	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCT		(X3) DATE SURVEY COMPLETED		
		505243	B. WING _			The state of the s	C 21/2013	
NAME OF P	ROVIDER OR SUPPLIER			FREET ADDRESS 430 LILLY ROA	CITY, STATE, ZIP CODE			
EVERGR	EEN NURSING & RE	HAB CENTER		OLYMPIA, WA				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH	VIDER'S PLAN OF CORRE CORRECTIVE ACTION SH REFERENCED TO THE AP DEFICIENCY)	IQULD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMEN	rs ,	F 000	2		<b>)</b>		
	Abbreviated Survey Nursing and Rehab 2013. A sample of discharged residen of 109.	esult of an unannounced conducted at Evergreen illitation Center on March 21, 4 current residents and 1 t was selected from a census elaints were investigated.		this for comp This is correct agree concluded	Plan of Correction of actility's written dilegaliance for the deficient the submission of this plan ction is not an admission with the deficient with the deficient with the deficient with the susions contained in the threat's inspection ref	nton of cies cited tof ion of or ncies or e		
		R.N., B.S.N., Investigator		A'	PR 0 9 2013	in the second se		
	Department of Soci	on 98504-5819 4.8420		DSH	S/ADSA/RCS			
			wanted a track of the bar	Control of the Contro				
2007 (17-2) (10-2)		ভারত বিষয় বিষ বিষয় বিষয় বি	NAME OF THE PROPERTY OF THE PR					

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other stategrands provided from providing it is determined that other stategrands provided from correction to the patients. (See instructions.) Except for rursing the findings stated above are disclosable to 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.

## DEPARTMENT OF HEALTH AND HU, AN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
The second secon		505243	B. WING		03/21/2013
	PROVIDER OR SUPPLIER REEN NURSING & RE	HAB CENTER	4	REET ADDRESS, CITY, STATE, ZIP CODE 30 LILLY ROAD NORTHEAST DLYMPIA, WA 98506	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE COMPLETION
F 309 SS=D	Each resident must provide the necession maintain the high mental, and psychological checks.  This REQUIREMENT by:  Based on observation review, the facility forceived the necession and psychological checks.	CARE/SERVICES FOR EING  receive and the facility must ary care and services to attain test practicable physical, social well-being, in a comprehensive assessment  On, interview and record alled to to ensure residents sary care and services to be highest level of physical, social well-being for 2 of 3 when assessments were not incidents in accordance with physician direction regarding social mot having their needs being	F 309	<ol> <li>Resident #1 has discifrom the facility. Resident #2 experient no negative outcome from this event.</li> <li>Residents who have falls in the last 14 dath had their records revisor completion of New Assessments and Pair Assessments if indices.</li> <li>Nursing staff will be On completion of New Assessments and New Flowsheets following Policy as well as document and Physician notific changes in pain followers.</li> </ol>	experienced ys have iewed eurological n ated.  re-educated eurological urological g facility cumentation cation of
FORMONS	413 with diagno	Imitted to the facility on ses to include Communication of the Communica		4. Residents who have as needing Neurolog Assessments and Ne Flowsheets complete audited by the IDT to clinical meeting until completion of the per policy.	rical urological ed will be hrough the daily

DEPARTMENT OF HEALTH AND HU AN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		E SURVEY IPLETED
		505243	B. WING	Secretary of the secret	03/	C 21/2013
	PROVIDER OR SUPPLIER REEN NURSING & RE	HAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 430 LILLY ROAD NORTHEAST OLYMPIA, WA 98506		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE
F 309	assessment tool, did Resident #1 require person for transfer required two person care.  On 3/13/13 at 11:40 note documented to called into Residen staff person heard was found on the fis sustained an injury.  The facility medical primary physician was documented as being neurological check.	ated 2/22/13 documented and an extensive assist of one s, dressing, eating, and his for toileting and hygienic a.m., a nursing Progress he Licensed Nurse A (LN) was t #1's room when a therapy the resident calling out and oor. Resident #1 had to his head and shin.  I director, not the resident's who managed the resident's admitted to the facility, was ing notified and ordered is to be performed per facility he resident's injuries and a	F 31	The IDT will review respain records for change pain level and ensure plantification as well as notification as notification as well as notification as	s in residents rysician ursing the pain al meeting will be at trends ted to the QI onths.	
	sustained an injury Neurological Asses Neurological Asses nursing staff to do every 15 minutes x every 30 minutes x every 1 hour x 4 hours x 4 times the staff were to documented after all extremities, lever resident's paintress	I after residents had fallen and to the head, was to do a sment. The facility sment Flowsheet directed a neurological assessment 4 times until stable, then 4 times until stable then, ours until stable, then every 4 in every 8 hours. The nursing nent the resident's vital signs, the pupil of each eye were to light. Metor function was to er assessing hand grasps and dof consciousness and the conse was to be documented.				Paris of

