Services

RECEIVED
AUG 29 2014
DSHS ADSA RCS
SPOKANE WA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE CEO, LNHA	(X6) DATE 8/21/14
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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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PRINTED: 08/20/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/11/2014
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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> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure interventions to prevent accidents were implemented for 1 of 4 sample residents (#2). The failed practice resulted in harm to the resident who fell and sustained serious injuries. Findings include: Resident #2 had diagnoses that included severe osteoporosis, generalized weakness, compression fractures, and pelvic fracture. Per record review, the resident had short term memory impairment, required assistance with transfers, and had a history of falls. Because the resident was at risk for additional falls, a care plan to prevent accidents was in place which directed staff not leave the resident in the bathroom unattended. The facility investigation determined that on 7/26/14 staff transferred the resident onto the toilet then left the room to obtain supplies. When staff returned, the resident was on the floor with a 7 centimeter laceration to her head that was bleeding profusely. Staff assisted the resident back onto the toilet and left her alone again while she went to find the licensed nurse. After the fall the resident was sent to the hospital where her laceration was treated and she</p>	F 323	<ol style="list-style-type: none"> 1. How the nursing home corrected the deficiency as it related to the individual: On 7/26/14, at the time of the occurrence, the employee was suspended pending investigation. During investigation it was determined that the staff member did not follow the plan of care. The staff member's employment was terminated on 7/29/14. 2. How the nursing acted to protect other residents in similar situation: A mandatory In-service was held on 7/29/14 on the necessity of care to be given per the care plan and as stated in the Kardex and the Care Tracker system 3. Measures the nursing has taken to ensure that the problem does not recur: Visual observations and audits have been conducted once a week on various shifts, on a continuous basis. 4. The nursing home plans to monitor its performance to make sure that solutions are sustained: Ongoing visual observations and audits will be conducted once a week on various shifts, on a continuous basis. 5. Dates when corrective action will be completed, will be 9/15/14. 6. The DON and RCM will be the persons responsible to ensure correction.

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F 323 Continued From page 2
was diagnosed with additional injuries that included [REDACTED]
During an interview on 8/11/14 at 2:30 p.m., an administrative nurse stated staff was not following the care plan when they left the resident unattended in the bathroom.
Staff's failure to implement the planned intervention resulted in significant harm to the resident who fell and [REDACTED]

F 323