STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505401	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PRESTIGE CARE & REHABILITATION - PARKSIDE	**308 WEST EMMA UNION GAP, WA 98903**

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 0554 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Allow residents to self-administer drugs if determined clinically appropriate.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of one resident (#1) reviewed for self medication administration was assessed by the interdisciplinary team prior to being allowed to self-administer a medication. This failure placed the resident at risk for inappropriate and unsafe medication use. Findings included . Resident #1. Review of the resident's medical record showed they were admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the 01/12/2020 comprehensive assessment showed Resident #1 was cognitively intact and took insulin ([MEDICATION NAME]) on a daily basis. During an interview on 03/02/2020 at 1:45 PM, Resident #1 reported a couple of months ago, Staff I, Licensed Practical Nurse, gave her another resident's insulin injection pen to give herself her insulin. The resident stated the doctor was called and I was alright. Further, the resident stated All of the nurses have me self inject my insulin, I have been doing this about eight months. Record review of the 01/07/2020 medication error report showed Resident #1 was handed by Staff I and gave [MEDICATION NAME] 5 units from another resident's pen. Record review of the resident's January 2020 physician orders [REDACTED]. Review of the resident's record showed there was no self medication assessment for Resident #1. Review of the resident's care plan last revised 01/16/2020 showed there was no plan to self administer medications. During an interview on 03/02/2020 at 3:10 PM, Staff B, Director of Nursing, stated she was aware Resident #1 administered their own insulin after it was prepared by the nurses. During an interview on 03/03/2020 at 11:00 AM, Staff J, Registered Nurse/Resident Care Manager, stated they were not aware Resident #1 self injected, I just found out. The nurses should not be giving Resident #1 the insulin pen without an assessment. During an interview on 03/03/2020 at 2:15 PM, Staff K, Medical Director, stated he was not aware Resident #1 was self-injecting insulin and she needed to have an order to do that safely. Reference: WAC 388-97-1060(3)(l)
F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the factility failed to notify the physician of x-ray results for a bone fracture for one of one resident (#3) reviewed for significant injuries. This failure potentially placed the resident at risk for receiving less than optimum care. Findings included . Resident #3. Review of the resident's medical record showed they were admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During concurrent interview and observation on 03/03/2020 at 9:20 AM, Resident #3 was lying in bed watching television. The resident stated they had a broken right ankle when staff used a sit-to-stand lift to transfer from the wheelchair to the bed. When I stood up, there was a jerk, a slip and a lot of pain in my right ankle. It doesnt hurt much now that I have a boot on. Review of a 12/26/19 comprehensive assessment showed the resident was cognitively intact, required extensive assistance from two staff for transfers due to lack of muscle coordination. The resident was receiving hospice services. Review of the resident's 05/06/19 transfer care plan showed they required a mechanical lift (Hoyer) with two staff assistance for transfers. Review of a 02/16/2020 at 2:00 PM alert note by staff Staff G, Licensed Practical Nurse (LPN), showed: It was reported to this LPN by CNA that resident c/o (complains of) pain to ankles, per CNA resident did cry out in pain with re-positioned from w/c (wheelchair) to bed, .resident states my right ankle hurts more than left, I think they are broken This LPN called Hospice and made (hospice) Registered Nurse (RN) aware of resident's concern. Review of a 02/17/2020 12:31 PM progress note by Staff I, LPN, showed LN (licensed nurse) asked the resident if he wanted a X-ray of the right ankle and he stated yes so LN ordered a X-Ray, they will be coming today. Review of an x-ray result faxed to the facility on [DATE], at approximately 5:50 PM, showed Resident #3 had a fractured right ankle. Review of a 02/18/2020 progress note at 10:35 AM showed the x-ray results were reported to the facility physician and an order received to send the resident to the hospital. The same day at 5:14 PM a progress note showed the resident's right ankle fracture was now splinted. During a telephone interview on 03/05/2020 at 10:00 AM, Staff G stated she did not call the doctor after Resident #3 complained of ankle pain, she called the Hospice nurse and was advised to monitor the resident. During an interview on 03/05/2020 at 1:40 PM, Staff B, Director of Nurses, stated she could not find documentation where the physician was notified of Resident #3's fractured ankle until 02/18/2020. (approximately two days after the incident.) Reference: WAC 388-97-0320
