| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 505230 | A. Building<br>B. Wing | 12/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Fir Lane Health & Rehabilitation Center | 2430 North 13th Street<br>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) |
|---|---|
| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49451<br><br>Based on observation, interview and record review the facility failed to ensure the resident environment was safe and free from hazards for 17 of 17 sampled residents (1 ,2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, and 17) residing in the facility's locked dementia unit. Resident 1 experienced harm when they sustained a significant second degree burn (burn that affects the epidermis [outer layer of skin] and the dermis [middle layer of skin] to the left hip when they were found unsupervised seated on a baseboard heater. This failure placed all residents on the dementia unit at risk for serious injury and decreased quality of life and constituted an Immediate Jeopardy (IJ).<br><br>On 12/10/2024, the facility was notified of an IJ at CFR 483.25, F 689, Accidents/Hazards/Supervision/Devices, when a resident sustained burns after being found unsupervised against a baseboard heater at the facility and placed other residents at risk of serious injury. The facility removed the immediacy on 12/13/2024 with an onsite verification by review of the temperature logs, staff education related to temperature checks and verification of repairs to the baseboard heaters which ensured an effective system was in place to safeguard, protect and prevent residents from hazards.<br><br><Dementia Unit><br><br>The dementia unit had 17 residents who resided on a locked dementia unit. Electronic health records indicated 16 of 17 residents had cognitive impairment and were at risk for wandering behaviors and indicated 17 of 17 residents had dementia or other cognitive impairing diagnoses. There were heaters in every resident room and in two common areas, that were accessible to all residents.<br><br>Findings included .<br><br>Resident 1 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease (a brain disorder that can cause problems with memory, thinking and behaviors), dementia (a group of symptoms that affects memory, thinking and interfers with daily life) and hypertension (high blood pressure). The Minimum Data Set (MDS), an assessment tool, dated 09/07/2024, showed the resident had cognitive impairment with hallucinations and delusions, had wandering behaviors and had one fall since admission and required staff assistance for activities of daily living.<br><br>Resident 1's care plan, dated 07/2022, showed Resident 1 required staff assistance for bathing, was independent with transfers and ambulation, had impaired safety awareness and was an elopement risk due to wandering.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Resident 1's progress note, dated 12/06/2024 at 7:53 AM, showed Resident 1 was found on the floor with their back against the heater with redness to the left side of the back, left arm and the left hip initial accessment of the affected area showed a 4.5 inches by 1/2 inch white linear burn and reddened area of approximately 3 by 4 inches.<br><br>Resident 1's hospital documentation, dated 12/06/2024, showed the resident sustained a three percent body surface area, partial thickness burn to their left buttocks and some redness to the skin on the left posterior arm and back with some broken blisters. Resident 1 was discharged back to the facility with wound treatment orders.<br><br>Review of the facility's investigation, dated 12/06/2024, showed Resident 1 was found sitting on the baseboard heater in the resident's room by Staff F, Nursing Assistant (NA). Staff F moved the resident away from the heater and left the resident to find the nurse. Staff F and a nurse returned to the resident. The resident was assessed and sent to the hospital for evaluation and treatment. The facility was unable to determine why the resident was next to the baseboard heater.<br><br>Resident 1's first documented skin assessment after return from the hospital, dated 12/08/2024, showed a 6 inch by 12 inch burn with blisters and open areas with yellow drainage.<br><br>Resident 1's wound assessment, dated 12/10/2024, showed a large 11 cm x 18 cm x 0.12 cm (4.3 inch x 7 inch) second degree, partial thickness, deep burn on the left buttock wrapping around the hip.<br><br>On 12/09/2024 at 10:52 AM, Staff F, said they were the NA on night shift on 12/06/2024. Staff F said she saw the resident out of her bed, sitting on the heater in the resident's room waving at her. Staff F said she moved the resident away from the heater and saw the resident's skin was between the panels of the heater and the left hip was burned. It was pretty bad .I freaked out and left the room to get the nurse .I had 16 residents that night by myself. Staff F said she and the nurse returned to the resident's room and Resident 1 had moved back against the heater. Staff F said they moved the resident away from the heater. Staff F said the resident was sent to the hospital for evaluation. Staff F said the resident was checked on at 2:00 AM and was found at approximately 3:30 AM.<br><br>On 12/09/2024 at 12:23 PM, Staff E, NA said the baseboard heaters were hard to regulate in the dementia unit.<br><br>On 12/09/2024 at 12:30 PM, Staff A, former Administrator, said since she had been administrator the facility had not had any issues related to the baseboard heaters and she was not aware of reported issues with the baseboard heaters. Staff A said prior to her working as the administrator she was aware that there was some issue with a heater but was not aware of the details. The Administrator said Resident 1 sustained a large second degree burn to the left hip from the baseboard heater in the resident's room. She said the facility completed an investigation and thought the resident sustained a burn after a fall onto the heater.<br><br>On 12/09/2024 at 12:40 PM, Resident 1's wound care was observed with Licensed Practical Nurse (LPN), Staff D. Resident 1's left hip had a large burn over the left hip, red in color and a small fluid filled blister remained intact in middle of the burn. The wound care was completed by Staff D and tolerated well by the resident.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | On 12/09/2024 at 12:40 PM, Staff D said she felt like the baseboard heaters in the dementia unit were hard to adjust. Staff D said some heaters didn't work properly and were too hot or too cold, especially in the day room.<br><br>On 12/10/2024 at 3:15 PM, observation of the following rooms baseboard heater temperatures with Staff A, C (Director of Nursing) and E (Maintenance Director):<br><br>- room [ROOM NUMBER]- The top of the baseboard was touched and was too hot to touch as it would burn the skin.<br><br>- Resident day room - The top of the baseboard was touched and was too hot to touch as it would burn the skin.<br><br>- room [ROOM NUMBER] - The top of the baseboard was touched and was too hot to touch as it would burn the skin.<br><br>It was determined at that time by Staff A, C and E that the facility infrared thermometer was not functioning accurately as the readings were coming up in the moslty mid 70 degree Fahrenheit (F) range despite being so hot to the touch, and the facility did not have a replacement infrared thermometer in the facility.<br><br>On 12/10/2024 at 4:45 PM, observation of 10 resident rooms in the dementia care unit was completed with Staff A, C and E. Staff E said she had gone to the dementia care unit and turned all baseboard heaters down a short time prior. Rooms 40, 41, 42, 43, 44, 45, 47, 49 and the dining room baseboard heaters were still too hot to hold the hand on as it would burn the skin. Rooms 46, 48 and the day room were cooler to the touch.<br><br>On 12/12/2024 at 11:00 AM, Staff B, Interim Administrator, said an electric company was in the facility and replacing all thermostats on the baseboard heaters in the dementia unit.<br><br>Reference WAC 388-97-1060 (3)(g) |