

1164

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

PRINTED: 04/17/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505491	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/01/2013
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NAME OF PROVIDER OR SUPPLIER VERETT CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1919 112TH STREET SOUTHWEST EVERETT, WA 98204
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F 000 INITIAL COMMENTS

F 000

RECEIVED
APR 23 2013
ADSA/RCS
Smokey Point

This report is the result of an unannounced Abbreviated survey conducted at Everett Care & Rehabilitation Center 1/29/13 and 2/1/13. A sample of 7 residents was selected from a census of 90.

The following complaint investigated as part of this survey:

- 2747386
- 2739882
- 2742240
- 2738253

The survey was conducted by:
I. N, MSN

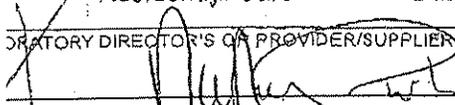
The survey team is from:
Department of Social & Health Services
Aging & Disability Services Administration
Residential Care Services, District 2, Unit B
3906 172nd Street NE, Suite 100
Arlington, WA 98223-4740

Telephone: 360-651-6860
Fax: 360-651-6940

"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Everett Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."

IDR AMENDED

Residential Care Date 4/17/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 4-23-13
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deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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.

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483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to evaluate and follow the plan of care to prevent the development of sores for 1 of 4 residents (Resident 1) who was identified to be at risk for skin breakdown. Failure to evaluate and follow-up on skin issues for Resident 1 resulted in actual harm and the development of sores. The facility did not provide a supportive pillow for neck positioning for Resident 2.

Findings include:
The facility's policy on "Skin Care & Pressure Ulcer Management Program", dated 9/11, read "managing pressure ulcers, ...uses the Assess, Plan, Implement & Evaluate ("APIE") approach to care giving. The program relies on standards of practice that focus on two aspects of care: 1) Prevention of pressure ulcer development, ...and 2) Treatment that uses a standardized approach to promoting healing and preventing infection when skin breakdown occurs".
The policy also directed staff to perform weekly

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1) Resident #1 was re-assessed on 2/1/13, care plan and treatment record were updated, pain assessed interventions in place by Nurse Manager.
Resident #2 was re-assessed on 2/1/13, care plan and treatment records were updated, pain assessed, interventions in place by Nurse Manager.

2) Residents with identified wounds as well as residents identified as "at risk" were assessed by Nurse Manager and Director of Nurses on 2/2/2013, care plan and treatment records were updated, interventions in place.

3) Licensed Nurses and CNA's were re-educated to wound identification, communication, treatment and care plan implementation 2/1-20/13 by Director of Nurses and Nurse Manager.

4) 5 resident skin check reviews on each nursing cart weekly times 12 weeks to be completed by Director of Nursing or designee to validate compliance of weekly skin checks. Identified wounds to be assessed, documented and updated as needed per policy and procedure.

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F 309	<p>Continued From page 2</p> <p>skin evaluations, to monitor daily and communicate skin issues with nursing assistants, access and evaluate pressure redistribution treatment, wound pain, individualized repositioning and monitoring and whether incontinent products wick away moisture or if appropriate for the prevention of skin breakdown.</p> <p>RESIDENT 1. Resident 1 was re-admitted from the hospital on 12/12 with diagnosis of _____ and a _____ in his foot. The Minimum Data Set (MDS) assessment, dated 12/9/12, documented the resident had no cognitive impairment, required extensive assistance of two people for his bed mobility and transfer, was incontinent of urine and bowel and had no pressure sores.</p> <p>Resident 1's plan of care (POC) revealed staff were to apply a barrier cream after each incontinent episode and to keep his skin clean and dry and to report any open areas to Licensed Nurses (LN). The LNs were to perform weekly skin assessments.</p> <p>On 2/1/13 at 8:45 a.m., the resident was observed seated in his wheel chair. At 10:50 a.m., incontinent care was observed after an incontinent episode of both urine and bowel. When the Nursing Assistants (NAs) wiped between the resident's upper groin/inguinal area and scrotum, he grimaced and stated it "burns" and "hurts".</p> <p>On 2/1/13 at 10:55 a.m., after incontinent care was provided, the resident's skin was assessed with LNA. His skin along his brief line on his right upper thigh/groin area was open and was</p>	F 309	<p>5 residents charts of identified residents with wounds to be reviewed by Director of Nurses or designee weekly times 12 weeks to validate treatments are being followed and care plans are up to date.</p> <p>Monthly skin sweeps of current residents will be conducted by Nursing Management Team x 3 months and any newly identified skin issues addressed per facility process.</p> <p>Interdisciplinary Team Rounds will be conducted weekly for identified residents with pressure ulcers beginning 2/20/13</p> <p>Director of Nursing to review, validate, track and trend reviews and present in PI (Performance Improvement Committee) monthly x 3 months.</p> <p>5) Director of Nursing</p> <p>02/20/2013</p>	
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F 309	<p>Continued From page 3</p> <p>excoriated and macerated due to the pressure and friction from his brief and irritation from his urinary and bowel incontinence. The open area on his right upper thigh/groin measured 11 centimeter (cm) by 5 cm in size and its wound base contained granulation tissue measuring 5.5 cm by 0.8 cm in size. The LN stated that the granulation tissue was "eschar". Another pressure sore area was noted along his brief line which measured 4.3 cm by 1cm in size and contained 50% slough in its wound base. The periwound areas of both open areas were tender. When the NAs wiped the areas, the Resident stated it was "painful".</p> <p>During this skin assessment with LN A, two new open pressure sores were identified along the brief line on the right ischial area of his right buttock where the brief compressed against his skin. One pressure sore measured 2cm by 1 cm in size and the other sore measured 1cm by 1cm in size. The wound bases contained granulated tissue. His left inguinal area had an open area which measured 10cm by 0.1cm and the wound base was red granulated tissue.</p> <p>His scrotal area had two open sores. One area measured 2.4cm by 2.3 cm in size with 50 % slough in the wound bed. The other open area on his scrotum was the size of a dime and had a red wound base.</p> <p>After the LN applied medicated creams to these open areas, the NACs were unable to properly secure his brief. The brief was ill fitting and the elastic portion of his brief was in direct contact with the open areas on his upper thigh/groin area and ischial region. The brief exerted pressure and</p>	F 309		
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irritation along the skin areas of his inner thigh area and along the ischial areas of the buttocks where the open pressure sores were located.

