

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

PRINTED: 03/01/2013  
FORM APPROVED  
OMB NO. 0938-0391

544

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505291	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/25/2013
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NAME OF PROVIDER OR SUPPLIER  RIVERVIEW LUTHERAN CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1841 EAST UPRIVER DRIVE SPOKANE, WA 99207
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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 announced Abreviated Survey conducted at Riverview Care Center on 2/22/13 and 2/25/13. A sample of 5 residents was selected from a census of 66. The sample included 4 current residents and the record of 1 former and/or discharged resident.

The following were complaints investigated as part of this survey:

- #2730139
- #2730537
- #2749851
- #2757965

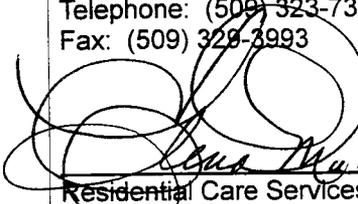
The survey was conducted by:

 BSW

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  
Fax: (509) 323-3993

  
Residential Care Services Date 3/1/13.

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DSHS ADUA RUS  
SPOKANE WA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 3-7-13
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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=D	<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 observation, interview, and record review, it was determined, the facility failed to ensure the facility was maintained in a manner that prevented accident hazards for 1 resident (#1) in a sample of 5. Findings include:</p> <p>Resident #1 had diagnoses that included [REDACTED]. The resident was independent with her walker but had poor safety awareness and wandered daily throughout the secured unit.</p> <p>Per the facility investigation, on 2/18/13 at 6:50 p.m., the resident was found lying on the floor of the temporary restorative gym (dining room in the secured unit) and was inside a partially put together cabinet which was left on the floor by staff. The resident sustained a 2 x 3 centimeter(cm) scrape on her mid-lower back. The investigation concluded the resident fell while ambulating without her walker, got beyond the table in the entry way and tripped over the unfinished cabinet which was left on the floor, accessible to residents.</p> <p>In an interview on 2/25/13, Staff #A stated the restorative gym was relocated to the dining room on the secured unit on 2/15/13, because of the</p>	F 323	<p>The nursing home will correct the deficiency as it relates to the resident by having the area immediately cleaned and cleared of the caused hazard. All nursing staff will be re-inserviced on resident monitoring and supervision as it relates to residential needs. The nursing home will protect residents in similar situations by continuing to have weekly construction meetings to review each change and how they affect the residents and their environment. Resident safety will continue to be a top priority. Also, all maintenance staff will be re-inserviced on environmental safety. The nursing home has taken safety measures such as placing a temporary gate to appropriately block off the area of</p>		

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F 323	<p>Continued From page 2</p> <p>construction in the building. Staff #A said the move was temporary until construction was completed on the other gym. He said restorative staff needed a cabinet assembled for use in the gym so maintenance started putting one together but left it unfinished on the floor of the gym. When asked what the plan was to keep residents safe, Staff #A stated he asked the restorative staff to put a table in front of the entry way to prevent residents from going into the area. The unfinished cabinet and the table being utilized as a barrier created environmental hazards for confused wandering residents.</p> <p>During observations on 2/22/13 and 2/25/13, the resident was observed walking with her walker throughout the secured unit. The restorative gym was also observed with a gate across the opening to the dining room/therapy gym.</p> <p>In an interview on 2/26/13 at 10:30 a.m., Staff #B said she worked with the resident on 2/18/13. She was helping residents to bed that evening and went to find Resident #1. The resident's walker was observed outside the dining room but the resident was not there. Staff #B said the dining room was dark and she heard the resident say "help." Staff #B found the resident in the dining room/restorative gym inside the unfinished cabinet on the floor. Staff #B said the resident looked very confused and frightened.</p> <p>Staff #B also said there was a metal cart in the gym and a metal bar (used for therapy) that was on top of the cabinet the resident was lying in. Staff #B said there was about a 1 foot opening on each side of the table which made it easy for a resident to get into the restorative gym.</p> <p>The facility failed to identify accident hazards and put safety measures in place prior to moving</p>	F 323	<p>Continued From Page 2</p> <p>occurrence, with construction plans for a permanent gate to be placed in the same location to prevent this situation in the future. The nursing home has also implemented a system in which charge nurses will be conducting environmental rounds twice per shift on all shifts to ensure environmental safety through the completion of construction. The nursing home plans to monitor performance through continued weekly construction meetings and the twice per shift environmental checks by charge nurses. This corrective action will be completed by 3/22/13. The title of the person responsible to ensure correction will be the Director of Nursing.</p>		

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F 323	Continued From page 3 the restorative gym to the secured unit dining room, where residents who wander and have dementia were placed at risk for injury.	F 323			