

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/29/2024
NAME OF PROVIDER OR SUPPLIER Shelton Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 153 Johns Court Shelton, WA 98584	
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49451</p> <p>Based on interview and record review, the facility failed to update care plan and/or implement new interventions after resident had a fall for 1 of 3 residents (Resident 1) reviewed for accidents. This failure placed residents at risk for injury and diminished quality of life.</p> <p>Findings included .</p> <p>Review of the facility falls policy, titled, Fall Evaluation (Morse Scale) and Management, revised 03/2018, showed post fall actions included reviewing and updating the care plan with newly identified interventions as needed.</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses including dementia, psychosis and a fractured right femur (long leg bone). The admission Minimum Data Set (MDS), an assessment tool, dated 06/30/2024, showed the resident was cognitively impaired, required staff assistance for transfer and toileting needs and had a fall with a fracture within the last 6 months.</p> <p>Resident 1's care plan, dated 06/24/2024, showed the resident was at high risk for falls.</p> <p>Resident 1's nurse note, dated 07/21/2024, showed Resident 1 had an unwitnessed fall and sustained a right femoral neck fracture and was sent to the hospital for evaluation.</p> <p>Resident 1's hospital discharge summary, dated 07/26/2024, showed Resident 1 required surgical repair for a right femoral neck fracture and was discharged back to the facility on [DATE].</p> <p>Resident 1's care plan, dated 06/24/2024, did not indicate the care plan had been revised with interventions to prevent further falls.</p> <p>On 08/29/2024 at 2:20 PM, Staff C, Resident Care Manger, acknowledged Resident 1's care plan did not indicate the resident had a fall and had not been revised with interventions to prevent further falls. Staff C said, should have updated the care plan.</p> <p>Reference WAC 388-97-1020(2)(c)(d)</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: 505507
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