

APR-11-2014 FRI 04:38 PM RCS LAKEWOOD

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P. 002

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

PRINTED: 04/11/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505217	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/24/2014
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NAME OF PROVIDER OR SUPPLIER STAFFORD HEALTHCARE AT RIDGEMONT	STREET ADDRESS, CITY, STATE, ZIP CODE 2051 POTTERY AVENUE PORT ORCHARD, WA 98366
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Standard Survey conducted onsite at Stafford Healthcare At Ridgemont on 3/21/14 and 3/24/14. The sample included 5 current residents and 3 former and or discharged resident out of a census of 92.</p> <p>The following are complaints investigated as part of this survey: #2970132 #2968751</p> <p>The survey was conducted by: Woodetta Owens, RN, MN</p> <p>The surveyor is from: Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, District 3, Unit A PO Box 45819 MS: N27-24 Olympia, Washington, 984504-5819</p> <p>Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p><i>[Signature]</i> 4/11/14 Residential Care Services Date</p>	F 000	<p>This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby denied. The submission of the Plan does not constitute agreement by the facility that surveyor's findings constitute deficiency or that scope or severity regarding any of the deficiencies cited are correctly applied.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE <i>Annette Crawford</i>	TITLE Administrator	(X6) DATE 4.11.14
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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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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, it was determined that the facility failed to ensure that the resident environment was free of accident hazards for 1 of 8 residents (#1) reviewed. Failure of the nursing assistant to ensure the wheelchair brakes were locked caused harm when Resident #1 attempted to independently transfer, fell, and sustained a fracture to the left subcapital femoral neck (left hip).</p> <p>Resident #1 admitted to the facility from the hospital on [REDACTED] with multiple diagnoses to include [REDACTED]</p> <p>The minimum data set (MDS), and assessment tool, dated 2/3/14 identified the resident required extensive assist of two people for toilet use and transfers.</p> <p>The MDS dated [REDACTED] identified Resident #1 had a brief interview for mental status (BIMS) score of 5, which indicated severe cognitive impairment.</p> <p>The care plan dated 1/21/14 identified the resident had short term memory loss, was forgetful and required the use of simple one step</p>	F 323	<p>F323</p> <p>The NAC observed the patient putting her brake into place, the brake visually seemed to be in place and the chair did not move during the patient's transfer onto the commode which implied to the NAC that the brake was securely set. This incident was an unexpected accident per definition in the DSHS Nursing Home Guidelines Purple Book.</p> <p>Per facility practice residents will continue to receive adequate supervision and assistance devices to prevent accidents. Resident care will be provided as indicated on each resident care directive. Facility staff will continue to encourage rehab patients to increase their abilities and to reach their therapy goals.</p>

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F 323	<p>Continued From page 2</p> <p>instructions. The care plan documented the resident was at risk for falls due to weakness and required frequent visual checks with reminders not to transfer independently.</p> <p>The care directive (a care guide for nursing assistants) updated on 2/3/14, documented the resident required stand by assist of two people for transfers.</p> <p>Review of the facility's investigation dated 2/19/14 revealed the nursing assistant (Staff B), assisted the resident to the restroom. According to Staff B's witness statement, Staff B locked the brake to the right side of the wheelchair, and she thought the resident locked the brake to the left side of the wheelchair per their normal routine. The resident put on her call light when finished. According to staff B, when she walked down to help the resident get back in the chair, she witnessed the resident trying to self-transfer, the chair moved from under the resident and the resident fell back. According to Staff B's witness statement she looked at the brakes and the left brake (the resident locked) of the wheelchair was pushed, but not all the way, and the chair moved to the left side.</p> <p>Following the fall, the resident was sent to the hospital for further evaluation and treatment.</p> <p>Review of the hospital's medical imaging report revealed the resident sustained an [REDACTED]</p> <p>The facility's investigation concluded, per the resident's usual routine to lock the left brake, but did not fully lock, caused the wheelchair to move and the resident to lose balance and fall.</p>	F 323	<p>Staff B was retrained regarding wheelchair locks on 2/19/14. Other nursing assistants received refresher training regarding wheelchair locks and environmental safety on 3/06/14, 3/26/14 and again on 4/7/14. Safety, during all types of resident transfers will continue to be a part of Stafford's orientation training for new employees.</p> <p>Environmental Safety Policy was reviewed/updated to provide a safe environment that meets individual resident needs.</p> <p>NAC Care Directives were reviewed for this patient and all in house patients to ensure accurate transfer and toileting directives in place.</p> <p>SDC will provide ongoing random transfer observations for high risk residents.</p>		

