

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

PRINTED: 03/27/2013
FORM APPROVED
OMB NO. 0938-0391

1362

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505126	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/18/2013
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NAME OF PROVIDER OR SUPPLIER AVALON HEALTH & REHABILITATION CENTER - PASCO	STREET ADDRESS, CITY, STATE, ZIP CODE 2004 N 22ND AVENUE PASCO, WA 99301
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Avalon Health & Rehabilitation Center - Pasco on 03/18/2013. A sample of 6 residents was selected from a census of 66 residents. The sample included 4 current residents and the records of 2 former/discharged residents.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#2763154 #2758655 #2753743</p> <p>The survey was conducted by: ██████████, R.N.</p> <p>The survey team is from: Department of Social & Health Services Aging and Long-Term Support Administration Residential Care Services, District 1, Unit C 3611 River Road, Suite 200 Yakima, Washington 98902</p> <p>Telephone (509) 225-2800 Fax: (509) 574-5597</p> <p><i>[Signature]</i> 3/26/13 Residential Care Services Date</p> <p>F 157 SS=D</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an</p>	F 000	<p>Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against Facility, of the Executive Director or any employees, agents, or other individuals who draft or may be discussed in this response. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the Facility of the truth, of any facts alleged or correctness of any conclusions set forth in the allegation by the survey agency.</p> <p>Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal, which may be filed solely because of the requirements under State and Federal law that mandate submission of the Plan of Correction with ten (10) days of the survey as a condition to participate in Title 18 and 19 programs.</p> <p>The submission of the Plan of Correction within this time frame should in no way be considered or construed as an agreement with the allegations of non-compliance or admissions by the Facility. This Plan of Correction is submitted as the Facility's credible allegation of compliance.</p>	F 157
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 3/28/13
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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 157	<p>Continued From page 1</p> <p>accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to notify in a timely manner the legal representative for 1 of 4 sampled residents (#1) reviewed who was having significant changes in condition. This failed practice prevented timely informed decision making. Findings include: Resident #1: Admitted to the facility with poor</p>	F 157	<p>F - 157</p> <p>Resident #1 no longer resides in the facility.</p> <p>The facility conducted a review of the residents to ensure proper notification occurred involving residents who may have experienced a change in condition. Proper notification was made for discrepancies noted.</p> <p>Licensed Nurses have been re-educated to the facility guideline of proper notification. Laminated information sheets of "when to call" have been developed and placed at each nursing station for Licensed Nurses to refer to.</p> <p>The Director of Nursing Services has developed a new monitoring system called the "Monitoring for Acute Condition Change (MACC)" meeting to ensure residents with changes of condition are monitored for proper notification.</p> <p>The Director of Nursing Services will ensure compliance through the use of the Monitoring for Acute Condition Change, Licensed Nurse charting, and the 24-hour report. Trends will be noted and addressed at the facility Quality Assurance meeting.</p>	<p>3/25/13 3/25/13</p>	

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F 157	<p>Continued From page 2</p> <p>circulation with [REDACTED] and [REDACTED]. Review of the resident's medical record revealed no evidence the resident's legal representative was notified of the following significant changes in the resident's condition:</p> <ol style="list-style-type: none"> 1) On 9/27/12 pressure ulcers were noted to the third and fourth digits of the resident's [REDACTED] foot and the second digit of his [REDACTED] foot. By 10/4/12 the second digit of his [REDACTED] foot had worsened in size and all three digits were noted with dry, brown eschar (dead tissue). 2) An antibiotic was ordered on 10/12/12 to be administered intravenously to the resident for 10 days for an infection to the [REDACTED] foot. 3) On 11/24/12 the resident was transferred to the Emergency Room due to trauma to his [REDACTED]. 4) On 12/5/12 two stage II pressure ulcers (partial thickness skin loss - presents clinically as an abrasion, blister, or shallow crater) developed on the resident's buttocks. 5) On 12/24/12 the resident's abdomen was hard, distended, and tender to the touch. He was restless and moaning in pain. He was catheterized at that time with 2000 cc's (cubic centimeters) urine obtained. Physician's orders were obtained to insert an [REDACTED] retention [REDACTED]. 6) On 12/28/12 antibiotic therapy was ordered to treat the resident's [REDACTED]. 7) On 2/1/13 documentation noted the resident's third toe on the left foot was [REDACTED] ([REDACTED]). 	F 157		

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F 157 Continued From page 3
 (b) and blue - antibiotic therapy was initiated.
 8) On 2/18/13 antibiotic therapy ordered for 10 days to treat a pressure ulcer to the resident's (b) x area.
 9) Resident sent to the podiatrist on 2/21/13 for a wound consult regarding his feet. The podiatrist called the resident's legal representative following the exam regarding the possibility of an (b) secondary to (b) and the red striping up the leg.
 A telephone interview on 3/26/13 at 6:00 p.m. with the resident's legal representative revealed he had not been informed of significant changes in the resident's condition such as the development of pressure ulcers, the progression of deterioration in the resident's toe condition and infections. He stated he was unaware the resident had gone to the podiatrist on 2/21/13 until the podiatrist called him later that day following the resident's exam. He had not had communication with the facility and was "shocked" when the podiatrist reported the resident was "in a bad way."