DEPARTMENT OF HEALTH AND HU...AN SERVICES CENTERS FOR MEDICARE & MEDICALD SERVICES

	ROVIDER OR SUPPLIER EEN NURSING & REHAB CENTER	. 4	REET ADDRESS, CITY, STATE, ZIP CODE 130 LILLY ROAD NORTHEAST DLYMPIA, WA 98506		
ID FIX .G	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X COMPI DA
309	Continued From page 3 staff had performed the neurological assessment thoroughly as directed.	F 309			
	A Pain data collection and assessment form dated 3/13/13, documented Resident #1's current condition that might be associated with pain was a light be associated with light because with light becaus				
	Resident #1 was documented as not having any limitations in his day to day activities for the past 5 days because of pain or difficulty sleeping.	S.			1
	Resident #1's documented expected level of pain was 0 (none), and that it was "extremely important" to him to completely eliminate his pain.				
	Resident #1 verbalized his pain as a "2" on a verbal numeric pain scale (0-10, 0 defined as no pain, and 10 being the "most intense pain imaginable"), a second pain scale, the Wong-Baker Face Scale, a series of 6 drawn faces that ranged from the face smiling, to a face crying, each with a numerical value underneath it. The smiling face was a 0 (" no hurt ") and the crying face was a 10 (" hurts worst "). The directions documented to have the resident to point to the appropriate face and explain the numerical value underneath it. Resident #1 was documented as a "2" (hurts little bit), although Resident #1 was blind.				
P	The pain location/type/frequency section of the form documented Resident #1's pain was located on his forehead and left shim and the reason for the assessment was Resident #1 had a change in condition. The pain assessment situmaty				

DEPARTMENT OF HEALTH AND HU AN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION		SURVEY PLETED
	e tuada turi ili delega yang di engaga Managaran	505243	B. WING		03/2	21/2013
	ROVIDER OR SUPPLIER EEN NURSING & RE	HAB CENTER	430 LI	ADDRESS, CITY, STATE, ZIP CODE LLY ROAD NORTHEAST IPIA, WA 98506		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REPERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	complain of pain. F laceration to left lov	dent usually does not ell-hematoma to forehead and	F 309			
	current pain medica needed)	ation orders which is prn (as				
	documented "fall w of pain x 1." There- had any further ass nursing intervention that pain although I pain assessment the	a.m., a Progress note ith injury, resident complained was no evidence the resident essment of that pain, or if any as were provided to alleviate. NA had done Resident #1's le day prior where he dremely important to him not				
	of 10, and was give documented as bei	ent #1 rated his pain as 5 out on the was my "helpful" but no further as given or description of pain				
		p.m., the resident was given complaints of pain rated as 5				
-	refused to eat. At 1 complained of pain given again medication was not was a change in the	documented Resident #1 0:00 p.m., the resident rated as 5 out of 10 and was . The effectiveness of the documented, although this e resident's pain assessment	200 200		-	
	Physician was notif	was no evidence to show the ied of Resident #2's changes futher evaluation was				
	completed:	Osolete		17800 H COL		

## DEPARTMENT OF HEALTH AND HU .N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		E CONSTRUCTION			E SURVEY PLETED
		505243	B. WING	·	West and	-	03/	C 21/2013
	ROVIDER OR SUPPLIER EEN NURSING & RE	HAB CENTER		4	REET ADDRESS, CITY, STATE 30 LILLY ROAD NORTHEA DLYMPIA, WA 98506			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFIC	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 309	There was no evidencurological assess thoroughly as the fadirected staff to do, notified of his incredocumented after the "5" in the 24 hours continued until he Resident #2>	a.m., the resident was found espiration, and was ence Resident #1's sments were completed acility protocol and form the resident's physician was ase of pain from a level ne head injury as a "2" to a after his injurious fall that	F	309				
	assessment tool, da Resident #2 require person for hygienic two persons for tolle Resident #2 was do impaired in his decimemory deficits.  On 3/7/13 at 4:15 pobserved in his root backwards when it he fell onto the floor of the fall, the resident was round when the was round when the resident was round when the was round when the resident he was round when the resident has resident he was round when the resident has resident he resident has resident has resident he resident has resident has resident he resident	mum Data Set (MDS), an ated 3/6/13 documented d an extensive assist of one cares, dressing and required eting, transfers and tolleting, cumented as moderately sion making with known Resident #2 was a pushing a wheelchair sipped toward the resident and striking his head. At the time on's vital signs were taken with injuries to his head and sident had a temperature of						
EOBMICAE SE	≎7/09-90) (Pr	Genlete Event ID-83401			Hon William	**************************************	lion cheo	(Carpartistical)