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, interview and record review the facility failed to ensure one of one resident (#3), reviewed for substantial injury, had their care plan implemented for mechanical device transfers between surfaces when staff used a stand assist lift device (sit-to-stand) instead of a total body lift device (Hoyer) that caused harm to Resident #3 diagnosed with [REDACTED].#6), reviewed for falls with injury, had appropriate supervision by staff, when the resident was left alone on the toilet and fell causing injury to the skin and unnecessary discomfort at end of life. Findings included . Resident #3. Review of the resident's medical record showed they were admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of a [DATE] comprehensive assessment showed the resident was cognitively intact, required extensive assistance from two staff for transfers, had lack of muscle coordination and was on Hospice. Review of the resident's [DATE] transfer care plan showed they required a mechanical lift (Hoyer) with two staff assistance for transfers. During concurrent interview and observation on [DATE] at 9:20 AM, Resident #3 was lying in bed watching television. The resident stated they had a broken right ankle when staff transferred using a sit-to-stand lift from the wheelchair to bed. When I stood up, there was a jerk, a slip and a lot of pain in my right ankle. Further the resident stated the pain was bearable, especially with the splint on. Review of the facility's [DATE] investigation showed on [DATE] at approximately 9:30 AM, Resident #3 asked Staff D, Nursing Assistant (NA), to transfer them from the bed to the wheelchair. The resident requested staff use the sit-to-stand to transfer. Staff D and Staff E, NA, transferred the resident using a sit-to-stand mechanical lift from the bed to the wheelchair. The resident was up approximately two hours. Further review of the [DATE] investigation showed, Sometime between 11:30 AM and 12:00 PM, resident requests to get back into bed. (Staff D) proceeds to set up the sit-to-stand, and place resident in the sling for transfer Staff F, NA, reports that when arriving in the room (to assist), resident was in mid transfer out of (their) chair. (Resident #3) was complaining of (their) foot hurting, (Staff F) adjusted the left foot, while Staff D adjusted the right foot, and they continued to the transfer (the resident) to the bed. Per (Staff D), at some point during the transfer .the wheelchair was stuck on the sit-to-stand below the resident's right foot and the right foot bent at the ankle as we were moving 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 -** Actual harm **Residents Affected -** Few	(continued... from page 1) sit-to-stand away from the wheelchair. Review of the initial [DATE] incident report, showed Staff G, Licensed Practical Nurse (LPN), documented: Resident voices his feet were mishandled and bend {sic} the wrong way while being transferred from w/c (wheelchair) to bed, (resident) voices the right ankle hurts the worse and (they) were scared that (their) ankles have been broken. Review of an x-ray obtained and reported on [DATE] showed Resident #3 had a fractured right ankle. Review of a [DATE] progress noted at 10:35 AM showed the x-ray results were reported to the facility physician and an order received to send the resident to the hospital. The same day a 5:14 PM progress noted showed the resident's right ankle fracture was not splinted. During an interview on [DATE] at 3:15 PM, Staff B, Director of Nursing, stated Staff D should have followed Resident #3's transfer care plan and used the Hoyer lift, but did not. Resident #6. Review of the resident's medical record showed they were admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Review of the facility incident log showed Resident #6 had four falls between [DATE] and [DATE]: * On [DATE] the resident was walking in hall with walker, fell near room doorway and sustained skin tear to the left eyebrow. The cause of the incident included Resident has [MEDICAL CONDITION] and is weak with altered gait at times. * On [DATE] the resident was found on the floor next to the bed with no injuries identified. A contributing cause was the resident'[MEDICAL CONDITION] seemed to be progressing and the resident was becoming weaker. * On [DATE] the resident was found to have multiple bruises on their arms. The resident stated they fell the prior day and got back up. A contributing cause was (Resident #3) was overestimating their abilities and declining rapidly [MEDICAL CONDITION]. Review of the [DATE] fall investigation showed at around 6:00 PM, Staff H, Registered Nurse (RN), assisted the resident to the bathroom on the commode. The RN left the resident on the commode and returned one minute later and found the resident on the floor. The resident sustained [REDACTED]. The investigation concluded the resident fell trying to get up off of the commode due to declining health and actively dying. Review of a [DATE] Hospice progress note showed the resident had a fall and acquired skin tears on (their) right back and left upper arm above the elbow. The right forearm skin tear had steri strips intact. The progress note further showed the resident's spouse was upset that the facility did not take care of (Resident #6) and he fell . During an interview on [DATE] at 3:00 PM, Staff H stated that day she saw Resident #6 trying to climb out of bed so the RN assisted the resident to the bathroom. I knew (Resident #6) had poor impulse control and I should not have left (their) side. During an interview on [DATE] at 3:00 PM a collateral contact stated (Resident #6) was declining rapidly and should not have been left alone on the toilet. (Resident #6) had bruises and abrasions that should not have happened. (Resident #6) died a week later. Reference: WAC [DATE](3)(g)