

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

PRINTED: 07/01/2013
FORM APPROVED
OMB NO. 0938-0391

1377

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 06/21/2013
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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 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Standard Survey conducted onsite at Tacoma Nursing and Rehab Center on 6/12 & 6/21/2013. The sample included 7 residents out of a census of 105. The sample included 7 current residents.</p> <p>The following are complaints investigated as part of this survey:</p> <p>#2817555 #2818574 #2817677</p> <p>The survey was conducted by: [REDACTED] RN, MSN</p> <p>The surveyor is from: Department of Social and Health Services Aging and Long-Term Support Administration Division of Residential Care Services District 3, Unit B 1949 S. State Street Tacoma, WA 98405-2850 Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p><i>Dina Bengen-Chime</i> 7/1/13 Residential Care Services Date</p>	F 000	<p>“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Tacoma Nursing and 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.”</p> <p style="text-align: right;">RECEIVED JUL 10 REC'D DSHS - ADSA RCS - REGION 5</p>	7/22/13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 7/10/13
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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 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and interview, the facility failed to provide necessary care and services related to assessment and monitoring of non-pressure skin conditions for 3 of 6 residents (#s 1, 4 & 5) reviewed for assessment and monitoring of non-pressure related skin conditions identified on admission to the facility.</p> <p>This placed residents at risk for lack of timely and accurate assessment and monitoring of skin conditions in which the facility would not be able to determine if the areas were healing or worsening and/or would not have an assessment for comparison if a new bruise or alleged new bruise occurred in the same area.</p> <p>Findings include:</p> <p>1. Record review revealed Resident #1 admitted to the facility during 7/2013 with multiple medical diagnoses and alterations in skin condition.</p> <p>Review of an admission skin assessment dated 4/25/13 documented on facility form "Skin Grid</p>	F 309	<p>F309</p> <p>Resident #1 has been discharged from the facility.</p> <p>Residents in facility, including residents #4 and #5, have received a full body, skin check to identify, assess and monitor any non-pressure skin conditions.</p> <p>LN's were re-educated on proper use of current non-pressure assessment tool to assure documentation, assessment and monitoring of non-pressure related skin conditions.</p> <p>A skin check audit tool has been developed to routinely audit treatment administration records to ensure documentation, assessment and monitoring of non-pressure related skin conditions.</p> <p>Progress and trends of audits will be reported during monthly QAPI meeting.</p> <p>DNS to ensure compliance.</p>	7/22/13

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F 309	<p>Continued From page 2</p> <p>for All "Other" Skin Problems" (skin flow sheet) revealed the resident admitted to the facility with the following skin conditions: 12.5 x 5.5 centimeter (cm) and 2.5 x 4.7 cm yellow, red, purple (YRP) bruises left antecubital (front of elbow); 2 x .1 cm and 2 x .3 cm red area right antecubital; 1.7 x 2.6 cm scab on left forearm; multiple scabs left mid arm above antecubital, 2.9 x 1.8 cm, 0.5 x 0.9 cm, and 0.3 x 0.5 cm; 22.5 x 10 cm, YRP bruise right forearm; 7.7 x 9.5 cm YRP bruise back of left hand; 9 x 8.5 cm YRP bruise back of right hand; 7 x 4.5 cm YRP bruise left armpit/axilla area; 3.7 x 7 cm YRP bruise right upper arm; 7.5 x 1 cm red area right upper fold below axilla.</p> <p>Review of the above skin flow sheets dated 4/25/13 revealed no further documentation of the description of the bruises/red areas noted on admission.</p> <p>Review of Resident #1's treatment records (TAR) dated 5/2013 and 6/2013 revealed orders for weekly monitoring and documentation of the bruises/red areas documented on admission. Weekly documentation showed the initial of the licensed nurse that completed the skin check. There was no description of the bruises/red areas to determine if there was improvement, worsening and/or resolution of the skin conditions.</p> <p>Review of a facility investigation dated 5/26/13 revealed Resident #1 alleged a staff beat her on the right chest and she sustained a bruise to her right chest and left arm. Further review revealed on 5/27/13, the resident alleged the injury/bruise was on her left chest. Review of nursing progress</p>	F 309		7/22/13

