STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505378	A. BUILDING _____ B. WING _____	07/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRESTIGE CARE & REHABILITATION - BURLINGTON	**1036 EAST VICTORIA AVENUE BURLINGTON, WA 98233**

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

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**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, interview and record review, the facility failed to provide adequate supervision of staff, and care and services for residents, that was necessary to avoid accidents and serious harm, for five of 10 residents (#1, #6, #7, #8 and #9) reviewed for accidents. The facility's failure to provide care and services per the resident's assessment and written care plan constituted an Immediate Jeopardy (IJ) situation on 07/10/2020, when it was found that a care giver rolled Resident #1 out of bed and the resident landed on the floor, sustaining major injuries which included a head injury, a fractured left upper arm and a fractured left femur (hip). The caregiver did not follow the resident's care plan for bed mobility. Additionally, the facility consistently failed to provide adequate supervision of staff and ensure the care plan was followed for bed mobility for Resident #6, #7, #8, and #9 placing them and all other residents with similar care needs at an increased risk of the likelihood of not receiving care and services as required, to prevent further accidents and or injuries. Findings included . Review of the facility's policy titled, Care Plan - Kardex/Baseline Care Plan, showed that direct care givers would have accurate information available to them to properly care for their residents. Problem areas and interventions related to each resident's safety/fall risk, transfers and bed mobility would be provided on the Kardex (a care guide to the care staff). Staff were responsible to give care per the Kardex. RESIDENT #1 Resident #1 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Complete [MEDICAL CONDITION] may have total sensory and motor function loss), anxiety, [MEDICAL CONDITION] and chronic pain. Review of the 5-Day Minimum Data Set (MDS) assessment dated [DATE], review of the resident's Activity of Daily Living (ADL) Self Care Performance Care Plan, printed on 05/05/2020, and review of the Visual/Bedside Kardex report, printed on 05/05/2020, showed the resident required two person extensive assistance for bed mobility, and directed staff that the resident required extensive ADL support. The goal was for the resident to have no further avoidable decline in his ADL ability. Interventions included two person extensive assistance for bed mobility. Review of the Documentation Survey Report v2 showed from 05/01/2020 through 05/05/2020 the resident received assistance with bed mobility with only one person assist on ten occasions and there was no documentation of the provided care on 05/03/2020. Review of the staffing information for the night of 05/02/2020 showed the one CNA (certified nursing assistant) was sheduled for the night shift from 10:00 PM to 6:00 AM, and there was a resident census of 24. Review of a progress note dated 05/03/2020 at 6:23 AM, showed, Aide (Certified Nursing Assistant) notified this LN (Licensed Nurse), res (resident) is on the floor. Asked what happened, aide said she asked him to turn toward the left side and he overdid it and fall. Res denied he's on pain, except he hit his head on the drawer and though he has a bump on his head. Asst (assessed) res found a little bump but will continue to monitor for latent injury. Review of the facility incident report dated 05/03/2020, showed that the CNA notified the LN that the resident was on the floor. While cleaning and changing the resident, the CNA asked the resident to turn. The CNA stated the resident had overdid it and ended up falling from his bed. The resident stated he hit his head and there was a little bump, the resident also scratched his left knee. At 9:13 AM, the resident was found unresponsive. The physician was notified and 911 was called to transport the resident to the emergency room . The resident finally roused for the paramedics and began yelling for his wife. The resident was in the hospital and was unavailable to interview. The care plan was reviewed and updated. The facility ruled out Abuse and Neglect, as the care plan was being followed (which was not accurate as the care plan was