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

PRIN: 08/03/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	505151		C 07/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASHMERE CONVALESCENT CENTER	817 PIONEER AVENUE CASHMERE, WA 98815

(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	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Survey conducted at Cashmere Convalescent on 7/31/12. A sample of 6 residents was selected from of census of 68. The sample included 6 current residents. The following were complaints investigated as part of this survey: #12-07-22079 #12-07-22732 Received Yakima RC6 AUG 28 2012 The survey was conducted by: Priscilla Becker, R.N. The survey was from: Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, District 1, Unit D 3611 River Road, Suite 200 Yakima, WA 98902 Telephone: (509) 225-2800 Fax: (509) 574-5597 8/7/12 Residential Care Services Date	F 000	PLAN OF CORRECTION-F323 SAFETY AND SUPERVISION HOW THE NURSING HOME PLANS TO CORRECT THE DEFICIENCY AS IT RELATES TO THE RESIDENT: Resident #1 has been moved to the new SCU. His new room is located close to the SCU Dining/Activity room. The nurses often have their medication cart parked near his room in the hall. There are more staff scheduled to work on this hall and his room is located where staff walk by often. This provides increased supervision for Resident #1. His care plan is changed to read "Keep in supervised area when up in w/c" under safety interventions instead of "Do not leave unattended". The nursing aid who did not follow the care plan leading to two falls in July on the evening shift no longer works here. She left without giving the facility a two week notice and did not come in for her last shift. She is not eligible for rehire. MEASURES THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THE PROBLEM DOES NOT RECUR:	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323	Our SCU has been moved to the West Hall which provides more space for our SCU population and consolidates staff and residents which leads to better supervision	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 8-24-12

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 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide planned supervision to prevent falls for 1 of 3 residents reviewed (#1) with falls. Despite the plan to supervise the resident directly, Resident #1 was left in his wheelchair unattended in his room resulting in two falls with injuries. Finding include: Resident #1: Review of the medical record revealed the resident had multiple diagnoses including muscle weakness with a fall history, a previous hip fracture, and dementia. On 6/07/12 the resident was assessed to be at continued high risk for falls. The plan of care identified safety interventions to prevent falls that included: a Hi/low bed, bilateral fall mats (at bedside), a sensor alarm to his bed and chair (to signal staff if the resident attempted to rise without assistance), anti-roll back brakes on his wheelchair, "Do not leave unattended", and non-skid socks for transfers. Review of the nursing entries revealed the resident had non-injury falls on 6/18/12 and 6/24/12. On 7/01/12 the resident had a fall with a resulting abrasion on his forehead and a skin tear to his right elbow.	F 323	for all residents residing there. Per our plan of correction for survey ending 6/29/12 there is a wander-guard system within the building to alert staff when at risk residents have wandered off the SCU so we can provide them w/ closer supervision until they are willing to come back to the SCU and are involved in some meaningful activity there. There are no guarantees that residents will not have falls or that injuries will not occur. Residents have the right to move about the facility at will just as nursing home staff has a responsibility to keep them safe. HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED: The DNS or designee will continue to monitor falls and/or injuries via incident reports and keep a log of such per regulations. Staff members who do not follow care plans will be counseled for first offense and written up for any further offense with consequences that may include being terminated. HOW THE NURSING HOME WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All nursing home residents have the potential to fall or have injuries. All residents have their	

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F 323	Continued From page 2 According to the 7/13/12 nursing entry and facility investigative documents, on 7/13/12 at 3:05 p.m. the resident was found lying on the floor in his room. The resident had a swollen right index finger identified after the fall. He had been left unattended in his wheelchair in his room and he attempted to transfer to the recliner chair in his room. Staff Member A had left the resident in his room and went to provide care for other residents. Staff Member heard Resident #1's alarm sounding, went to check, and found the resident on the floor. A 7/16/12 nursing entry stated the resident complained of pain in his finger but refused medication. The right index finger was noted to be red and swollen. Later that day the resident went to see the physician. A 7/16/12 x-ray documented there was no fracture or dislocation but the 7/16/12 physician's office visit note, identified a fracture in the resident's right second finger. The resident was to wear a splint on the finger. The resident later refused the splint. Review of the 7/22/12 nursing entry and investigative documents revealed that at 5:15 p.m. the resident had a fall from his wheelchair in his room while reaching down. The resident sustained a skin tear, approximately 3/4 inches long, to his upper forehead when his head struck the wall. Investigative findings identified that the plan of care was not followed. Staff Member A had not placed the safety alarm and the resident had been left unattended in his room. Observations on 7/31/12 at approximately 1:40 p.m. and 5:00 p.m. noted the resident was up in his wheelchair in his room and no staff were	F 323	safety interventions reviewed quarterly and at the time of any fall or injury. We will continue to monitor and address safety concerns and make appropriate interventions as needed. Now that we have changed the location of our SCU to the West Hall staff is more efficiently placed through-out the building to be able to supervise residents more closely. DATE THAT THE CORRECTIVE ACTION WILL BE COMPLETED: August 24, 2012	

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F 323	Continued From page 3 present. The resident's right second and third fingers appeared to be taped together (buddy taped for support). Additionally, the resident had steri-strips over a small healing skin tear/laceration above the right side of his forehead. The resident was observed moving his wheelchair around slowly in his room. Staff Member A was interviewed on 7/31/12 at approximately 5:10 p.m. and she stated she was the only nursing assistant on the wing that evening, as usual. The safety plan for Resident #1 included placing him in areas where he could be readily observed such as the nursing station or in the hallway. Staff Member A recalled that during the fall incidents on 7/13/12 and 7/22/12 the resident had been in his room without a staff member. When interviewed on 7/31/12 at approximately 5:30 p.m., the Director of Nursing stated the resident's plan of care was not implemented at the time of the 7/13/12 and 7/22/12 fall incidents. Despite the fall history of the resident in his room and the directive to not leave him unattended, staff continued to leave the resident up in his wheelchair in his room without staff being present.	F 323		