

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

PRINTED: 04/05/2013
FORM APPROVED
OMB NO. 0938-0391

677

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/28/2013
NAME OF PROVIDER OR SUPPLIER CASHMERE CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Cashmere Convalescent Center on 3/28/13. A sample of 4 residents was selected from a census of 56. The sample included 2 current residents and the records of 2 former and/or discharged residents.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#2770613 #2779777</p> <p>The survey was conducted by: [REDACTED] R.N.</p> <p>The survey team was from: Department of Social & Health Services Aging & Long Term Support Administration Division of Residential Care Services, District 1, Unit D 3611 River Road, Suite 200 Yakima, WA 98902</p> <p>Telephone: (509) 225-2800 Fax: (509) 574-5597</p> <p><i>David Moon</i> 4/5/13 Residential Care Services Date</p>	F 000	<p>Received Yakima RCS APR 12 2013</p>	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 4-12-03

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.

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

PRINTED: 04/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/28/2013
NAME OF PROVIDER OR SUPPLIER CASHMERE CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	<p>Continued From page 1</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, record review, and interview, the facility failed to ensure 1 of 4 residents reviewed (#1) received necessary supervision and assistive devices to prevent accidents. Resident #1, a resident with a known fall history, was left in the dining room without supervision and without her safety alarm attached. The resident got up, began walking, and fell sustaining a fractured hip. Findings include:</p> <p>Resident #1: Review of the medical record revealed the resident was admitted to the facility on 12/12 with multiple diagnoses including [REDACTED] and a history of falling. A 1/14/13 fall risk assessment noted the resident remained at high risk for falls.</p> <p>Resident #1's plan of care identified she was to have pull away alarms on her bed and wheelchair to signal staff if she attempted to transfer independently rather than waiting for staff assistance. She required one staff member for assistance with transfers and ambulating. The resident's wheelchair was her primary mode of transportation.</p>	F 323	<p>Plan of Correction for complaint survey of 3/28/13</p> <p>F323-Safety and Supervision</p> <p>HOW THE NURSING HOME WILL CORRECT THE DEFICIENCY AS IT RELATES TO THE RESIDENT:</p> <p>Staff member A, a nursing assistant was sent home immediately upon discovering that he had neglected to follow the safety interventions for resident #1. An investigation was completed revealing his neglect. The neglect was reported to the Department of Health. He returned to work and is currently on probation with close monitoring of his performance with a focus on knowing and following each of his residents' safety interventions. Weekly updates will be completed and placed in his employee file. Resident #1's care plan was updated with</p>		

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

PRINTED: 04/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/28/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CASHMERE CONVALESCENT CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	<p>Continued From page 2</p> <p>According to a 9/15/12 nursing entry, the associated facility investigation, and the September 2012 treatment record, the resident had a fall in the Annex dining room sustaining a bruise on the top of her head and a bruise on her right hip. The resident was left unattended in the dining room and got up on her own and fell.</p> <p>Nursing entries identified that on 3/24/13 the resident was sent to the hospital ER for evaluation of stools that tested positive for the presence of blood. The frail, cognitively impaired resident was sent back to the facility to receive hospice care.</p> <p>A 3/24/13 nursing entry documented that Resident #1 was found on the floor in the Annex dining room. Her right leg was rotated externally and she was crying out in pain. The resident was sent to the hospital for an evaluation.</p> <p>Review of the facility investigation documented that on 3/24/13 Staff Member A, a nursing assistant, assisted Resident #1 into a straight chair in the Annex dining room before lunch and then left the dining room to assist other residents. Resident #1 got out of the chair and walked along the edge of the table. She then lost her balance and fell sustaining a right hip fracture. The resident's alarm was not on and no staff were present.</p> <p>When interviewed on 3/28/13 at approximately 12:30 p.m., the Director of Nursing stated that staff were to be present in the dining room with residents. However, on 3/24/13 as noted, Staff Member A took Resident #1 to the dining room</p>	F 323	<p>appropriate safety interventions.</p> <p>HOW THE NURSNG HOME WILL ACT TO PROTECT RESIDENTS IN SIMILAR SITUATIONS:</p> <p>An in-service was completed with the nursing assistant staff on March 29, 2013 where all safety needs for residents and especially for residents who take meals in the Annex were reviewed. See attached.</p> <p>MEASURES THE NURSING HOME WILL TAKE OR THE SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR:</p> <p>On April 8, 2013 the Annex was closed as a dining area. All residents who were eating in there have had their eating assignments changed to the main dining room. In the main dining room staff members are</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/28/2013
NAME OF PROVIDER OR SUPPLIER CASHMERE CONVALESCENT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	<p>Continued From page 3</p> <p>and placed her in a stationary chair without her alarm. The resident(s) were left in the dining room without staff supervision.</p> <p>Hospital records documented the resident had a right hip fracture. Resident #1 was sent back to the facility for comfort care later on 3/24/13.</p> <p>Observation of the Annex dining room on 3/28/13 at approximately 12:40 p.m. revealed the door to the Annex dining room was closed to the hallway. Six residents were present and three residents were eating. No staff members were present in the dining room. Shortly thereafter, Staff Member B, a nursing assistant, opened the door and entered the room stating she had just taken a resident to her room around the corner. Two staff members had reportedly been in the dining room to supervise earlier during the meal service.</p> <p>Staff Member A was interviewed on 3/30/13 at approximately 11:20 a.m. and stated s/he was aware of the resident's fall alarm and previous fall in the dining room. On 3/24/13 Staff Member A had taken Resident #1 to the dining room and left her unattended while s/he went to assist another resident out on the unit. Staff Member A reported that s/he usually brought Resident #1 down last. Reportedly, staff only needed to be present if the food or drinks were there in the dining room.</p> <p>Staff Member C, a licensed nurse on-duty on 3/24/13, was interviewed on 3/30/13 at approximately 11:40 a.m. and discussed the supervision plan in the dining room. One staff member was to remain in the dining room if residents were present. The other caregiver could assist with transporting residents but</p>	F 323	<p>in and out before meals bringing residents in for the meal and an NAC is assigned to be in there as the hostess ten minutes before trays arrive to serve and assist with beverages and to pass out clothing protectors.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED:</p> <p>Staff development nurse, primary nurse and DNS will continue with ongoing monitoring of NAC #1's performance, especially regarding knowing and implementing safety interventions for all residents.</p> <p>Ongoing logging/tracking of falls with focus on prevention of falls in the dining areas will be completed monthly and</p>		

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

PRINTED: 04/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505151	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/28/2013
NAME OF PROVIDER OR SUPPLIER CASHMERE CONVALESCENT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 323	Continued From page 4 residents were not to be left in the dining room unattended. After all the residents were down to the dining room two staff members would be present during the meal services.	F 323	reviewed at quarterly QA meetings. DATES WHEN THE CORRECTIVE ACTION WILL BE COMPLETED: April 8, 2013 TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION: DNS <i>Additional information for DOC: A fall committee has been initiated to meet monthly to review safety, falls & interventions 4 NAC's have volunteered to join this committee w/ RA RN & DNS</i>	