changed after the resident's fall and discharged from the facility to the hospital). Review of the care plan showed the revised (after the fall) interventions for bed mobility was changed to, 1 person extensive assist (which showed it was initiated on 01/13/2020 and revised on 05/06/2020). Review of Staff A's, CNA, Witness Report, dated 05/03/2020, showed the resident had a side rail on the right side of the bed and no side rail on the left side of the bed. Staff A documented that, as I was changing him, he rolled out of the bed as he turned on his left side. Review of the hospital's After Visit Summary, dated 05/03/2020, showed the resident was referred to local orthopedics for the left humeral (upper arm) fracture the resident sustained [REDACTED]. Review of the hospital's History and Physical, with an admission date of [DATE], showed the resident also had a left femoral neck fracture ([MEDICAL CONDITION]) noted on 05/03/2020 after the resident had suffered a fall from bed at the skilled nursing facility. Review of the initial concern reported on 05/05/2020 at 12:25 PM, showed that on 5/3/2020 at 5:00 AM, there was a CNA who rolled the resident over in bed and he fell on the floor. The family was notified about an hour and a half later. The family asked the facility if the resident was going to be x-rayed, they informed the family that he was not going to receive x-rays. After multiple family members called the facility, the facility sent the resident to the hospital to be x-rayed, 14 hours later, and it was discovered the resident sustained [REDACTED]. In a follow up report on 05/05/2020 at 11:21 AM, the resident's family member stated that they were sure that the resident's care plan indicated he should have received care with turning for incontinent care from two staff members. The family member continued to state that it took the facility 14 hours to get the resident to the hospital to be x-rayed following the incident. In a phone interview on 05/05/2020 at 6:08 PM, the family member stated that the resident was a paraplegic and that there was only one aide (CNA) and one nurse on duty the night the resident fell . The family member stated that the prior Sunday, 05/03/2020, was when they received a call at 6:30 AM, informing them the resident had fallen. The family member stated that they knew the resident was a two person assist for bed mobility and if there had been two staff assisting, he would not have fallen onto the floor. They continued to state that the resident had told them that there was only one aide on duty on that night shift and he had told them (the family) many times the facility had been short staffed. The family member stated that they were very angry and it should have never happened. The family member continued to state that they knew the resident needed two people when they were rolling the resident over in bed. The family member stated that the nurse had told them that they were very short handed and she had a call out to her boss to see if the resident should be shipped out for an x-ray, the family stated that the nurse was very flustered. A co-phone interview was conducted on 05/08/2020 at 3:06 PM, with the Director of Nursing Services (DNS) and Staff A. Staff A stated that she worked the night shift and usually worked with two CNAs (her and another CNA). Staff A stated she knew how to care for a resident and how much care the resident required because it was on the Kardex. Staff A stated the Kardex was easily accessible on the computer. Staff A stated, that the night Resident #1 was rolled off the bed, she had gone into the resident's room to do peri-care (personal care), she rolled the resident to his right side and performed peri-care, then instructed him to move (roll) to his left side. Staff A stated that the resident grabbed the head board and the weight of his legs kind of went down (off the bed) and the rest of his body followed. Staff A stated that when the resident fell , he hit his head on the nightstand and then Staff A called the nurse. Staff A stated that she was working alone that night from 12:30 AM until 4:00 AM. Staff A, confirmed she was providing care to the resident by herself. The DNS continued to state that the MDS Coordinator usually updated the care plans but she had been off. The DNS stated that the care plans had not seemed personalized and was trying to update the

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.

