

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 02/26/2014
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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
F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Riverview Lutheran Care Center on 2/26/14. A sample of 4 residents was selected from a census of 61. The sample included 3 current and the records of 1 former and/or discharged resident.</p> <p>The following complaint was investigated as part of this survey: # 2955680</p> <p>The survey was conducted by: Susan R. Bergeron, R.N.</p> <p>The survey team is from: Department of Social &amp; Health Services Aging &amp; Long Term Support Administration Residential Care Services, District 1, Unit A Rock Pointe Tower 316 W. Boone Ave, Suite 170 Spokane, Washington 99201-2351</p> <p>Telephone: (509) 323-7303 Fax: (509) 329-3993</p> <p><i>[Signature]</i> Residential Care Services Date 3/10/14</p>	F 000	<p>Riverview Lutheran Care Center takes great pride in providing a quality environment for residents and their families. We take each and every comment seriously and respond quickly and appropriately to these concerns.</p> <p>This plan of correction response is solely to comply with State and Federal Regulations for participation in the Medicaid and/or Medicare program. In no way does this plan of correction admit to or agree with any of the allegations or conclusions made by the investigators mentioned in this document.</p> <p><b>RECEIVED</b> MAR 17 2014 DSHS ADSA RCS SPOKANE WA</p>	3/31/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE ADMINISTRATOR	(X6) DATE 3/17/2014
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A 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=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 1 of 4 sample residents (#1), received the necessary assistance and supervision with the use of an assistive device to ensure the resident was transferred safely. The failed practice resulted in actual harm to the resident who fell and sustained injuries. Findings include: Resident #1 had diagnoses that included dementia, generalized weakness, and a non-healing scalp wound. According to the record, the resident had a history of falls and was determined by the facility to be high risk for further falls. The resident's care plan indicated he was to be transferred via a mechanical lift. Facility policy indicated two staff were required for all mechanical lift transfers. According to the record, on 2/2/14 the resident fell and struck his head during a transfer with the mechanical lift. The resident sustained a laceration to the right side of his head measuring 3 x 0.5 cm (centimeters) that was surrounded by an area of torn skin that measured 4.5 x 3 cm. An additional skin tear measuring 5 x 0.5 cm was found on the left side of the resident's head. The wounds were treated with first aid at the facility</p>	F 323	<p>F323</p> <p>The nursing home will respond to this deficiency as it relates to this resident, and protect other residents in similar situations. With initially educating and counseling staff directly involved with appropriate disciplinary action on 2/3/14. The facility will included new staff orientation education of mechanical lift transfer policy. The facility will also establish required annual resident transfer training. Re-in servicing all NAC staff on resident safety specifically as it relates to transfers with a mechanical lift by 3/31/14. To monitor our performance and to</p>	3/31/14
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F 323	Continued From page 2 and the resident has since been discharged. Per the facility investigation, the fall was the result of staff's failure to follow facility policy regarding the need for two staff for all mechanical lift transfers. The staff member involved in the incident stated she transferred the resident without assistance because she was not aware of the facility's policy. During an interview on 2/26/14 at 1:10 p.m., an administrative nurse stated all staff receive appropriate training related to the need for two staff for mechanical lift transfers. The facility's failure to ensure transfers were performed in a safe manner placed the resident at risk for substantial injury.	F 323	make certain solutions are sustained, the facility will to do random observation and verbal testing of the direct care staff to ensure correct knowledge of residents and individual safety needs as related resident transfers as part of our quality assurance. This corrective action will start today 3/17/14 and be completed no later than 3/31/14. The Director of Nursing will be responsible to ensure the correction.	3/31/14