

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505522	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/08/2024
NAME OF PROVIDER OR SUPPLIER Salmon Creek Post Acute & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 2811 NE 139th Street Vancouver, WA 98686	

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 - Minimal harm or potential for 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** 48392</p> <p>Based on interview and record review, the facility failed to ensure fall mats (a cushioned surface used for the purpose of reducing injuries from falls) were in place on either side of the resident's bed, as directed in the comprehensive care plan, for 1 of 3 sampled residents (Resident 1) reviewed for accident hazards. This failure placed residents at risk of a fall with injury and a diminished quality of life.</p> <p>Findings included .</p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses including weakness and reduced mobility. Resident 1's quarterly Minimum Data Set assessment, dated 04/05/2024, indicated the resident was dependent for bathing needs and required maximum assistance to roll right and left.</p> <p>Resident 1's care plan, initiated 11/18/2020, showed Resident 1 was, At risk for falls due to history of falls, impaired balance/poor coordination, potential medication side effects, unsteady gait and cognitive deficits. An intervention, initiated 12/04/2020, showed, Staff to place fall mats on either side of [Resident 1's] bed at all times and remove them from the floor when she is out of bed.</p> <p>A Facility Investigation showed on 05/14/2024 at approximately 9:35 AM, Resident 1 fell from bed onto the floor.</p> <p>On 05/22/2024 at 11:15 AM, Staff C, Nurse Unit Manager, indicated they were present within minutes of when Resident 1 fell , and said there were no fall mats next to or near the bed of Resident 1 , at the time of the fall.</p> <p>On 06/05/2024 at 3:40 PM, Staff B, Registered Nurse and Director of Nursing Services, said if the care plan for Resident 1 indicated there should be fall mats then fall mats should have been there.</p> <p>Reference WAC 388-87-1060 (3)(g)</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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