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) care plans to be personalized. The DNS stated that she had made changes to the resident's care plan on 05/06/2020 (after the resident had been discharged to the hospital after the resident's fall) and confirmed the care plan prior to her changes had indicated the resident had been a two person assist for bed mobility. In observation on 06/12/2020 at 1:36 AM, the facility was staffed with one nurse and two CNAs. In an interview on 06/12/2020 at 1:44 AM, Staff B, CNA, stated that there were sheets in the residents' closets and in the computer that would tell the staff how to provide the residents care. In an interview on 06/12/2020 at 1:54 AM, Staff C, CNA, stated that the facility had an electronic medical record that had the resident's Kardex and Care Plan. Staff C stated that she typically worked with another CNA and a nurse but with the holidays as well as staff getting sick every once in a while, it does happen that they work with only one CNA and a nurse. Staff C stated that currently there were about five residents who required two person assistance. Staff C stated that she recalled Resident #1, he was paralyzed and had one bar on the right side of his bed. Staff C stated that if she had to change him herself she would stand on the side of the bed that did not have a bar. In an interview on 06/12/2020 at 2:07 AM, Staff D, Licensed Practical Nurse (LPN), stated that she was aware there had been times when only one CNA had worked during the nightshift. Staff D stated that they tried to have two CNAs on night shift, but sometimes there were emergencies and staff would have to go home. Staff D stated that she remembered Resident #1 and recalled that he rolled better to the right side of the bed that had the bar rail. In an interview on 07/02/2020 at 2:00 PM, Staff E, CNA, stated that she was unsure the last time she was supervised while performing bed mobility or transfers but possibly in March 2020. Staff E stated she recalled Resident #1, that he was paralyzed from the waist down and he had been care planned for a two person assist with bed mobility. She continued to state that the resident had one rail on the right side of his bed and was unsure why he only had one. Staff E stated that he could roll himself to the right and to the left, It was sketchy, I am not going to lie, he had a lot of strength. Staff E, confirmed what she meant by sketchy was that it made her feel a little bit uncomfortable, it would be easy to roll out of bed. In an interview on 07/02/2020 at 2:24 PM, Staff H, Licensed Practical Nurse (LPN), stated that she recalled Resident #1, that he needed two person assistance for bed mobility and he could help with his cane rail (the bar rail that was on the right side of the bed). She stated, No, when asked if he had been safe for a one person assist with bed mobility, He had no control over his lower body. In an interview on 07/02/2020 at 3:11 PM, Staff J, LPN, stated that there should be two aides on the night shift but sometimes there was only one and she would help out. Staff J stated that she recalled Resident #1 and that one person could reposition him. She stated that he could turn himself, usually she would turn him away from her. She stated that she would place her hand on him to make sure he turned correctly. She stated that the night he fell she was on duty. She stated that it was her and one aide only and that she was going to help the aide but the aide had told her the resident was easy and that she could do it by herself. Staff J stated that she thought it was okay as the aide had said she had turned him often with one person and Staff J had as well. Staff J stated on the night the resident had fallen, she believed the aide could handle it and other residents needed pain medication. In an interview on 07/02/2020 at 3:17 PM, Staff F, CNA/RA (Restorative Aide), stated that she had not been supervised or checked on her bed mobility skills. Staff F stated that Resident #1 was usually a two person assist with bed mobility, if one person assisted him, they would stand on the side of the bed that did not have a rail. Staff F stated that she would turn the resident toward herself, he liked to grab the head board, and he could fall really easy. She stated that it was common sense. In an interview on 07/02/2020 at 3:52 PM, Staff G, CNA, stated that there had been times, was just reality that they had to provide a one person assist with bed mobility on a resident who was a two person assist, it was fast paced and when short staffed with someone calling in. Staff G stated that all the aides are busy, if she had to perform a one person assist for bed mobility for a resident who was care planned to have two person assist she would put a pillow under the fitted sheet to support the resident and pull the resident toward her and turn them toward the pillow. Staff G stated that Resident #1 was care planed always for two people assist. In an interview on 07/02/2020 at 4:15 PM, Staff I, LPN, stated that she recalled