F 157

F 312 483.25(a)(3) ADL CARE PROVIDED FOR SS=D DEPENDENT RESIDENTS

F 312

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced

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F 312	<p>Continued From page 4</p> <p>by: Based on record review and interviews the facility failed to ensure personal hygiene/grooming was provided in accordance with the plans of care for 3 of 6 residents (#'s 2,3,4) dependent on staff for assistance with activities of daily living. This failed practice placed residents at risk for physical discomfort and loss of dignity. Findings include:</p> <p>Resident #2: Admitted to the facility with diagnoses which included [REDACTED]. Review of the resident's medical record and facility investigation report revealed on 2/8/13 at approximately 5:30 a.m. Staff Member A (Licensed Nurse) noted a strong urine odor. The resident's brief was saturated with urine. The resident was awake and stated he did not remember being changed. His drawsheet and bottom sheet were also saturated with urine. The bottom sheet had a brown outer ring of dry urine. Upon assessment by the above LN redness was noted to his [REDACTED].</p> <p>Review of the resident's plan of care noted staff was to provide extensive assistance with perineal care due to his incontinency. Nursing approaches were to check his briefs every 1-2 hours and provide perineal care with moisture barrier cream.</p> <p>Resident #3: Admitted to the facility with diagnoses which included [REDACTED]. Review of a facility investigation report and the resident's medical record revealed on 2/8/13 at approximately 5:30 a.m. Staff Member A (Licensed Nurse) upon entering the resident's room noted a strong smell of urine. The resident</p>	F 312	<p>F - 312</p> <p>Monitoring and treatment of Resident #2 and #3's skin continues. No skin breakdown has occurred. Resident #4 no longer resides in the facility.</p> <p>Staff member B and D were terminated from employment. Staff member C has been reprimanded to the proper supervisory role related to providing necessary services for the residents.</p> <p>Facility management conduct focused rounds to review necessary services are provided. Ongoing Skills Checks are conducted for employees upon hire and periodically thereafter for Certified Nursing Assistants and Licensed Nurses to continually educate employees on providing necessary services. Resident Abaqis interviews and Observations are conducted upon resident admission and quarterly thereafter to identify issues related to necessary services and dignity.</p> <p>Unit Managers will monitor for compliance through facility rounds.</p> <p>Unit Managers will report issues of non-compliance to the Director of Nursing Services who will ensure compliance through further education, and / or employee counseling. The Administrator and the Director of Nursing Services will compile any</p>	<p>3/25/13 3/25/13</p>
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F 312	<p>Continued From page 5</p> <p>stated "I'm wet, I've been wet for awhile". Upon assessment by Staff Member A the resident's brief, bottom sheet, and draw sheet were saturated with urine. In addition, there was a brown ring of dry urine on the sheets. A skin assessment performed at that time revealed redness to the resident's [REDACTED]</p> <p>Review of the resident's plan of care revealed he was incontinent of bowel and bladder and required maximum assistance from staff. Nursing approaches were to provide incontinent care after incontinent episodes as needed.</p> <p>The Nursing Assistant (Staff Member B) assigned to care for Resident #'s 2 and 3 during the above night shift had been observed "nodding off" while seated at the nursing station just prior to Staff Member A entering the residents' rooms. The investigation concluded there was reasonable evidence to support the NA had not rendered care during her shift to either resident.</p> <p>An interview on 3/18/13 at 4:15 p.m. with Staff Member A revealed that from what he could tell by his assessment the skin redness observed on 2/8/13 was due to the residents' not receiving care by Staff Member B during her shift.</p> <p>Resident #4: Admitted to the facility with diagnoses which included [REDACTED] and [REDACTED] (full thickness [REDACTED] - presents as a [REDACTED]) to the [REDACTED]. Review of a facility investigation report revealed on 2/17/13 at 2:30 p.m. Staff Member C (Licensed Nurse) had entered the resident's room and noted he was soiled with feces. She informed Staff Member D (assigned Nursing Assistant) the resident</p>	F 312	<p>F - 312 Continues:</p> <p>trends noted from focused rounds and Abaqis tracking to review and establish action plans for trends noted during the Quality Assurance meeting.</p>	<p>3/25/13 3/25/13</p>

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F 312	<p>Continued From page 6</p> <p>required perineal care. Staff Member C reentered the resident's room at approximately 6:00 p.m. and noted he continued to be soiled with feces. She again approached Staff Member D and instructed her to provide care to which she responded she would. Two hours later at 8:00 p.m. Staff Member C checked on the resident and noted he still had not received perineal care. She went out to the smoking area to get Staff Member D and brought her in to provide care at which time it was rendered (5.5-6 hours later). The investigation noted that when Staff Member D was instructed to provide care to the resident following dinner she stated, "I was spaced out and forgot".</p> <p>During a telephone interview on 3/21/13 at 2:30 p.m. with Staff Member C, she stated she initially had informed Staff Member D at 2:30 p.m. on 2/8/13 the resident was soiled with feces to which she replied she would take care of it. At 6:00 p.m. when she went to the resident's room to administer medications she noted he still had not been cared for. She informed Staff Member D of the problem and she stated she had forgot and would do it right then. Staff Member D stated she observed Staff Member D going into the resident's room. When she had to reapproach Staff Member D at approximately 8:30 p.m. she asked if she had given care to the resident to which she responded, "no."</p> <p>Review of the resident's plan of care noted he required extensive assistance by staff with care, and was incontinent of bowel and bladder.</p>	F 312			