

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

PRINTED: 10/11/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505154	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/04/2012
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NAME OF PROVIDER OR SUPPLIER REGENCY AT TACOMA REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2102 SOUTH 96TH STREET TACOMA, WA 98444
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Standard Survey conducted onsite at Regency at Tacoma on 9/25, 9/26 & 10/04/2012. The sample included 18 residents out of a census of 91. The sample included 11 current residents and the records of 7 former residents.</p> <p>The following are complaints investigated as part of this survey:</p> <p>#2664845</p> <p>The survey was conducted by:</p> <p>Donna J. DeVore, R.N., MSN</p> <p>The surveyor is from:</p> <p>Department of Social and Health Services Aging and Disability Services Administration Residential Care Services, District 3, Unit B 1949 S. State Street Tacoma, WA 98405-2850</p> <p>Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p><i>Linda Boniquez</i> 10/11/12 Residential Care Services Date</p>	F 000	<p>RECEIVED</p> <p>OCT 26 REC'D</p> <p>DGHS - ADISA RCS - REGION 5</p>	11/6/12
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 10/26/12
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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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NAME OF PROVIDER OR SUPPLIER TACOMA NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2102 SOUTH 96TH STREET TACOMA, WA 98444		
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F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop a comprehensive care plan for 2 of 4 residents (former Resident #2 & current Resident #11) that had [REDACTED] and for 1 of 3 residents (former Resident #2) admitted with a [REDACTED]</p> <p>Failure to develop a care plan placed the residents at risk for unmet care needs related to [REDACTED] and potential infection [REDACTED]</p>	F 279		

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F 279	<p>Continued From page 2</p> <p>Findings include:</p> <p>1. Record review revealed Former Resident #2 was admitted during [REDACTED] with multiple medical diagnoses including [REDACTED]</p> <p>Review of a nursing admission skin assessment dated 9/12/12 revealed a dressing was noted on the resident's left upper chest [REDACTED]</p> <p>Review of the resident's interim care plan developed on admission on [REDACTED] revealed no evidence of a care plan/interventions to monitor the resident's [REDACTED] and/or [REDACTED]</p> <p>On 10/4/12 at 8:20 a.m., interview with Staff A (director of nursing) revealed the admitting nurse was responsible for developing a care plan for newly admitted residents. The facility's interim care plan format included interventions for care and monitoring [REDACTED] and for [REDACTED] under skin integrity.</p> <p>Further record review revealed Resident #2 had a change of condition requiring transfer to the hospital on [REDACTED]. Review of the resident's hospital record revealed there were no complications noted from the lack of monitoring of the resident's [REDACTED] or [REDACTED]</p> <p>2. Expanded review of current residents in the facility [REDACTED] revealed Resident #11 admitted to the facility during [REDACTED] with diagnoses that included [REDACTED]</p> <p>Review of the record with Staff C (care manager)</p>	F 279	<p>Licensed Nurses were inserviced on their responsibility to inspect any skin beneath a dressing, splint/brace or any other device, where the skin cannot be easily visualized, unless specifically ordered to not do so, and to update the resident's care plan for ongoing monitoring/treatment as ordered.</p> <p>The admission review process has been revised to include a focused review of the resident's admission assessment and care plan to ensure pacemakers and surgical incisions are documented and ongoing monitoring/treatment is in place as ordered.</p> <p><u>On Going Compliance</u></p> <p>The care plans for new residents admitted with a pacemaker and/or surgical incision will be audited to ensure ongoing monitoring/treatment is occurring as ordered. Audit will be conducted monthly x 3, and then randomly x 3 months.</p> <p>Results will be trended and reported at monthly QA meeting.</p> <p><u>To Ensure Compliance</u></p> <p>DNS or Designee</p> <p>11/6/12</p>

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F 279	Continued From page 3 revealed there was no care plan for monitoring of the resident's [REDACTED] until 10/4/12 at which time Staff C revised the care plan to include the [REDACTED]. Staff C informed the investigator it was not in place prior to this date; Staff C stated she called a cardiologist on this date to set up an appointment for [REDACTED] function check scheduled for [REDACTED]. There was no evidence Resident #11 had [REDACTED] function check documented since admission. During exit interview at 3:30 p.m., Staff A was informed about the above record review and staff interview.	F 279		11/6/12
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide evidence of care plan revision to prevent pressure ulcers for 1 of 3 residents (Former Resident #1) reviewed for current and/or resolved pressure ulcers. The facility failed to provide evidence of updating/revising interventions for risk factors	F 314	<p><u>Immediate action for cited Residents</u></p> <p>Resident #1 is no longer in the facility.</p> <p>Resident #17 was immediately assisted to bed by staff for pressure relief.</p> <p><u>Residents in Similar Situations</u></p> <p>All current residents with pressure ulcers were assessed and interventions for risk factors or contributing factors were updated or revised as needed.</p>	

