

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

PRINTED: 04/24/2014
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 04/16/2014
--	--	--	---

NAME OF PROVIDER OR SUPPLIER TACOMA NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2102 SOUTH 96TH STREET TACOMA, WA 98444
--	---

(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
--------------------	--	---------------	---	----------------------

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 4/9/14 & 4/16/14. The sample included 6 residents out of a census of 96. The sample included 4 current residents and the records of 2 former residents.</p> <p>The following are complaints investigated as part of this survey:</p> <p>#2978638 #2989906 #2987959</p> <p>The survey was conducted by:</p> <p>Donna J. DeVore, RN, MSN</p> <p>The surveyor is from:</p> <p>Department of Social and Health Services Aging and Long-Term Support Administration Division of Residential Care Services District 3, Unit B PO Box 45819, MS: N27-24 Olympia, WA 98504-5819</p> <p>Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p><i>Phongun-Grimes</i> 4/24/14 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>	5/9/14
-------	--	-------	--	--------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X8) DATE 5/7/14
---	----------------------------	-------------------------

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.

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

PRINTED: 04/28/2014
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 04/16/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TACOMA NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2102 SOUTH 96TH STREET TACOMA, WA 98444
---	---

(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
--------------------	--	---------------	---	----------------------

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 observations, record review and interview, the facility failed to provide adequate supervision to ensure staff followed the plan of care to prevent accidents for 1 of 4 sampled residents (#1) reviewed for falls. Resident #1 fell from his bed that was not in the low position and the floor mattress was not in place next to the bed.</p> <p>This failure resulted in harm to Resident #1 who sustained a head injury that required treatment in the emergency room.</p> <p>Findings include:</p> <p>Review of a facility investigation dated 4/5/14 revealed Resident #1 was found on the floor, face down, next to his bed. Documented assessment by licensed nurse Staff D revealed "a large deep wound and bleeding to left side of forehead". Pressure and application of ice were completed prior to transfer to the emergency room for evaluation and treatment which included sutures and a head/neck scan which were negative for internal bleeding or fractures.</p>	F 323	<p>F 323</p> <p>Tacoma Nursing and Rehab strives to ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to minimize risk of injury.</p> <p>Resident #1 remains in the facility; safety devices are utilized per individualized plan of care.</p> <p>Any resident that requires safety interventions is a potential risk.</p> <p>Employee C received training/counseling related to this occurrence prior to providing additional care to others.</p> <p>Expanded staff training was initiated on 4/5.</p> <p>Random audits will be completed for one month to ensure that staff is following individualized safety plans for residents.</p>	5/9/14
---------------	--	-------	--	--------

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

PRINTED: 04/28/2014
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 04/16/2014
NAME OF PROVIDER OR SUPPLIER TACOMA NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2102 SOUTH 96TH STREET TACOMA, WA 98444	
(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
F 323	<p>Continued From page 2</p> <p>Telephone interview with Staff D on 4/21/14 at 8:30 a.m. revealed she responded to Resident #1's call for help. Upon entering the room, she saw the resident face down on the floor, next to his bed. Staff D stated there was blood on the floor under the resident's head. She stated the head wound was approximately 3 centimeters long and irregularly shaped. Staff D stated staff provided first aid before transferring the resident to the emergency room.</p> <p>During interview, Staff D stated the mattress which was care planned to be on the floor next to the bed was not in place when she entered the room. The bed was not in the lowest position; Staff D stated it looked like the bed was at the level that would be used to transfer the resident from the bed to wheel chair.</p> <p>Record review revealed Resident #1 admitted during 2012 with multiple diagnoses including dementia, history and falls and irregular heart rate. Review of the most recent comprehensive assessment dated 3/20/14 revealed the resident was assessed as severely cognitively impaired and required two staff to assist with movement in bed and transfers.</p> <p>Review of care directives dated 1/7/14 and updated 4/7/14 revealed fall from bed preventive measures included keep bed in lowest position, mattress to the right of the bed with mat to the right of the mattress and scooped mattress.</p> <p>Telephone interview with Staff C (certified nursing assistant) on 4/17/14 at 2:00 p.m. revealed she provided Resident #1 morning care which included dressing him. She stated Resident #1 required two staff for transfer so she went to the</p>	F 323	<p>Trends (if any) will be brought to QA for recommendations regarding additional actions and on-going monitoring if it is deemed necessary.</p> <p>DNS/Designee will be responsible for compliance.</p>	5/9/14

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

PRINTED: 04/28/2014
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 04/16/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER TACOMA NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2102 SOUTH 96TH STREET TACOMA, WA 98444
---	---

(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
--------------------	--	---------------	---	----------------------

F 323 Continued From page 3

door to look for her care partner. Staff C stated she went across the hall which she thought would just take a minute. She stated she assisted her partner with a resident transfer in that room and then heard Staff D call for assistance in Resident #1's room.

Staff C stated when she left Resident #1's room the floor mattress was up against the opposite wall. The bed was not all the way down; it was at a height so the resident could transfer to the wheel chair. She had everything all ready for the transfer; she said she did not anticipate leaving the room and when she did leave, she thought it would be for just a few minutes. Staff D acknowledged responsibility for leaving Resident #1 in an unsafe position.

During survey on 4/16/14 at 8:55 a.m., Resident #1 was observed in the main dining room sitting upright in a tilt-in-space wheel chair eating breakfast with assistance from staff. Observations of the resident while in bed were not possible due to timing of observations during a meal and activity.

On 4/16/14 at 9:20 a.m., interview with Staff E (certified nursing assistant) assigned to care for Resident #1 revealed he was knowledgeable about fall prevention interventions for the resident while in bed and in the chair. Observations of the Resident's room earlier at 8:45 a.m. revealed fall prevention devices documented on care directives were available in the resident's room.

Telephone interview with Staff A (director of nursing) at 1:30 p.m. revealed the resident's most recent falls occurred on 9/2013 and 11/2013 which involved the resident sliding from the wheel

F 323

5/9/14

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

PRINTED: 04/28/2014
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 04/16/2014
NAME OF PROVIDER OR SUPPLIER TACOMA NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2102 SOUTH 96TH STREET TACOMA, WA 98444		
(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
F 323	Continued From page 4 chair. Prior to those dates, a fall from the wheel chair was documented during 10/2012. There were no falls recorded from bed during the above time periods prior to 4/5/14. During exit interview on 4/16/14 at 1:15 p.m., administrative staffs A and B (director of nursing and administrator) discussed and provided evidence of individual and expanded staff training dated 4/5/14. Training emphasized following care directives and to always leave residents in safe position when leaving the bedside, including while doing tasks in the room.	F 323		5/9/14