

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2024
NAME OF PROVIDER OR SUPPLIER Colville of Cascadia, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 East Elep Street Colville, WA 99114	

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>27590</p> <p>Based on interview, and record review, the facility failed to ensure 1 of 3 residents (Resident 1), reviewed for accidents, was free from injury. Resident 1 experienced harm when they were transferred in a sit to stand (designed to assist patients who have some mobility but need help to rise from a sitting position) by staff, the resident's arm sling got caught and wrapped around their neck causing them to become unresponsive; staff left the resident unattended in the lift to get help, the resident fell out of the lift, and was found on the floor. This failure placed the residents at risk for falls and serious injury</p> <p>Findings included .</p> <p>Review of a facility assessment, dated 04/01/2024, showed Resident 1 had diagnoses to include heart disease and Diabetes. The resident was able to make their needs known, required maximum assistance with bed mobility and was dependent with transfers. The resident used a sit to stand lift to be transferred.</p> <p>Review of the facility investigation, dated 06/10/2024, showed Resident 1 requested to use the bathroom. Staff A, Nursing Assistant, put the resident in the sit to stand lift to transfer them to the commode. The resident had a sling on their left arm. The resident was raised in the lift and stated their neck hurt. Resident 1's face then went red, they let go of the handles on the lift, and was hanging by the sling, unresponsive. Staff A went out to the hall to get help and heard the resident fall to the floor. Staff entered the room, the resident was on the floor, and remained unresponsive. Staff called 911 and sent the resident to the hospital.</p> <p>Review of hospital records, dated 06/10/2024, showed Resident 1 arrived at the hospital alert and oriented. The resident was able to explain what occurred prior to passing out at the facility. There were abrasive areas on the resident's neck, but staff were unable to determine if it was from the sling or a rash. The resident had no complaints of pain. It was documented that the resident had a strangulation event at the nursing facility due to being placed in a device to be transferred, their sling got caught in the lift, which went around the resident's neck. The resident was left alone in the room while staff got help and when staff entered the room, the resident was on the floor and unresponsive.</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>During an interview on 06/25/2024 at 2:00 PM, Staff B, Resident Care Manager (RCM) and Staff C, RCM stated the staff member that completed the investigation no longer worked at the facility. Staff B and C stated Resident 1 was sent out to the hospital, the facility was not aware the sling had gone around the resident's neck until the hospital called with report. Resident 1 was evaluated by therapy after the incident and was changed to Hoyer lift (a lift for a person to be lifted and transferred with minimal physical effort).</p> <p>Reference: WAC 388-97-1060(3)(g)</p>		