

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505409	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER Summitview Rehab and Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3801 Summitview Avenue Yakima, WA 98902	

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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30528</p> <p>Based on interview and record review, the facility failed to implement interventions to prevent injuries or falls, during resident transfers (helping residents move safely from one place to another) for 2 of 5 residents (Resident 1 and Resident 4) reviewed for falls or injuries acquired during transfers by staff. Resident 1 experienced harm when the facility failed to use a two-person transfer, as determined necessary by the comprehensive care plan, during a transfer from the resident's bed to wheelchair, resulting in pain and ankle fractures and put residents that require transfer assistance at risk for injury.</p> <p>Findings included</p> <p>Record review of the facility's policy titled, Safe Lifting and Movement of Residents, dated 07/2017, showed that a resident's safety will be incorporated into the goals and decisions regarding the safe moving of residents; Nursing staff, in conjunction with the rehabilitation staff, shall assess individual residents' need for transfer assistance. Staff will document resident transferring and lifting needs in the care plan.</p> <p>Record review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, dated 03/2022, showed that care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.</p> <p><Resident 1></p> <p>Record review showed Resident 1 was admitted on [DATE] with multiple diagnoses including heart failure, orthostatic hypotension (a condition in which the blood pressure quickly drops when a person stands up after sitting or lying down), and dementia (a loss of mental ability severe enough to interfere with normal activities of daily living, ADLs).</p> <p>Review of the 09/16/2024 comprehensive assessment showed Resident 1 was dependent on staff for their ADLs, including transfers to and from their bed/chair and had moderate cognitive impairment.</p> <p>Review of Resident 1's Bedside Care Plan dated 09/19/2024 showed that the resident was dependent on two staff for transfers.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 505409	If continuation sheet Page 1 of 3

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a physical therapy note dated 10/18/2024 showed that Resident 1 was referred for assessment and treatment due to functionally declining in their ability to participate with transfers going from one-person assistance to two-person maximum assistance.</p> <p>Review of an incident investigation dated 11/20/2024 showed that Staff C, Nursing Assistant (NA) heard a pop sound when they pivot transferred (the resident bears at least some weight on one or both legs and spins to move their bottom from one surface to another) Resident 1 from their bed to their wheelchair. Resident 1 reported there was pain in their left ankle immediately after.</p> <p>Review of a 11/20/2024 written statement from Staff C showed they transferred Resident 1 from their bed to the wheelchair and heard the pop sound as the resident sat down and noticed the resident's left foot was caught under the wheelchair. Staff C reported the incident immediately to Staff D, Registered Nurse (RN). Review of the statement showed Staff C reported they were not following the resident's care plan.</p> <p>Review of a 12/16/2024 investigation summary by Staff B, Director of Nursing Services, showed Resident 1 had x-rays of their left foot/ankle that were negative for fractures on 11/20/2024 and 11/21/2024. The resident was changed to a mechanical lift and continued to have pain in their ankle. A MRI (magnetic resonance imaging, a scan that produces very clear images of the organs and structures inside the body) of the resident's left leg on 12/13/2024 showed left medial and lateral malleolar fractures (a bone fracture on the inside part of the tibia (inner and larger of the two bones between knee and ankle) and a bone fracture at the end of the fibula (outer and smaller of the two bones between the knee and ankle).</p> <p>During an interview on 01/23/2025 at 11:45 AM, Staff C stated they thought Resident 1's transfer assist care plan was for one to two staff depending on the resident's strength at the time and did not know Resident 1 had required two staff assistance for transfers.</p> <p><Resident 4></p> <p>A record review showed Resident 4 was admitted on [DATE] with rib fractures. Review of their 12/02/2024 comprehensive assessment showed the resident was dependent of staff for transfers between surfaces and was cognitively intact.</p> <p>Review of Resident 4's care plan dated 10/24/2024 showed that the resident required to assistance from two staff for transfers.</p> <p>Review of a 12/02/2024 fall investigation showed that Staff E, NA, attempted to transfer Resident 4 from the wheelchair to the toilet alone and the resident ended up on the floor. A statement given by Resident 4 at the time showed before I knew it, I was on the floor. Review of a 12/10/2024 note added to the incident investigation by Staff F, RN, showed Staff E was not familiar with Resident 4's transfer care plan and did not follow the care plan. Resident 4 was monitored for three days for injuries.</p> <p>(continued on next page)</p>		

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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 01/24/2025 at 2:25 PM, Staff F stated that resident transfer status was included on all the Bedside Care Plans that were maintained inside the resident's closet door. Staff should always review to ensure resident safety. Staff F stated that when there were changes to a resident's transfer status, they would make the changes on the Bedside Care Plan and tell the unit nurse the change so they could inform the NAs. Staff E stated there was no system to inform the NAs who were not working on the day of the change.</p> <p>During the exit interview on 01/24/2025 at 3:30 PM, Staff A, Administrator, stated staff should be aware of changes and follow the resident care plan.</p> <p>Reference: WAC 388-97-1060(3)(g)</p>		