Resident #1. Staff I stated that for repositioning it would take two staff, but sometimes would have one person and she would tell the staff to let her go to assist. Staff I stated that Resident #1 was a big man, the staff could always come get us (the nurses), and they (the CNA) may have to wait two to five minutes before the nurse could come and assist. Staff I stated that she did not know if it would have been safe for one person, I would not be able to do it just myself, it would not be safe for him (Resident 1). In an interview on 07/02/2020 at 6:23 PM, the Administrator stated that she knew Resident #1 had fallen before he was sent to the hospital but was not notified that the resident's fall had occurred while not following the care plan, she could only recalle that he fell out of bed. The Administrator stated that she signed off on all the incident reports and pulled up Resident #1s incident report and confirmed she had signed off on the report on 05/18/2020. The Administrator stated that they usually go over the incident reports within five days and they usually print out the confirmation when they call the report into the State Hot Line. The Administrator confirmed there was no documentation of the confirmation number but on the facility's incident report line listing it indicated the fall had been called into the State Hot Line. The Administrator stated that the disconcerting thing was that the aide was not on that side of the bed when turning. We train to turn toward staff and I know she was at the foot of the bed. She stated that they entrust the staff to provide the care per the care plan. She stated that they do teaching and retraining, and that Staff A had expressed her inability to fully understand and read the care plan, after the fact, when they went through the care plan. On 07/07/2020 at 12:11 PM, the facility provided a list of residents (#6, #7, #8 and #9) who required two person assistance for bed mobility. In a phone interview on 07/09/2020 at 12:56 PM, Staff M, CNA, stated that she knows the care needs of the residents by the care plan, which used to be found behind each resident's door but now was on the computer in the Kardex. Staff M recalled Resident #1, and stated that he would pull himself to the right with the cane rail and if she held onto his legs and rolled him back toward her, he would have more protection but she had to control his lower half so he would not flip off the bed. Staff M stated that he needed two person assistance with transfers but for general care changing in the bed one person could do it safely. Staff M stated that it would entail how you position yourself, if you protected his lower half you could to it safely. Staff M stated she also took care of Resident #6 and he required a two person assist to turn in the bed. In a phone interview on 07/10/2020 at 12:33 PM, Staff K, Physical Therapist, stated that Resident #1 had come up with holding onto the headboard by himself as the facility felt having two cane rails was a restraint concern. Staff K stated that she recalled training two CNAs, Staff G and Staff L, but did not complete an in-service sign in sheet. Staff K stated that the CNAs were directed to stand in front of the resident, that way he would be safe and to position pillows behind him. Staff K stated that a resident rolling away from you (the person providing care) there was no control and one would need to be in a position to keep the resident safe. Staff K stated that the CNAs should receive training on where to stand when repositioning residents in their (the CNAs) basic training. RESIDENT #6 Medical record review for Resident #6 showed the following: The MDS Quarterly assessments dated 02/06/2020 and 05/08/2020, showed the resident required extensive assistance of two person for bed mobility; The Care Plan printed on 07/08/2020, identified the resident was at risk of falls and required two person extensive assist with bed mobility initiated on 01/14/2020; The Kardex printed on 07/08/2020, showed the resident required two person extensive assistance for bed mobility; The in Room Care Plan reviewed on 07/10/2020, showed 2+ persons extensive assist for bed mobility; The Documentation Survey Report v2, showed bed mobility was provided with one person assistance 61 times in May 2020, 62 times in June 2020, and nine times between 07/01/2020 through 07/08/2020. RESIDENT #7 Medical record review for Resident #7 showed the following: The MDS 5 Day assessment, dated 04/21/2020 and the Quarterly MDS assessment dated [DATE], showed the resident required extensive assistance of two person for bed mobility; The Care Plan printed on 07/08/2020, identified the resident was at risk of falls and required two person extensive assist with bed mobility initiated on 01/14/2020; The Kardex printed on 07/08/2020, showed the resident required two person extensive assistance for bed mobility; The in Room Care Plan reviewed on 07/10/2020, showed the resident required one person extensive assistance for bed mobility. The in room care plan