

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505182	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2024
NAME OF PROVIDER OR SUPPLIER Providence Mount St Vincent		STREET ADDRESS, CITY, STATE, ZIP CODE 4831 35th Avenue Southwest Seattle, WA 98126	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>44296</p> <p>Based on observation, interview, and record review the facility failed to ensure an environment free of avoidable accidents/injuries for 1 of 7 residents (Resident 1) reviewed for accidents. The failure to ensure nursing staff followed the resident care plan (CP) and facility policy while transferring Resident 1 using a mechanical lift resulted in harm when the resident was transferred by one staff person instead of two staff persons, obtained a laceration on the right leg, and was hospitalized for five days. This failure placed residents requiring a mechanical lift transfer at risk for injury, hospitalization , and diminished quality of life.</p> <p>Findings included .</p> <p>The facility policy Mechanical Lift Use reviewed 04/2023 showed residents transferred using a mechanical lift required two staff to operate the lift to ensure resident safety and prevent injuries. One staff will stabilize the resident while a second staff guides the resident to the transfer destination, gently lowering the resident into a resting position.</p> <p>Review of the 12/15/2023 nursing staff training document showed the facility provided mechanical lift training to staff. The training document showed the facility required two staff to operate the mechanical lift when transferring residents. The staff sign in sheet showed Staff D (CNA, Certified Nursing Assistant) attended the training.</p> <p>The 03/29/2024 Admission Minimum Data Set (MDS, an assessment tool) showed Resident 1 was cognitively intact, able to make themselves understood, had clear speech and was able to understand others. The MDS showed Resident 1 was assessed to have limited range of motion in both legs, unable to stand or walk, and was dependent on staff for all transfers from the bed to a wheelchair. Resident 1 had a skin condition that caused blisters and open wounds to their skin requiring wound care.</p> <p>The 04/09/2024 Comprehensive CP showed Resident 1 had a self-care deficit related to decreased mobility, would receive the assessed level of assistance during care, and directed staff to use Resident 1's Kardex (instructions to staff how to provide care) when providing care. The CP showed therapy and nursing updated the Kardex to show Resident 1's required care. The CP showed Resident 1 was at increased risk of skin impairment and referred to the Kardex for interventions for prevention of impaired skin integrity.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 1' Kardex, printed on 05/06/2024, showed Resident 1 was dependent on staff for transfers from bed to the tilt-in-space wheelchair and required two staff to use a mechanical lift to move the resident. The Kardex showed Resident 1 had very fragile skin and asked staff to be careful in skin care. The Kardex instructed staff to place a pad under Resident 1's knees when using the mechanical lift to prevent injury to the skin.</p> <p>Review of the 04/25/2024 facility incident investigation report showed at 1:45 PM, Resident 1 was transferred from the bed to the wheelchair using the mechanical lift by Staff D without assistance from a second staff person. The report showed Resident 1's right lower leg was cut by the footrest resulting in a laceration (deep cut) measuring 11-12 centimeters (cm) in length by 8-9 cm in width and the connective tissue (layer of tissue between the outer skin and inner muscle) exposed. The report showed a large amount of blood was on the floor, the nurse was notified, and Staff D transferred Resident 1 back into bed using the mechanical lift and there was no second person to assist. Resident 1 was transferred to the emergency room for medical treatment that was not able to be provided at the facility.</p> <p>Review of the 04/25/2024 hospital records showed Resident 1 arrived at the emergency room at 10:29 PM, with a 11 centimeter (cm) long, 8 cm wide and very deep laceration on the right leg with visible connective tissue of the leg muscle. The hospital records showed Resident 1 complained of pain and discomfort at the site of the wound. The records showed Resident 1 required blood draws by the lab, intravenous (IV) fluids, blood thinning medication injections, and narcotic pain medication injections. A surgical consult was required for the deep wound that required an operation for repair, Resident 1 was admitted to the hospital for further evaluations due to required evaluations in preparation for surgery since Resident 1 had multiple complicating medical conditions. Resident 1 remained in the hospital for five days before surgical treatment was completed and then returned to the facility.</p> <p>In an interview on 05/06/2024 at 1:46 PM, Staff B (Director of Clinical Operations) stated Staff D stated in an interview they completed the mechanical lift transfer independently and did not have a second person to assist them. Staff B stated the facility expectation was that two staff were required to be present and assist in a mechanical lift transfer. Staff B stated Staff D was terminated from employment for not following the CP and not following facility policy.</p> <p>In an interview on 05/14/2024 at 12:55 PM, Resident 1 stated Staff D was using the mechanical lift to move Resident 1 from the bed to the wheelchair. Staff D did not have a second person to assist and Resident 1's right leg was injured by a metal piece of the wheelchair. Resident 1 stated it hurt badly, they yelled out Ow and saw that their leg was bleeding all over the floor. Resident 1 stated Staff D used the mechanical lift to put them back in bed, again without a second person to assist. Resident 1 stated Staff D put towels on their leg for the bleeding and it took a long time for the nurse to come and look at their leg and then Resident 1 had to go to the hospital because the cut was deep and would not stop bleeding. Resident 1 stated Staff D had used the mechanical lift by themselves multiple times in the past without a second person to assist.</p> <p>In an interview on 05/14/2024 at 1:22 PM, Staff C (Resident Care Manager) stated there was staff training how to use a mechanical lift at the end of 2023. Staff were expected to have two persons to transfer a resident with a mechanical lift for the resident's safety. Staff C stated Staff D attended the training and was expected to have two staff assist with a mechanical lift transfer.</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 05/14/2024 at 1:58 PM Staff A (Director of Nursing) stated Staff D attended recent facility training in December 20203 which reviewed the facility policy on mechanical lift transfers which required two staff to operate the lift. Staff D was required to follow the facility policy. REFERENCE: WAC 388-97-1060(3)(g).		