STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505473	A. BUILDING _____ B. WING _____	**05/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
UNIVERSITY PLACE REHABILITATION CENTER	**5520 BRIDGEPORT WAY WEST UNIVERSITY PLACE, WA 98467**

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 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to protect the resident from neglect by failing to ensure care plan interventions were followed as required for one of four residents (Resident #1) reviewed for abuse and neglect. This failure resulted in harm causing the resident to fall, sustain fractures to the right femur (thigh bone) and right rib, and end up being admitted in the hospital. Findings included . Review of the facility's policy and procedure titled, Protection of Residents: Reducing the Threat of Abuse &Neglect, dated 03/20/20, stated that it was the policy and practice of the organization to protect all residents from all types of abuse and neglect. The facility's policy and procedure defined neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect may be the result of a pattern of failures or may be the result of one or more failures involving one resident and one staff person. Review of Resident #1's admission record dated April 2019, showed that the resident admitted on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #1's care plan updated 10/07/2019, showed that the resident had cognitive impairment, self-care deficit and was a risk for fall. Interventions required total dependence on two-person assistance with bed mobility, transfers and personal hygiene. The care plan also indicated that the resident had a stage 4 pressure ulcer (ulcer that extends into the deep tissues and as far down to the bone) and was on an air mattress bed that required two-person assistance during bed mobility and transfers. Review of Resident #1's Kardex (a care directive for the nursing assistants) undated, showed that the resident was totally dependent on two staff for repositioning and turning in bed. Review of a progress note dated 05/22/20 at 8:00 AM, showed that the licensed nurse (LN) was notified by a nursing assistant certified (NAC) that Resident # 1 was on the floor at around 5:00 AM. The NAC was in the room with the resident and witnessed the fall. A head to toe assessment found a bump to left side back of head of the resident with no bleeding noted. Bilateral lower extremities were checked, the resident complained of pain to right hip and shortening to the right leg was noted. Review of a progress note dated 05/22/20 at 1:52 PM, showed that Resident #1 admitted to the hospital with [REDACTED]. An observation on 05/26/20 at 3:20 PM, showed Staff D, NAC, and Staff E, NAC, provided care to a resident on an air mattress bed. During an interview on 05/26/20 at 3:25 PM, Staff D, NAC, stated that two-person assistance was required for a resident on an air mattress bed. According to Staff D, NAC, the resident's care plan and Kardex indicated the level of assistance required by the resident and if two-person assistance was needed, the staff would get another aide from her hall to help or ask the nurse for help. During an interview on 05/26/20 at 3:30 PM, Staff E, NAC, stated that the Kardex was checked every day for any changes in care. Staff E, NAC stated when two-person assistance was required for any type of care, then staff must get another aide to help or the nurse if the other aides were busy. During an interview on 05/26/20 at 3:50 PM, Staff F, LPN, (Licensed Practical Nurse) stated the nursing aides would come ask for help with moving or transferring a resident that needed two-person assistance. Staff F, LPN, stated that the nursing aides usually helped each other out but would come ask the nurse, if needed. During an interview on 05/26/20 at 4:10 PM, Staff G, NAC, stated it was easy to find the care needed for each resident in the Kardex which was found in the computer. Staff G, NAC, stated the Kardex would show how to transfer a resident or move them in bed. It would also show if the resident could move independently or required one or more staff to assist with care. Staff G, NAC, stated that if two-person assistance was indicated for repositioning in bed then to always get a second person to help. Staff G, NAC further stated that it would not be safe to do two-person care with one person. During an interview on 05/26/20 at 4:15 PM, Staff B, Director of Nursing Services (DNS) stated that on 05/22/20, Staff C, NAC, had pulled a drawsheet to turn the resident (Resident #1) onto her right side and the resident continued to roll out the right side of the bed onto the floor. Staff B, DNS, stated that Resident #1's care plan indicated the resident was to have two people to provide care, and Staff C, NAC, failed to follow the care plan. Review of the facility's investigation report dated 05/26/20, showed that on 05/22/20, Resident #1 sustained a fall with significant injury while Staff C,NAC, provided care. According to the investigation report, the DNS and Executive Director (ED) conducted a phone interview with Staff C, NAC and determined that the staff was aware Resident #1 required two-person assistance with bed mobility, transfers and personal hygiene and proceeded with resident care on her own. During an interview on 05/26/20 at 5:30 PM, Staff A, ED, stated that Resident #1's fall was preventable and that Staff C, NAC, failed to follow the care plan. Reference WAC 388-97-0640 (2)(a)(3)(c) . .

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.