

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

PRINTED: 11/26/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505510	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/19/2013
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NAME OF PROVIDER OR SUPPLIER AVALON CARE CENTER - FEDERAL WAY	STREET ADDRESS, CITY, STATE, ZIP CODE 135 SOUTH 336TH STREET FEDERAL WAY, WA 98003
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Avalon Care Center Federal Way on 11/19/13. The sample of four residents was based on a census of 110.</p> <p>The following complaint was investigated as part of this survey:</p> <p>#2908991</p> <p>The survey was conducted by:</p> <p>Susan Loewen, MSN, RN Complaint Investigator</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, District 2, Unit F 20425 72nd Avenue South, Suite 400 Kent, WA 98032-2388</p> <p>Telephone: (253) 234-6039 Facsimile: (253) 395-5070</p> <p><i>Mike Anbesse</i> 11-26-13 Residential Care Services Date</p>	F 000	<p>RECEIVED NOV 22 2013 DSHS/ADSA/RCS Region 4</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Sandra Wilkinson* TITLE Administrator DATE 12-09-13

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.

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F 323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to supervise direct care staff in the administration of hot packs to one of four Residents (#1) reviewed for implementation of care and services. This failure caused Resident #1 to experience second degree burns to the left lateral/posterior buttock area and placed the resident at risk for infection.</p> <p>Findings included:</p> <p>According to the 10/25/13 Minimum Data Set, Resident #1 had impaired decision-making, continuously experienced disorganized or incoherent thinking, required two person extensive assistance for activities of daily living including bed mobility and toileting, had a diagnosis of hemiplegia following a stroke, was at risk for skin issues and had an unstageable pressure ulcer to the buttock area.</p> <p>According to the facility's 11/08/13 evidence of investigation, Resident #1 asked Staff C, a Licensed Nurse, for hot packs to relieve pain in the area of a stage four pressure ulcer. Staff C instructed Staff D and E, Nursing Assistants, to</p>	F 323	<p>DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction does not constitute admission of, or agreement with, the facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of federal law.</p> <p style="text-align: center;">RECEIVED DEC 12 2013 DSHS/ADSARCS Region 4</p>	
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F 323	<p>Continued From page 2</p> <p>administer the hot packs to Resident #1. According to a statement dated 11/13/13, when Staff D and E asked Staff C for assistance, Staff C explained how the hot pack functioned and expected Staff D and E to administer the hot packs to Resident #1's buttocks. Staff documented in the investigation Staff C did not instruct Staff D or E how the instant hot packs should be administered or that they should be removed after 20 minutes. According to Staff B (Director of Nursing), Staff D and E applied the instant hot packs directly to Resident #1's skin at approximately 2:30 a.m. on 11/08/13. Ten and one half hours later that day (1:00 p.m.) staff observed Resident #1 with blisters to the left lateral/posterior thigh/buttocks and hot packs "twisted" up in the linens. Clearly the hot packs were applied for greater than the prescribed 20 minutes.</p> <p>According to Staff B, interviewed on 11/19/13 at 1:15 p.m., there was a physician's order instructing Nursing Staff to administer hot packs to Resident #1. Staff B said Resident #1 had decreased sensation as the result of a stroke and suffered from hemiplegia on the side affected by the burns.</p> <p>According to Physician's Orders dated 01/13/13, staff were instructed to apply, "one hot pack for twenty min(utes) every four hours as needed for discomfort. DO NOT APPLY DIRECTLY TO SKIN." Facility staff did not follow the 20 minute direction, and applied the hot packs directly to the resident's skin, in direct conflict with Physician ordered direction. According to the fifth edition of Nurses' Guide to Clinical Procedures, physician prescribed treatments are to be administered as written and by Nursing Staff.</p>	F 323	<p>F 323</p> <p>Use of hot packs discontinued facility wide on 11/08/13. Burn treated according to physician orders. Resident educated on 11/08 as to why hot packs would not be utilized going forward. Alternate comfort measures implemented.</p> <p>Licensed nurse suspended on 11/08 pending complete investigation, then terminated and reported to Nursing Board. Nursing Board closed case with no follow up necessary.</p> <p>Licensed nurses in-serviced on proper delegation guidelines on 11/11/13.</p> <p>Nursing assistants in-serviced on proper delegation guidelines on 11/11/13.</p> <p>Staff Development Coordinator to include delegation protocols monthly for 3 months. CQI Team to review and determine frequency at that point.</p>	
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F 323	<p>Continued From page 3</p> <p>According to investigation documents dated 11/08/13, staff were aware the resident sustained burns related to the inappropriate application of hot packs and notified the physician. The Advanced Registered Nurse Practitioner (ARNP) note dated 11/26/13 indicated second degree burn wound is slow to heal as a result of multiple factors.</p> <p>Weekly skin round documents dated 11/13/13, five days after identification of the burns, indicated Resident #1 was monitored for two second degree burns to the left thigh measuring "5x3 (centimeters- cms)" and "4 x2 (cms)."</p> <p>According to wound tracking documents dated 11/19/13, staff assessed the first burn as, "5.0 x 3.0(cm)" with a 0.2 cm depth, having moderate serosanguinous drainage and 80% granulation. The second burn was assessed as 4 x 2 cm with a 0.1 cm depth., also having moderate drainage and 80% granulation.</p> <p>Resident #1 was observed on 11/19/13 at 1:55 p.m. receiving personal care following toileting. The resident said of the incident, "(They) laid it (instant hot pack) right on the skin, if you don't lay it (instant hot pack) on the skin it will be all right."</p> <p>Two open wounds were observed on the resident's left later/posterior buttock area. Staff H, interviewed on 11/19/13 at 1:55 p.m., described the wounds as "second degree burns."</p> <p>According to investigative documents dated 11/13/13, "physician orders cannot be delegated to the NACs (Nursing Aides Certified)." Staff C failed to recognize the administration of hot packs as a potential hazard to a resident with decreased cognition and decreased skin sensation and</p>	F 323	<p>F 323 Continued</p> <p>New hire packets for nursing personnel to include written acknowledgement of delegation protocols. CQI Team to monitor routinely.</p> <p>DNS responsible for ensuring compliance.</p> <p>Administrator and CQI Team to ensure continued compliance.</p> <p>Corrected action implemented November 12, 2013</p>	
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F 323	Continued From page 4 paralysis to the left side. Further, once delegating this task, Staff C did not provide direct care staff necessary supervision in the administration and removal of the hot packs. At no time during the application of these hot packs did staff monitor their effectiveness. These failures resulted in Resident #1 sustaining multiple second degree burns.	F 323		
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