was last updated on 12/03/2019; this is inconsistent with the MDS, CP, and Kardex; The Documentation Survey Report v2, showed bed mobility was provided with one person assist 77 times in May 2020, 74 times in June 2020, and 13 times between 07/01/2020 through 07/08/2020. RESIDENT #8 Medical record review for Resident #8 showed the following: The Quarterly MDS assessment the Annual MDS assessment dated [DATE], showed the resident required extensive assistance of two person for bed mobility; The Care Plan printed on 07/08/2020, identified the resident was at risk of falls and required a two person extensive assist initiated; The Kardex printed on 07/08/2020, showed the resident required two person extensive assistance for bed mobility; The in Room Care Plan reviewed on 07/10/2020, showed the resident required one person extensive assistance for bed mobility. The in room care plan was last updated on 11/25/2019; this is inconsistent with the MDS, care plan (CP) and Kardex; The Documentation Survey Report v2, showed bed mobility was provided with one person assistance 86 times in May 2020, 75 times in June 2020, and 16 times

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) between 07/01/2020 through 07/08/2020. In a phone interview on 07/09/2020 at 5:04 PM, Staff L, CNA, stated that she knew how to care for the residents from their care plans and they were in each resident's room in plastic folders usually discreetly behind the resident's door in a plastic folder. Staff L stated that she was unaware of anywhere else to review the resident's care plan and she had not seen the Kardex on the computer. Staff L stated that Resident #8 was not able to reposition without care, he needed two person assist for transfers but not sure about bed mobility. She stated that the resident was able to transfer by herself and nearly everyone used a one person for bed mobility but would grab another CNA if the resident was not having a good day. Staff L stated that she was able to chart if used a one or a two person assist. RESIDENT #9 The Quarterly MDS assessment dated [DATE], showed the resident required extensive assistance of two person for bed mobility; The Care Plan printed on 07/08/2020, identified the resident was at risk for falls and required extensive assist of two for bed mobility; The Kardex printed on 07/08/2020, showed the resident required two person extensive assistance for bed mobility; The in Room Care Plan reviewed on 07/10/2020, showed the resident was independent with bed mobility. The in Room Care plan was last updated on 11/08/2019; and The Documentation Survey Report v2, showed bed mobility was provided with one person assistance 73 times in May 2020 and June 2020, and 15 times between 07/01/2020 through 07/08/2020. In conclusion, the facility failed to ensure adequate supervision and care which staff provided to Resident #1, #6, #7, #8, and #9 in accordance with each resident's assessment and CP, directing staff to provide two staff person, extensive assistance with bed mobility. When one staff assisted the resident, this constituted an Immediate Jeopardy situation. This failed practice resulted in Resident #1 being rolled out of bed by a caregiver, and sustaining serious injuries including hiting his head on the nightstand, onto the floor, fracturing his arm and hip and subsequently hospitalized , and placed Resident #6, #7, #8, #9 and all other residents of similar needs at an increased risk of likelihood of serious harm or injury pertaining to not receiving adequate supervision and the necessary care and services to prevent further accidents and or injuries. Reference: (WAC) 388-97-1060 (3)(g)
F 0947 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.** Based on interview and record review, the facility failed to provide at least 12 hours of in-service education per year to Certified Nursing Assistants (CNA) for five of five CNA personnel files reviewed (Staff A, N, O, P, and Q). Additionally, the training did not include the required resident abuse prevention training or the dementia management training, and was not individualized based on performance evaluations and facility assessment. This placed residents at risk for harm and not receiving competent care. Findings included . A review of the employee and personnel files for five CNA's, Staff A, N, O, P, and Q, showed they did not have the required 12 hours per year in-service training that included resident abuse prevention training, dementia management training and other identified training needs/requirements needed to meet the needs of each resident per the facility assessment. Additionally, the facility showed no evidence of documentation that they implemented and permanently maintain and record an in-service training program for nurse aides that was appropriate and effective, as determined by each nurse aide evaluations and/or the facility assessment. In an interview on 07/10/2020 at 2:33 PM, the Administrator confirmed the lack of training for Staff A, N, O, P and Q. Reference: (WAC) 388-97-1680 (2)(a-c)