STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505096	A. BUILDING _____ B. WING _____	**03/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TOPPENISH NURSING & REHAB CENTER	**802 WEST THIRD AVENUE TOPPENISH, WA 98948**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to provide adequate supervision, follow the resident's plan of care regarding sling types, and implement safety interventions during a mechanical lift transfer involving one of three residents (#1) reviewed for falls with injuries. This failed practice resulted in actual harm to Resident #1 who fell to the floor from the mechanical lift and sustained a hematoma (collection of blood outside blood vessels) and abrasion to the forehead necessitating a transfer to the emergency room . Findings included . Resident #1. Review of the resident's medical record showed [DIAGNOSES REDACTED]. Review of the resident's comprehensive assessment, dated 10/23/19, showed she required extensive assistance with two staff for dressing, toileting, turning in bed, and transfers using a mechanical lift; and extensive assistance with one staff for eating and personal hygiene. Review of the resident's plan of care, dated 07/05/18 and 07/06/2018, showed the resident had limitation in range of motion to both hands, right and left arms due to arthritis and left shoulder dislocation. Nursing orders on the plan of care, dated 07/22/18, showed staff was to use the sling that attached crossways through the resident's legs. The nursing order was revised on 12/03/2018, showing the sling was an extra large size that attached crossways through the legs. The plan of care, dated 07/22/2018, showed the resident had impaired cognition and was slow to respond at times. Review of a facility investigation report showed on 01/12/2020 at 2:20 PM the resident was transferred from the wheelchair to the bed using the mechanical lift device. The resident was leaning to the left side and fell out of the sling onto the floor landing on her left side. She sustained a hematoma and abrasion to the forehead. The investigation report showed the resident had chronic contractures that curved her upper body to the left, which prevented a barrier to proper center positioning on some of the sling types. Review of hospital records, dated 01/12/2020, showed the resident had fallen out of the mechanical lift sling striking her right upper forehead causing a hematoma. The resident had very limited range of motion and strength to all her extremities with severe contractures of her joints. Review of a written statement dated 01/12/2020, by Staff A, Nursing Assistant (NA), showed that just as she started moving the mechanical lift to the bed the resident slid out of the sling. The statement showed Staff B, NA, was moving the resident's wheelchair and was unable to help prevent the fall or guide the resident. Review of the written statement by Staff B, dated 01/12/2020, showed when Staff A was moving the sling towards the resident's bed Staff B was moving the resident's wheelchair and was not able to help prevent the fall. Review of the Operation Manual for the mechanical lift, utilized in the resident's transfer on 01/12/2020, showed the second staff member involved in the transfer was to support the resident's legs as the primary staff member moved the lift into position over either the resident's bed or wheelchair. Observation on 03/10/2020 at 2:30 PM of a reenactment of the incident by Staff A and Staff B, showed Staff B moved the resident's wheelchair, which included a headrest and two footrests, and placed it against the wall. At the time the wheelchair was being moved by Staff B, Staff A began moving the mechanical lift. Staff B had her back to the resident and the mechanical lift at the time of the fall, thus was not supporting the resident's legs to prevent injuries as recommended in the above Operation Manual. In addition, both Staff A and Staff B stated the resident's left shoulder was hanging out past the edge of the sling causing her to lean to the left prior to moving the mechanical lift. They had attempted to reposition her shoulder, however due to her contractures and weight were unable to do so. They stated the sling that was utilized during the transfer on 01/12/2020 was not the type that crossed at the legs (as ordered on the resident's plan of care), but rather did not cross at the legs, which lessened the support and security. Staff A stated during an interview on 03/10/2020 at 1:30 PM, that she had transferred the resident several times using the mechanical lift, however she utilized the cross sling (leg straps would criss cross each other and attach to adjacent sling support hooks) as that type of sling was safer to use. She stated the resident at the time of the fall on 01/12/2020 was in a full sling (legs straps did not criss cross) that had been placed under her by the day shift NA. Staff A stated most of the time the resident kept her neck on top of her left shoulder, and was very stiff. She stated both her and Staff B tried to reposition the resident in the sling, prior to the transfer, as she was leaning to the left side but were unable as the resident's weight prevented them from being able to move her. Staff A stated Staff B was trying to move the resident's wheelchair away from the lift at the time of the resident's fall from the mechanical lift. The resident was hanging in mid-air when Staff A began moving the mechanical lift. The resident immediately fell out of the sling onto the floor, hitting her head on the floor. On 03/10/2020 at 2:10 PM Staff B stated, the resident was in a wheelchair and was to be transferred into bed. Staff A was operating the mechanical lift and she was assisting with the transfer. Staff B stated both she and Staff A were trying to push the resident's body into the sling as she was leaning to the left, however they were unsuccessful. She stated she was parking the resident's wheelchair to the side and by the time she turned around (had her back to the resident and mechanical lift) the resident was already on the floor. Reference (WAC) 388-97-1060(3)(g)

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

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.