DEPARTMENT OF HEALTH AND HU. IN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	EMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING		СОМ	E SURVEY PLETED
		505243	B. WING		'JAZZIUZ.'		C 21/2013
	ROVIDER OR SUPPLIER	HAB CENTER		STREET ADDRESS, CITY, S 430 LILLY ROAD NOR OLYMPIA, WA 9850	THEAST		
(X4) ID PREPIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION SHOULD NOTE TO THE APPROPRIES OF THE APPROPRI	D BE	(X5) COMPLETION DATE
F 309	101.5 Fahrenheit (F	F). The physician was notified e received to monitor the	F3	309			
	sustained an injury Neurological Assess Neurological Assess nursing staff to do a every 15 minutes x every 30 minutes x every 1 hour x 4 ho hours x 4 times the nursing staff to doc signs, pupils, includ were equal and rea was to be document grasps and all extress	after residents had fallen and to the head, was to do a sment. The facility sment Flowsheet directed a neurological assessment 4 times until stable, then 4 times until stable then, urs until stable, then every 4 n every 8 hours. It directed the ument the resident's vital ling if the pupil of each eye ctive to light. Motor function ated after assessing hand emities, level of consciousness tain response was to be	•				
	had performed the	mentation to show the staff neurological assessment orm directed which was facility	3				
0	three previous falls the resident had str neurological monito and a total of 9 falls facility. There was r monitored the resid	aled Resident #2 had had since January 2013, where uck his head requiring ring per the facility protocol since his admission to the no evidence the facility had ent thoroughly neurologically				ĺ	
	for each incident:						
F328	Refer to F323 483.25(5) FREE OF	Accident	F.3	23			
ORIVION SOL	elleren billione side cas	CHECKE. PORTURESON		PECHINID	The state of	afton shee	idealee#eniale