Review of the Treatment Administration Record (TAR) for December 2012 indicated that the LNs were to apply an antifungal cream twice a day to "skin folds and buttocks area, and D/C (discontinue) diaper when in bed to decrease skin breakdown". In addition to the twice a day application of an antifungal cream, the LNs were to apply nystatin ointment twice a day to the groin which was started on 12/3/12.

Review of the TAR for January 2013 revealed the LNs were to perform weekly skin assessments. The January 2013 TAR revealed no skin assessment had been documented for 1/21/13.

The January 2013 TAR also read: " cleanse scrotum area, put pillow case underneath scrotum area to heal skin tear. Apply barrier cream around it. Change pillow case each time patient is soiled or as needed (PRN). Due to the skin tear on the scrotum , the LNs were to apply barrier cream for every shift.

During an interview on 2/1/13 at 12:25 p.m. NAC(NAC F) stated the skin breakdown on his right upper groin area was present last week and had informed the LN. She stated she also reported the open area "yesterday" to the LN. NAC F stated the LN "gave her cream to put on the opened area from the medication cart. The NAC stated she was not aware the resident's brief was to remain off when he was in bed and had not applied pillow cases under his scrotum as she felt it "was not appropriate".

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F 309	Continued From page 5	F 309		
<p>During an interview on 2/1/13 at noon, the Resident Care Manager (RCMA) stated that according to the resident's treatment plan of care, the LNs were to apply two different creams twice a day, an antifungal cream and nystatin. RCM A stated the facility's policy for skin prevention was to have NACs apply a cream "Remedy" after each incontinent episode. She verified there was no documentation to inform the NACs that Resident 1 was not to use a incontinent brief when he was in bed.</p>				
<p>Review of the facility's "Skin Condition Documentation Form", dated 1/30/13, documented he had a skin tear on his scrotum which measured 3cm by 2cm in size and had a small amount of exudate. The wound base was documented to have 75% slough, was painful and the surrounding skin had erythema and was tender. Another "Skin Condition Documentation Form", dated 1/31/13, documented the resident had excoriation on his scrotum. The excoriated area was measured as 0.5 cm by 0.5 cm in size.</p>				
<p>The nursing notes, dated 1/30/13, documented the resident had a skin tears on the scrotum. Another entry documented he had multiple wounds. Another entry for 1/30/13 read: "scrotal blister x1 =2x3 cm and R (right) thigh x1 3 by 3 cm. The following day, the entry for 1/31/13, read R thigh x1= 2 by 2 cm. this AM sites scabbed over".</p>				
<p>Even though the Nursing Assistant had informed the LN regarding the open area on his groin, there was no documentation on a "Skin Condition Documentation Form" to monitor the open areas.</p>				

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F 309 . Continued From page 6

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Even though the LNs were applying routine creams twice a day, the open area was not recognized until the surveyor assessed the resident's skin with LN on 2/1/13. During the time, the open area on his inner thigh/groin measured 11cm by 5 cm in size which was painful for the resident and newly identified areas on his ischial area were noted and his open areas on his scrotum contained slough.

RESIDENT 2:

Resident 2 was admitted to the facility on [redacted] with a [redacted] disease. The resident lacked [redacted] and was dependent on staff all her care needs.

Resident 2 was identified to be at risk for skin breakdown due to her immobility and to keep pressure off her ear, to prevent the re-development of the pressure sore. The staff were to place a supportive neck pillow around her neck to keep pressure off her ears. The staff was to observe every shift for sign and symptoms of skin breakdown, redness/discoloration or O/A (open area).

Observation on 2/1/13 throughout the day, the resident was observed in bed with the head of her bed elevated. There was no supportive pillow around her neck to relieve the re-developed pressure sore on the outer area of her left ear.

On 1/29/13, the Director of Nursing (DNS) stated the pressure area on Resident 2's ear was from the pressure and irritation from her glasses.

On 2/1/13 at approximately at 2:55 p.m., LN D

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IDENTIFICATION NUMBER:

505491

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____
B. WING _____

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02/01/2013

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EVERETT, WA 98204

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Continued From page 7
was asked about the supportive neck pillow. The
pressure relief pillow was not in place and her
neck pillow was located in the bottom of her
closet which was soiled without a pillow case. The
re-developed pressure sore on her left ear was
on the outer aspect of the ear. When the
resident's glasses were put on the Resident, the
hard ware of her glasses did not rest against her
ear.

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Review of the facility's "Pressure Ulcer
documentation Form", the pressure sore on the
left ear was assessed on 1/14/13 as Stage 2
Pressure Sore (Stage 2- partial thickness skin
loss involving epidermis. The ulcer is superficial
and presents clinically as an abrasion, blister, or
shallow crater) with maceration. It measured
1cm by 1cm in size and by 1/26/13 the pressure
sore contained slough.

Interivew on 2/1/13 with the Resident Care
Manager (RCM T) stated the resident's pressure
sore developed in 2011 and the plan of care was
to reposition the resident and to use a pillow to
relief pressure on her ear.

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