

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/19/2012
FORM APPROVED
OMB NO. 0938-0391

RECEIVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505473	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ JUN 29 11:00 B. WING _____ DSHS - ADSA BCS - REGION 5	(X3) DATE SURVEY COMPLETED C 06/13/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5520 BRIDGEPORT WAY WEST UNIVERSITY PLACE, WA 98467
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Standard Survey conducted at University Place Care Center on 05/29/12 & 06/13/12. A sample of 5 residents was selected from a census of 100.</p> <p>The following were complaints investigated as part of this survey:</p> <p>12-05-16461</p> <p>The survey was conducted by:</p> <p>Kathleen Jamison RN, MN</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Disability Services Administration Residential Care Services, District 3, Unit A 1949 S. State Street Tacoma, WA 98405-2850</p> <p>Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p><i>[Signature]</i> 6/19/12 Residential Care Services Date</p>	F 000	<p><u>The following written allegation of compliance is intended to meet the requirements for a plan of correction under state and federal law and is not an admission that the survey findings are correct or that they rise to the level of deficiencies under applicable law</u></p>	
-------	--	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Christine Miller</i>	TITLE LNHA	(X6) DATE 6/26/12
--	----------------------	-----------------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505473	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/13/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5520 BRIDGEPORT WAY WEST UNIVERSITY PLACE, WA 98467
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure 1 of 5 Sampled Residents (#1) received proper care and treatment to ensure patency of enteral tube (tube used for the delivery of nutrition and medication into the body when swallowing is compromised). Failure to provide care and implement interventions to reduce opportunities for clogging the enteral tube resulted in repeat of clogged tube and potential for the resident to not receive medication and nutrition.</p> <p>Findings include:</p> <p>Interview with interested party on 05/29/12 at 11:25 a.m. revealed Resident #1 presented at the hospital twice in two days with a clogged enteral feeding tube. The interested party indicated the resident presented to the out-patient center from the facility with a clogged enteral tube on [REDACTED]. The facility was educated regarding</p>	F 328	<p><u>F-328 Treatment/Care for Special Needs</u></p> <p>Resident #1 is receiving care and treatments as ordered.</p> <p>Facility reviewed the care and treatments of other residents receiving enteral tubes. No further issues identified.</p> <p>Facility nursing staff have been inserviced and will continue to be inserviced on administration of medications via enteral tubes, proper care and treatment, and interventions to attempt to unclog enteral tubes.</p> <p>Audits will be conducted by the DNS or designee to determine ongoing compliance. Results will be forwarded to Quality Assurance Committee for review of trends/patterns.</p> <p>Correction Date: 6/22/12 and ongoing</p> <p>Director of Nursing or designee will be responsible for compliance.</p>	

Christine Miller, LNHA 6/26/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505473	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/13/2012
--	---	--	--

NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5520 BRIDGEPORT WAY WEST UNIVERSITY PLACE, WA 98467
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 328	<p>Continued From page 2</p> <p>crushing medications prior to administering the medication. On [REDACTED] the resident returned again with a clogged enteral tube. The interested party indicated concern of the resident not receiving medication nutrition.</p> <p>Interview with Family Member on 06/06/12 at 12:05 p.m. revealed " the nurse opened the potassium. He was supposed to get the liquid potassium, that ' s what he took at home. It happened two times the tube clogged. "</p> <p>Record review revealed an order dated [REDACTED] directing staff to " may crush meds and give through g-tube. Meds not able to be crushed may be in liquid form. Give all meds via g-tube. "</p> <p>Record review of incident report dated 05/24/12 listed under occurrence " clogged g-tube. " The incident report indicated the physician was notified and " appt made to be sent out in AM to declog g-tube. " The investigation did not include any intervention used to attempt to unclog the enteral tube. The investigation did not provide interventions to prevent reoccurrence.</p> <p>During interview on 06/13/12 at 4:50 p.m. Staff A reported initiating the investigation and contacting the physician. Staff A admitted not implementing any interventions to unclog the tube. Staff A was not aware of interventions by other staff to unclog the tube.</p> <p>Record review revealed on [REDACTED] Resident #1 ' s enteral tube was found to be clogged again. The resident was sent to the hospital on [REDACTED] for he tube to be replaced.</p>	F 328		
-------	--	-------	--	--

Christine Miller, LNHA 6/26/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505473	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/13/2012
NAME OF PROVIDER OR SUPPLIER UNIVERSITY PLACE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5520 BRIDGEPORT WAY WEST UNIVERSITY PLACE, WA 98467		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 3 The facility was aware of the risk of clogging the enteral tube and potential for the resident to not receive medication and nutrition after the tube clogged on [REDACTED]. Interventions were not implemented to prevent reoccurrence and the enteral tube clogged again on [REDACTED].	F 328		

Christine Muller, UNHA 6/26/12