DEPARTMENT OF HEALTH AND HU IN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER  EVERGREEN NURSING & REHAB CENTER    STREET ADDRESS, CITY, STATE, JP CODE   430 LILLY ROAD NORTHEAST OLYMPIA, WA 98506	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
EVERGREEN NURSING & REHAB CENTER  (A3) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TROM DEFICIENCY MUST BE PRECEDED BY FULL TRAG  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FRESULATORY OR LSC IDENTIFYING INFORMATION)  F 323  Continued From page 7  HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by:  Based on observation, interview and record review, the facility falled to provide sufficient supervision, monitoring and interventions to prevent falls for 1 of 3 residents (# 2) reviewed for accidents and incidents. This failure placed residents at risk for continued accidents that could cause harm.  Findings include:		e de la companya de La companya de la co	505243	B. WING	T. T	03/21/2013
FREGULATORY OR LSC IDENTIFYING INFORMATION)  F 323  Continued From page 7 HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide sufficient supervision, monitoring and interventions to prevent falls for 1 of 3 residents #2) reviewed for accidents and incidents. This failure placed residents at risk for continued accidents that could cause harm.  Findings include:			HAB CENTER	4	30 LILLY ROAD NORTHEAST	
HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by:  Based on observation, interview and record review, the facility failed to provide sufficient supervision, monitoring and interventions to prevent falls for 1 of 3 residents (# 2) reviewed for accidents and incidents. This failure placed residents at risk for continued accidents that could cause harm.  Findings include:  Resident #2 was admitted to the facility on 132 with diagnoses to include  Resident #2 was admitted to the facility on person for hygienic cares, dressing and required two persons for tolleting massiers and following.  Resident #2 required are rektensive assist of one person for hygienic cares, dressing and required two persons for tolleting interiors and following.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	IOULD BE COMPLETION
HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by:  Based on observation, interview and record review, the facility failed to provide sufficient supervision, monitoring and interventions to prevent falls for 1 of 3 residents (#2) reviewed for accidents and incidents. This failure placed residents at risk for continued accidents that could cause harm.  Findings include:  Resident #2 was admitted to the facility on 132 with diagnoses to include  The resident's Minimum Data Set (MDS), an assessment tool, dated 3/6/13 documented Resident #2 required arrekternisty assist of one person for hygienic cares dressing and required two persons for tolleting irransfers and follotings.  Resident #2 was admitted to the facility on persons for tolleting irransfers and follotings.  Resident #2 was admitted to the facility on persons for tolleting irransfers and follotings.	E 233	Continued From no	-0.7	F 000		
as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  2. Residents who have been identified as a Fall risk by a fall assessment will have their Care Plans reviewed to ensure interventions are in place to reduce the resident's risk of falling.  3. Nursing staff will be inserviced on identifying residents who are at risk for prevent falls for 1 of 3 residents (# 2) reviewed for accidents and incidents. This failure placed residents at risk for continued accidents that could cause harm.  Findings include:  Resident #2>  Resident #2>  Resident #2 was admitted to the facility on (walk), a history of falls and (walk), a history of falls and assessment tool, dated 3/6/13 documented Resident #2 required an extensive assist of one person for hygienic cares, dressing and required two persons for tolleting transfers and telegrage.  Resident #2 was documented as moderately	1 71	HAZARDS/SUPER The facility must en	VISION/DEVICES sure that the resident	F 323	condition or change in	d no decline in his ADL's as
This REQUIREMENT is not met as evidenced by:  Based on observation, interview and record review, the facility failed to provide sufficient supervision, monitoring and interventions to prevent falls for 1 of 3 residents (#2) reviewed for accidents and incidents. This failure placed residents at risk for continued accidents that could cause harm.  Findings include: <resident #2="">  Resident #2 was admitted to the facility on 1/132 with diagnoses to include 1/132 with diagnoses</resident>		as is possible; and adequate supervision	each resident receives		their Care Plans review	ment will have
by: Based on observation, interview and record review, the facility failed to provide sufficient supervision, monitoring and interventions to prevent falls for 1 of 3 residents (# 2) reviewed for accidents and incidents. This failure placed residents at risk for continued accidents that could cause harm.  Findings include:  Resident #2 was admitted to the facility on (walk), a history of falls and (walk), a history of falls and (walk), an assessment tool, dated 3/6/13 documented. Resident #2 required arrextensive assist of one person for hygienic cares, dressing and required two persons for toileting, drensfers, and tellibling. Resident #2 was documented as moderately.					interventions are in place	e to reduce
Resident #2>  Resident #2 was admitted to the facility on 132 with diagnoses to include 133 with diagnoses to include 143 with diagnoses with		by: Based on observative review, the facility for supervision, monitor prevent falls for 1 or accidents and incidents at risk for	ion, interview and record alled to provide sufficient ring and interventions to f 3 residents (# 2) reviewed for ents. This failure placed		for falls and initiating interventions that will re-	o are at risk
The resident's Minimum Data Set (MDS), an assessment tool, dated 3/6/13 documented Resident #2 required an extensive assist of one person for hygienic cares, dressing and regulired two persons for toileting transfers and toileting. Resident #2 was documented as moderately						
assessment tool, dated 3/6/13 documented  Resident #2 required an extensive assist of one person for hygienic cares, dressing and regulired two persons for toileting drainsfers and toileting Resident #2 was documented as moderately		132 with diagno	ses to include			
two persons for tolleting transfers and folloting  Resident #2 was documented as moderately		assessment tool, da Resident #2 require	ated 3/6/13 documented d an extensive assist of one	a de la California		
	.,	two persons for toile Resident #2 was do	eting transfers and folloting comented as moderately			

