STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505400	A. Building B. Wing	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Enumclaw Health & Rehab Center	2323 Jensen Street Enumclaw, WA 98022

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 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** 42203 Based on interview, and record review the facility failed to ensure the correct type of sling was used to safely transfer 1 of 3 residents (Resident 1) reviewed for mechanical lift transfers. Resident 1 experienced harm when they were transferred incorrectly and sustained a spinal injury. Findings included . <Facility Policy> According to the facility's policy titled Fall Evaluation and Management, after a fall residents would be evaluated, cared for, and appropriate notifications made. Review of the Quarterly Minimum Data Set (MDS - an assessment tool) dated 04/20/2024, showed Resident 1 had adequate hearing and adequate vision with corrective lenses. The MDS showed Resident 1 had intact memory and diagnoses including a seizure disorder, brain damage, and a condition that caused convulsions (involuntary jerking movements). The MDS showed Resident 1 had functional limits to both the upper and lower extremities range of motion and was assessed to be totally dependent on staff for transfers. Review of the May 2024 Medication Administration Record (MAR) showed Resident 1 received a muscle relaxant continuously via a pump for convulsions. Resident 1 also received the same medication orally as needed. Record review of Resident 1's care plans and evaluations from admission on 08/04/2022 through 05/21/2024 showed no documented assessment to establish what kind or size of sling Resident 1 required for safety during transfers. Review of the Functional Mobility Care Plan (CP) revised 04/26/2024 showed Resident 1 required the assistance of two staff for transfers. The CP included an 11/27/2023 intervention that showed Resident 1 required the use of a mechanical lift for transfers. This CP did not document the size or type of sling Resident 1 required for transferring with a mechanical lift. The CP did not document which sling(s) should be used or were compatible with the lift (continued on next page)

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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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the 11/02/2023 risk for falls CP, revised 11/02/2023, showed Resident 1 was at risk for falls due to their brain injury, balance problems, use of psychoactive medications, and their seizure disorder. The CP included an 08/15/2022 goal for Resident 1 to be free of falls. Review of an alert charting progress note dated 05/21/2024 at 9:55 PM showed Resident 1 fell from their sling while being transferred by two Certified Nursing Assistants (CNAs) with a mechanical lift. The note showed the resident slid from the sling; the CNAs assisted the resident to the floor. The CNAs identified no injury at that time. The note showed on 05/21/2024 at 10:15 PM Resident 1 complained of back pain, and upon assessment by the nurse, a one-inch-long by one-inch-wide dark red bruise along the spine and a two-inch-by-two-inch closed abrasion on the back right rib cage were identified. The note showed the nurse informed the physician who ordered an X-ray as soon as possible. Review of the nursing progress note, dated 05/22/2024 at 2:53 PM, showed a spinal X-ray was obtained that morning and Resident 1 was noted to have a mild compression fracture of their T5 vertebra, and the resident was sent out to the hospital. A progress noted dated 05/22/2024 at 9:42 PM note showed Resident 1 returned to the facility later that day. Review of the 05/22/2024 emergency room (ER) notes showed Resident 1 was diagnosed with compression fractures to their T4 and T5 vertebrae. In an interview on 05/24/2024 at 9:35 AM Staff A (Director of Nursing) stated the two CNAs (Staff B and Staff C) assisting Resident 1 when they fell were new hires at the time. Staff A stated Resident 1 was assessed to require a medium whole-body sling for use with the mechanical lift. Staff A stated Resident 1 complained in the past of discomfort during transfers and was provided a split sling (a sling braces the body across the back and has straps that loop under the thighs for support) instead of the sling the resident was assessed to require. Staff A was unsure when this change occurred. Staff A stated Resident 1 began to have tremors during the transfer and slid through the sling and was guided by staff to the floor. In an interview on 05/24/2024 at 10:13 AM Resident 1 stated they did not think the sling was put on right. Resident 1 stated the sling felt different. Resident 1 stated they felt they were leaning more forward than normal when elevated in the sling that day. Resident 1 stated Staff C bumped the wheel of the lift with the resident's wheelchair, at which point Resident 1 began to move, and then slid through the sling on to the floor. Resident 1 stated the Staff B and Staff C placed them back in bed. Resident 1 stated both CNAs were upset, and the resident attempted to calm Staff C who was most upset. In an interview on 05/24/2024 at 10:40 AM Staff B stated Staff C asked for their assistance to transfer Resident 1 on the night of 05/21/2024. Staff B stated they used the split sling to transfer Resident 1 but was not sure if this was the resident's usual sling. Staff B stated after the wheelchair bumped the wheel of the lift Resident 1 began to spasm and fell to a sitting position on the floor. Staff B stated they and Staff C then moved Resident 1 back into their bed from the floor and informed the nurse. After this, the nurse came the Resident 1's room and assessed the resident for injury. In an interview on 05/24/2024 at 11:10 AM Staff D (Staff Development Coordinator) stated the therapy department was responsible for assessing lifts and slings for residents who required them for transferring. Staff D stated once therapy determined the type and size of sling required, they informed the resident care manager. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 05/29/2024 at 11:48 AM Staff E (Director of Rehabilitation) stated they did not know where an assessment for a sling would be located and that this process was not the therapy department's responsibility. Staff E stated in [AGE] years they had no recollection of therapy participating in this process. In an interview on 05/29/2024 at 12:24 PM Staff A stated the therapy department was responsible for sling assessments. Staff B stated they would have to double check with Staff E regarding sling assessments. Staff B stated the assessment would be reflected on the CP. Staff B stated Resident 1 used the split sling since they started working at the facility. Staff B stated if facility staff discussed the risks and benefits of using the split sling with Resident 1, it was done so orally and there was no record of that process. Review of the CP showed an intervention for a medium full body sling was added to Resident 1's CP on 05/22/2024, the day after the fall from the sling. There was no size and type of sling documented in the CPs prior to the fall. REFERENCE: WAC 388-97-1060 (3)(g).