

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

PRINTED: 01/22/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505154</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/15/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>TACOMA NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2102 SOUTH 96TH STREET TACOMA, WA 98444</b>	
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Abbreviated Standard Survey conducted onsite at Tacoma Nursing and Rehabilitation Center on 1/7/15 &amp; 1/15/15. The sample included 12 residents out of a census of 95. The sample included 8 current residents and the records of 4 former residents.</p> <p>The following are complaints investigated as part of this survey:</p> <p>#3062647 #3064720 #3063429 #3054993</p> <p>The survey was conducted by:  Tara Hawks, RN, BSN</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 PO Box 45819, MS: N27-24 Olympia, WA 98504-5819</p> <p>Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p><i>[Signature]</i> 1/22/15 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: center;"><b>RECEIVED</b> <b>JAN 28 2015</b> <b>DSHS RCS Region 3</b></p>	1/31/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE Administrator (X6) DATE 1/28/15

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 observation, interview and record review it was determined that the facility failed to ensure the staff followed through with recommendations by the physician for 3 of 6 Sample Residents (#s 1, 2 &amp; 3) reviewed for physician orders. This failure placed residents at potential risk for having health conditions left untreated. Additionally, the facility staff failed to ensure a pressure reducing mattress was used for a resident with identified skin risk for 1 of 3 Sample Residents (#1) reviewed for care and services. This failure placed Resident #1 at potential risk of avoidable skin breakdown.</p> <p>Findings include:</p> <p>PHYSICIAN RECOMMENDATIONS:</p> <p>Resident #1 Resident #1 admitted to the facility on [REDACTED] 14 from a hospital with diagnosis to include [REDACTED]</p> <p>Review of Resident #1's hospital records revealed during her hospital stay the resident received a set amount of insulin daily and additional insulin when her blood sugar was high.</p>	F 309	<p>F 309</p> <p>Resident #1 is no longer in the facility</p> <p>Resident #2 and #3 remain in facility. Physician notes in "History and Physical" were clarified and transcribed to "physician orders".</p> <p>Residents whose physician visits and documents plan without corresponding orders are at potential risk.</p> <p>Residents whose family chose to provide beds from home are at potential risk.</p> <p>Chart audits were completed to ensure that there are no treatment plans documented by physician without corresponding physician orders. Any discrepancies that were found were corrected.</p> <p>Physicians/ARNP's were educated on need to communicate with staff when they have visited residents and to flag notes for staff to review.</p> <p>Licensed nurses were educated to review MD notes and orders after visits to ensure that corresponding</p>	1/31/15

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F 309	<p>Continued From page 2</p> <p>Hospital records indicated they were giving the resident the same amount of insulin as she took at home. Hospital records indicated when Resident #1 discharged from the hospital the physician recommended she continue to receive insulin with the dose flexible based on how high her blood sugar was.</p> <p>Review of Resident #1's physician orders when she admitted to the facility revealed directives to nursing staff to check the resident's blood sugar three times daily for three days then re-evaluate. There was no orders for the resident to receive insulin.</p> <p>Review of Resident #1's Medication Administration Record (MAR) for November 2014 revealed staff did document the blood sugars three times daily, however, there was no documentation in the record indicating the physician had been notified of the blood sugar results. Further review of the MAR revealed all of Resident #1's blood sugar readings were more than twice what normal blood sugars range.</p> <p>During an interview on 1/15/15 at 1:35 p.m. Staff B reviewed Resident #1's record and confirmed the blood sugar results were higher than normal and there was no indication the physician had been notified.</p> <p>Further review of Resident #1's record revealed a physician's note titled "History and Physical" dated 11/26/14 which contained documentation written in the section titled "Current Diagnosis" that included [REDACTED] "not controlled, continue [REDACTED]"</p> <p>During an interview on 1/15/15 at 1:45 p.m. Staff</p>	F 309	<p>orders were written for any "plan" documented by physician.</p> <p>Facility audit was completed to identify residents that were utilizing personal beds. Risks/Benefits of utilizing facility pressure reducing mattresses were discussed and documented.</p> <p>Facility will complete random audits after physician visitation monthly for one quarter or as needed per QA recommendations to ensure on-going compliance.</p> <p>Facility will provide risks/benefits of bringing beds in from home prior to allowing resident to utilize their own sleep surface in the facility.</p> <p>Rounds by DNS or designee will ensure that sleep surface was not brought in without facility knowledge.</p> <p>Results of audits will be brought to QA committee for review and further recommendations.</p> <p>DNS/Designee will be responsible for compliance</p> <p>Compliance date: 1/31/15</p>	1/31/15	