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F 309	<p>Continued From page 3</p> <p>notes dated 5/27/13 revealed Staff G documented "Resident noted bruise to left upper axilla and stated that was where he beat me". Staff G documented she again assessed the resident's upper chest and right arm and noted no red marks or no bruising noted. Staff G noted review of Resident #1's record revealed she admitted to the facility with a bruise to her upper left axilla.</p> <p>During telephone interview on 6/24/13 at 10:45 a.m., Staff G stated she saw in the record that the resident admitted with a bruise to the area in which she alleged being injured. Staff G stated she did not know if the bruise was being monitored at that time. Staff G stated she could not recall the size of the bruise but stated it was purple with fading green and yellow and it was in the same place as the bruise documented on admission.</p> <p>Staff G confirmed there was no description of the bruise in the record at that time to use for comparison except for the documentation on the date of admission 4/25/13, approximately four weeks earlier.</p> <p>During survey, Resident #1 was interviewed at 11:00 a.m. on 6/21/13 at which time there was no bruising noted on the resident's left upper axilla/lateral chest which was the location the resident pointed to during the interview. Review of the resident's TAR dated 6/2013 showed documentation the bruise resolved on 6/13/13.</p> <p>2. Record review revealed Resident #4 admitted to the facility during 2013 with multiple medical diagnoses including alterations in skin condition.</p>	F 309		7/22/13	

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F 309	<p>Continued From page 4</p> <p>Review of Resident #4's nursing admission assessment dated 4/12/13 revealed the resident admitted with the following skin conditions: 3.5 x 4.5 cm and 1.5 x 1.5 bruises right forearm; 2 x .3 cm chest scratch, 6 x 4 cm and 2.5 x 1.5 cm bruises right forearm; 5.5 x 7.5 cm left hand bruise; skin tear 1 x .5 cm right shoulder blade; 1 x .5 cm bruise right groin.</p> <p>Review of skin flow sheets dated 4/12/13 revealed the two bruises on the resident's left forearm were described and documented. Skin flow sheets for the remaining areas as above were not available in the record and were not provided when additional information was requested from facility administrative staff.</p> <p>Review of Resident #4's TARs dated 4/2013 and 5/2013 did not reveal assessment/description of the areas including the chest, right arm, left hand, shoulder blade and right groin; documentation was limited to the licensed nurse's initial for the weekly skin checks.</p> <p>Record review revealed Resident #5 admitted to the facility during 2013 with multiple medical diagnoses including alterations in skin condition.</p> <p>3. Review of facility skin flow sheets dated 4/16/13 revealed Resident #5 admitted with the following skin conditions: 2.6 x 1.4 cm purple green bruise right forearm; 3.5 x 4.6 cm purple green bruise groin (body diagram depicted left groin); 19 x 13 cm purple green bruise left hip/thigh; 4 x 3.6 cm purple green bruise back of left hand and 2 x 1.2 cm purple green bruise left antecubital.</p>	F 309		7/24/13

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F 309	Continued From page 5	F 309			7/22/13
<p>There was no further assessment/monitoring documented on the flow sheet until seven weeks later on 5/29/13 which indicated each of the areas was resolved on that date.</p> <p>Review of Resident #5's TARs dated 4/2013 and 5/2013 revealed one entry "monitor bruise to left hand, left hip and groin and thigh, right forearm, left antecubital until resolved". Review of the TAR revealed a licensed nurse's initial each week through 5/20/13; there was no further evidence of assessment/description of the bruises.</p> <p>During interview at 12:30 p.m. on 6/21/13, licensed nurse C stated facility policy for skin assessment and monitoring included starting a skin flow sheet for any new skin condition that included assessment/description of the area and assessment/monitoring of the area weekly, including documenting the assessment on the skin flow sheet and initialing the TAR.</p> <p>Staff E (licensed nurse) was interviewed at 12:45 p.m. on 6/21/13. Staff E stated the same as Staff C above related to facility policy for assessment and monitoring of skin conditions.</p> <p>At 1:30 p.m. on 6/21/13, Staff F (licensed nurse) stated when a new skin condition was identified, a skin flow sheet was started that included assessment/description of the area. As far as monitoring, she would initial the TAR each week indicating the skin check was completed. She stated she would not document ongoing assessment of the area on the skin flow sheet unless there was a change.</p>					

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F 309	Continued From page 6 During interview at 12:00 p.m. on 6/21/13, administrative Staff A provided the facility's policy for skin assessment and monitoring. Staff A stated staff should be doing a weekly full body assessment and documenting their findings on the skin flow sheet that included a description each week until it was resolved. Staff A stated a recent audit showed staff were not always following the process and in-service education for licensed staff was planned.	F 309		7/22/13