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F 314	<p>Continued From page 4 (non-compliance and bed mobility) identified as contributing factors to development of unavoidable pressure ulcers on Resident #1 's heel and coccyx.</p> <p>The facility also failed to ensure a care plan was followed related to priority laydown for pressure relief for 1 of 3 residents reviewed for recurrent pressure ulcers (Resident #17).</p> <p>This failure placed both residents #1 and #17 at high risk to develop pressure ulcers.</p> <p>Findings include:</p> <p>1. Record review revealed former Resident #1 admitted during [REDACTED] with multiple diagnoses including [REDACTED]</p> <p>Review of the record revealed on 7/23/12 an intact blister measuring 2.8 centimeters (cm) by 1.2 cm was noted on the resident's left heel. Treatment with foam and gauze wrap was started. Review of nursing progress notes dated 7/23/12 at 9:45 p.m. revealed the resident was offered heel protectors; however, the resident refused at that time.</p> <p>Review of the record revealed Resident #1 went to the emergency room on [REDACTED]. Review of the emergency room record revealed a 0.2 by 0.1 by 0.1 cm Stage II pressure ulcer was noted on the resident's coccyx while in the emergency room. The facility was notified upon the resident's return; medical treatment was initiated and an air mattress was obtained for the resident's bed.</p>	F 314	<p><u>System Measures</u></p> <p>Current residents with pressure ulcers will be reviewed weekly on skin team rounds for risk factors or contributing factors with documentation of updates/revision of interventions as needed.</p> <p>Current residents identified as a priority laydown due to pressure ulcers or high risk of developing pressure ulcers were reviewed and nursing staff inserviced on the necessity to follow the plan of care.</p> <p><u>On Going Compliance</u></p> <p>Random audits monthly x 3 of residents with pressure ulcers and who are a priority laydown to ensure risk factors, contributing factors are updated/ revised and plans of care are followed.</p> <p>Results will be trended and reported at monthly QA meeting.</p> <p><u>To Ensure Compliance</u></p> <p>DNS or Designee</p>	10/6/12
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F 314	<p>Continued From page 5</p> <p>Review of the facility's assessment of the resident's heel and coccyx pressure ulcers dated 8/1/12 revealed the facility assessed the pressure ulcers as unavoidable due to the resident having multiple risk factors including significant weight loss prior to admission, low protein and iron levels and changes in medical condition during her stay in the facility.</p> <p>The facility's assessment also documented the resident's non-compliance with turning side to side and observations by staff of the resident propping herself on her elbows to slide up in bed, using her right foot to push off and drag her left leg/heel.</p> <p>Review of the resident's care plan related to pressure ulcers dated 7/27/12 did not provide evidence the facility had interventions in place that addressed educating the resident and staff about bed mobility methods to diminish shearing on the resident's heel and coccyx and/or the risks associated with not turning and repositioning to provide pressure relief.</p> <p>During exit interview on 10/4/12 at approximately 3:30 p.m. Staff A (director of nursing) confirmed the above information as documented in the facility's pressure ulcer assessment and the resident's care plan.</p> <p>2. Record review revealed Resident #17 was admitted to the facility during [REDACTED]. The resident had a history of recurrent pressure ulcers to both hips dating back to 8/2011. The facility's assessment identified multiple risk factors for pressure ulcer development including [REDACTED].</p>	F 314		11/6/12
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F 314	<p>Continued From page 6</p>  <p>On 10/4/12 at 10:05 a.m., Resident #17 was observed in the main dining room for an activity (Bible study). The resident was positioned in a wheel chair tilted back approximately 45 degrees.</p> <p>Observations of the resident's room revealed an air mattress was in place on the resident's bed with a sign above the resident's bed "turn every hour".</p> <p>Interview with Staff E (certified nursing assistant assigned to care for Resident #17) at approximately 10:15 a.m. revealed she was knowledgeable about the resident's care plan that included, in part, turning and repositioning every hour and priority lay down after meals.</p> <p>At 11:12 a.m. Resident #17 was observed being wheeled out of the dining room to an area in the hallway outside of the resident's room. Staff E stated the nurse was going to give the resident her medications, and then Staff E was going to return the resident to bed.</p> <p>Staff E confirmed she took the resident to the dining room that morning around 8:00 a.m. for breakfast. The resident remained in the dining room after breakfast for the activity. Staff E stated she did not follow the care directive for priority laydown after meals because the resident was in the activity after breakfast. Observations and staff interview revealed Resident #17 was in the tilted wheel chair in the dining room for approximately 3 and one half hours.</p>	F 314		11/6/12
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F 314	<p>Continued From page 7</p> <p>At 11:25 a.m., Staff E and another nursing assistant transferred Resident #17 to bed using a Hoyer lift. The resident was observed to be incontinent of a moderate amount of urine. Observations of the resident's back and buttocks with Staff C (care manager) revealed an area of blanchable redness on the right sacral area measuring approximately 4 cm by 2 cm and blanchable redness across the resident's upper buttocks approximately 8 cm by 2 cm.</p> <p>During exit interview at approximately 3:30 p.m. on 10/4/12, Staff A was informed about the above observations. Resident #17's care plan for pressure relief related to priority lay down was not followed which placed the resident at risk for further skin breakdown.</p>	F 314		11/6/12