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F 309	<p>Continued From page 3</p> <p>B confirmed Resident #1 was not receiving [REDACTED] at that time the physician wrote "continue [REDACTED]"</p> <p>During an interview on 1/15/15 at 1:55 p.m. Staff C and Staff F both reported the History and Physical form is brought into the facility and completed by the physician. After completion the physician puts the form in the resident's chart. Staff C and Staff F both reported the facility staff do not see the History and Physical form. In addition to not seeing the History and Physical, staff reported they do not always know who or how many residents the physician has seen while in the facility.</p> <p>The History and Physical form was not accurate to the resident's current care. Without staff reviewing the History and Physical there was no identification of the error and Resident #1 continued to not receive the appropriate care to treat her [REDACTED]</p> <p>Resident #2 Review of Resident #2's medical record revealed a History and Physical dated 12/19/14. The physician had written "high fiber diet" on the form. Further review of the record revealed no documentation indicating the resident was on a high fiber diet.</p> <p>During an interview on 1/15/15 at 2:15 p.m. Staff D reviewed the record and confirmed Resident #2 was on a general diet and there had not been any order or requests made for increased fiber in her diet.</p> <p>There was no documentation in the record indicating that staff had seen the history and</p>	F 309		1/31/15	

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F 309	<p>Continued From page 4</p> <p>physical or received the recommendation for increased fiber.</p> <p>Resident #3 Review of Resident #3's medical record revealed a History and Physical form dated 12/29/14. The physician had written [REDACTED] x 10 days". The antibiotic [REDACTED] did not include the strength of the medication.</p> <p>Further review of the Resident #3's record revealed a physician's order dated 1/7/15 for [REDACTED] 100mg by mouth two times daily for two weeks. The medication recommended on 12/29/14 was not written as an order or administered to the resident for over 1 week.</p> <p>There was no documentation in Resident #3's record to indicate the physician's recommendation for antibiotics on 12/29/14 was ever communicated to the nursing staff.</p> <p>Failure to communicate to nursing staff recommendations placed Resident #3 at risk for an untreated health condition.</p> <p><b>SERVICES TO PREVENT PRESSURE ULCERS</b></p> <p>Observations on 1/7/15 at 11:30 a.m. revealed an open area on Resident #1's skin that was approximately 6cm long by 4 cm wide and the depth was through all layers of the skin. There was thick odorous drainage from the wound.</p> <p>Resident #1 admitted to the facility on [REDACTED] 14. Review of hospital transfer records indicated the resident had been identified as being at high risk for skin breakdown. Review of her record indicated she did not have any skin issues in the</p>	F 309		1/31/15

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F 309	<p>Continued From page 5</p> <p>location of the pressure ulcer when she admitted to the facility.</p> <p>During an interview on 1/15/15 at 1:50 p.m. Staff B reported all residents who admit to the facility are given pressure reducing mattresses to promote skin health.</p> <p>Staff B reported Resident #1 was not given one of the pressure reducing mattresses because a family member had brought in her personal mattress. Staff B reported the mattress was similar to those in hospitals but she did not know if it was pressure reducing. Staff B reported the resident and/or her family were not given any type of education related to the risks of not using a pressure reducing mattress.</p> <p>Failure to ensure Resident #1 had a pressure reducing mattress placed her at potential risk for increased pressure and/or damage to her skin.</p>	F 309		1/3/15	