## DEPARTMENT OF HEALTH AND HU. .N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION		E SURVEY PLETED
A CONTRACTOR		505243	B. WING	· ·		03/2	C 21/2013
NAME OF P	ROVIDER OR SUPPLIER			STR	ÈET ADDRESS, CITY, STATE, ZIP CODE		
EVERGR	EEN NURSING & REI	HAB CENTER		4	30 LILLY ROAD NORTHEAST DLYMPIA, WA 98506		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REPERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	Continued From pa	ক :	F3	323	4. Residents who have been	identifi	ed.
	short term memory	deficits.			as having a fall will have		
		njury Assessment Prevention			Plans audited by the ID7	to ensu	re
		lan of Care documented			Completion of their Neur	ological	
	· · · · · · · · · · · · · · · · · · ·	or falls on 9/11/12, 10/4/12,		• [	Assessments and individ	ual	
	10/23/12, 12/5/12, 1	1/2/13, 2/24/13 and 3/3/13.			Interventions have been		
"	Pecident #2's care	planned fall prevention			their Plan of Care to redu		
		s were documented on the		,	risk of further falls.		
v *		sident to have non-skid socks,			Trends identified from the	e andits	
		per protocol, therapy consult			will be presented to the		,
		encouraging the resident to			committee x 3 months.	<b>Κ. τ</b>	
		er, removal of the resident's			committee x 3 monuis.		
		, reminding the resident to			TD TD TG / 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	aible for	
		brakes when getting up and dent to his room and call light.			IDT/DNS/Admin resport compliance.	121016 101	
		?·					
		.m., Resident #2 was			Date of compliance: 04/	30/13	
		m pushing a wheelchair tipped toward the resident and			pace of companies		[
		striking his head. At the time		İ			
		ent's vital signs were taken					
· · · .		vith injuries to his head and					
		hysician was notified by fax.		- }			
		ed to monitor the resident for					
	the next 72 hours.			-			4
	The facility protocol	after residents had fallen and	4.5		and the second s		
		to the head, was to do a					
	Neurological Assess		3 6				
		sment Flowsheet directed					
		neurological assessment					
		4 times until stable, then 4 times until stable then,	20 20 20 TO	<u></u> .			
		urs until stable, then every 4	A CAMPINE	A C T		VARIATION OF THE	भूपाएँ सामा वार्यः स्वादि
		every 8 hours: It directed the					
	nursing staff to doct	ment the resident's vital	- Carrier - Carr		Marketing to the Control of the Cont		nanan nan nan nan nan nan nan nan nan n
	signs, pupils, includ	ing if the pupil of each eve				Program Complete	L. 2017-2017-201
Prince No.	A STATE OF THE STA			2.46			and the same
OPAN STATE	(###7:00) Previous Versions	Charles Community of the Community of th		1	III VIEW VAN ERIO	TO PERSONAL STREET	erane (i i i
			or electronic action	again.			CHICAGO TO A STATE OF THE STATE
	والمناف المناف ا		100			care la	111

DEPARTMENT OF HEALTH AND HU. N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE COMP					
Å.		505243	B. WING	, <u></u>		03/	C 21/2013	
	ROVIDER OR SUPPLIER	HAB CENTER	( -	43	REET ADDRESS, CITY, STATE, ZIP CODE 30 LILLY ROAD NORTHEAST DLYMPIA, WA 98506			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323			F3	323				
	was to be documer grasps and all extre	active to light. Motor function nted after assessing hand emities, level of consciousness pain response was to be		7,00				
	(RCM) A, the Assis (ADNS), and the Di (DNS) stated the fa	N) B, Resident Care Manager tant Director of Nursing rector of Nursing Services icility protocol for neurological w the form and continue is for 72 hours.						
	had performed the	mentation to show the staff neurological assessment orm directed which was facility						
		ntervention after the fall on ture falls was documented as eck while in room."	·					
. \	• • • • • • • • • • • • • • • • • • • •	tion to the staff what was nt" or documentation to show vere done.	• •			, <b>3</b>		
-		ntervention was not specific sessed as effective in						
	total of nine falls sir facility, all of the fall	aled Resident#2 had had a loce his admission to the s where he resident had	Control of the contro	*				
veale v	monitoring per the f	required neurological acility protocol had no cility had monitored the	To 1 90000					
		neurologically or attempted to dividualized nursing			lituris 20150000 Toxand	nuationsheet		
				ne l'air e	lir), li 1600[si]	Metalnest State		

DEPARTMENT OF HEALTH AND HU' 'N SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA / IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATI	E SURVEY IPLETED	
4	apoliti kan terri	505243	#B.::WING	I. <u> </u>		ne)	C <b>21/2013</b>
	NAME OF PROVIDER OR SUPPLIER  EVERGREEN NURSING & REHAB CENTER			43	EET ADDRESS, CITY, STATE, ZIP CODE 30 LILLY ROAD NORTHEAST LYMPIA, WA 98506	1 031.	2 (720)3
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	Continued From particular interventions to pre		F3	323			
	thought processes previous fall history interventions to pre	nown to have altered cognition, and impaired memory and a r. The care planned nursing event Resident #2 from falling zed to the resident's abilities ent falls.		-		· · · ·	
	Refer to F309				19		
•							, ,
	•						
	7 tr. + +						
12473	NOTAL TO SERVICE STATE OF THE		\$ <b>3</b> 22 35 33				
					A System	Bergeran College	
ORM CMS-25	67/(17299) Previous Versions	evis oletë Event ID: 33JD11		Faci	IIV/ID/AVAY/800/866/	ation sheet	Page 11 of 1
				100			1
		. )	gamen galantilla				