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F 323	Continued From page 3 On 3/24/14 at 12:15 p.m., during an interview, the licensed nurse (Staff J) reported according to her investigation it was the resident's normal routine to lock one side of the wheelchair while staff locked the other side of the wheelchair. When asked, Staff J stated she interviewed several nursing assistants, a licensed nurse (Staff K) and a nursing assistant (Staff F) who stated it was the normal routine to lock the brake of one side of the wheelchair and for the resident to lock the other side. Review of the investigation revealed Staff K's witness statement which documented, in part, "in the past while transferring, the resident would lock the left side of the wheelchair and I would lock the right." Individual interviews conducted with nursing assistants (Staff D), (Staff E) and (Staff F), stated they locked both brakes for the resident, and it was not their usual routine to have the resident lock the left side and for them to lock the right or vice versa. On 3/21/14 at 1:55 p.m., during an interview, Staff D reported she had to constantly remind the resident to lock the wheelchair brakes because the resident did not remember. Staff D reported there were times she would return to assist the resident, and the resident would have self-transferred back to the wheelchair from the toilet. When asked, Staff D stated she did not have the resident lock one side while she locked the other, and for safety she would always check to ensure the wheelchair brakes were locked before leaving.	F 323	The Quality Assurance Performance Improvement Committee will continue to review resident falls monthly to ensure proper plan of care/NAC Care Directives are in place and make recommendations as appropriate. DNS will monitor compliance.	4/11/14	

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F 323	<p>Continued From page 4</p> <p>On 3/21/14 at 2:12 p.m., during an interview, Staff E reported the resident was not good about locking her wheelchair brakes and needed reminding. When asked, Staff E stated she would lock the wheelchair brakes for the resident and did not have the resident lock one side while she locked the other. Staff E stated there were times she would return and the resident would have self-transferred back in the wheelchair from the toilet. Staff E stated for safety she would lock the wheelchair brakes for the resident before leaving the resident in the restroom.</p> <p>On 3/24/14 a 12:16 p.m., during an interview, Staff F reported she locked the brakes to the wheelchair when the resident would transfer. When asked, Staff F stated she did not have the resident lock one side of the wheelchair brake while she locked the other. Staff F stated for safety she would just lock them both.</p> <p>On 3/24/14 at 12:03 p.m., during an interview, the physical therapist (Staff G) reported the resident was not consistent with locking her wheelchair brakes.</p> <p>On 3/24/14 at 12:24 p.m., during an interview, the Administrator (Staff A) was informed of the above findings.</p> <p>Staff B assisted the resident to the restroom and documented it was routine for the resident to lock one side of the wheelchair brake while she locked the other. According to the care plan, the resident was forgetful and required reminders not to independently transfer. Staff B left the resident in the bathroom unattended with the wheelchair, and failed to ensure the wheelchair brakes were locked. When the resident attempted to</p>	F 323		

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F 323	Continued From page 5 Independently transfer, the wheelchair moved and the resident fell. Failure of the nursing assistant (Staff B) to ensure the wheelchair brakes were locked, caused harm when Resident #1 fell and sustained a left hip fracture when attempting to independently transfer to the unlocked whee/chair.	F 323			