

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

PRINTED: 09/13/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505483	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/06/2012
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NAME OF PROVIDER OR SUPPLIER ALASKA GARDENS HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 6220 SOUTH ALASKA STREET TACOMA, WA 98408
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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 Alaska Gardens Health & Rehab on 8/30 & 9/6/12. The sample included 8 residents out of a census of 94. The sample included 7 current residents and the record of 1 former resident.</p> <p>The following are complaints investigated as part of this survey:</p> <p>#2664041 #2656921 #2657300</p> <p>The survey was conducted by: Donna J. DeVore, R.N.; MSN</p> <p>The surveyor is from: 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>Loida Baniqued</i> 09/14/12 Residential Care Services Date</p>	F 000	<p>DISCLAIMER CLAUSE</p> <p>PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW.</p> <p>RECEIVED</p> <p>SEP 27 REC'D</p> <p>DSHS - ADSA RCS - REGION 5</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE ED	(X6) DATE 9/25/12
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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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F 314 SS=G	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide necessary care and services to promote healing of a pressure ulcer acquired in the facility for 1 of 4 residents (Former Resident #1) reviewed for pressure ulcers.</p> <p>The facility failed to provide evidence of evaluating the effectiveness of care plan interventions and/or revising the interventions in a timely manner to prevent worsening of the pressure ulcer.</p> <p>The facility failed to timely notify the physician when the condition of Resident #1's pressure ulcer initially was not showing signs of improvement.</p> <p>These failures resulted in harm for Resident #1 who required hospitalization for wound care including surgical debridement and wound vacuum.</p> <p>Findings include:</p>	F 314	<p>1. How corrective action accomplished for the identified residents?</p> <p><i>Resident #1 no longer resides at facility.</i></p> <p>2. How you will identify other residents with the potential of being affected by the same practice?</p> <p><i>Residents with pressure ulcers have had their care plans assessed and updated to validate effectiveness of interventions to assist in preventing worsening of pressure ulcers.</i></p> <p><i>Any resident with a worsening pressure ulcer or no improvement have had documentation that their physician has been notified</i></p>		

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F 314	Continued From page 2 Closed record review revealed Resident #1 admitted to the facility during [REDACTED] 12 for therapy following surgical repair of a right hip fracture. Review of an admission skin assessment dated [REDACTED] 12 revealed the resident did not have pressure ulcers when admitted. Review of the resident's record revealed a care plan dated 7/6/12 for Fracture - Trauma Care that identified impaired physical mobility as a risk for impaired skin integrity due to immobility. Interventions, in part, included turn and reposition every two hours and pressure reducing mattress. Review of a facility form "Pressure Evaluation" dated 6/29/12 revealed the resident developed two Stage II pressure ulcers (partial thickness skin loss). One was located on the right ischium (lower buttock) documented as 3 centimeters (cm) by 1 cm. The ulcer resolved on 7/10/12. The second Stage II pressure ulcer was noted also on 6/29/12 on the left ischium. Review of weekly documentation of the above pressure ulcer showed the following measurements/treatments: 6/29/12 - 1.5 by 2 cm (no depth), Stage II, pink/beefy red wound bed, no drainage. Treatment cleanse with normal saline, apply skin prep, cover with duoderm, change every 3 days and as needed. 7/3/12 - 2.3 by 2.0 cm, (depth not indicated), Stage II, serosanguineous drainage, minimal amount, same treatment.	F 314	3. Address what measures will be put in place to ensure deficient practice will not recur IDT skin team has been re educated on EHC skin policy by the DNS including care planning and physician notification. After weekly IDT skin rounds care plans will be reviewed to validate interventions continue to be appropriate and assess for possible new interventions. RCMs will be responsible to inform physician of no change or worsening or pressure ulcer after weekly IDT skin round assessments are completed.	

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F 314	<p>Continued From page 3</p> <p>7/10/12 - 2.5 by 2.3 cm (depth not indicated), Stage II, sero-sanguineous drainage, minimal amount, same treatment.</p> <p>7/17/12 - 4.1 by 3.5 cm (depth not indicated), Stage not identified, 30% eschar (thick leathery necrotic (dead) tissue), 10% slough (necrotic tissue in the process of separating from viable portions of the body), serous drainage, minimal amount, red surrounding skin, wound edges hard, painful to touch. Discovered on 7/14/12 (documentation dated 7/17/12 during weekly wound rounds), treatment change obtained for Santyl and foam dressing.</p> <p>7/17/12 - new - left ischium ulcer split - 1.5 by .5 cm, undetermined Stage, 100% slough, red surrounding skin. Discovered on 7/14/12 and same treatment as above.</p> <p>Review of "Pressure Ulcer Care Plan" dated 6/29/12 (date the pressure ulcers were discovered) revealed, in part, the same interventions as identified on the care plan for Fracture/Trauma for turning and repositioning every two hours and pressure reducing mattress. The care plan also included an intervention to notify the physician of failure to demonstrate progress in healing after 14 days.</p> <p>There was no evidence the interventions already in place were evaluated for effectiveness given that the resident developed two pressure ulcers on 6/29/12. There was no evidence of care plan revision and/or addition of new interventions until 7/16/12 after the pressure ulcer on the left ischium/buttock had worsened.</p>	F 314	<p>4. How will the plan be monitored to ensure the solutions are sustained?</p> <p><i>DNS to audit resident care plans with pressure ulcers to validate that interventions have been reassessed to validate appropriateness.</i></p> <p><i>DNS to audit charts to validate that the physician has been notified of no improvement or worsening of pressure ulcers.</i></p> <p><i>Audits to be completed 1 x week for 4 weeks, then monthly x 2 months.</i></p> <p><i>Findings of audits to be brought to CQI for further evaluation.</i></p> <p>5. The DNS is responsible for compliance</p> <p><i>Date certain October 10, 2012</i></p>	

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F 314	<p>Continued From page 4</p> <p>During interview on 9/6/12 at 12:20 p.m., Staff C (care manager) confirmed the physician was not notified when Resident #1's wound increased in size, showed drainage and no sign of progress in healing after 14 days. Staff C stated there was no indication for a change in treatment or notification of the physician because the amount and characteristics of the drainage had not changed. Staff C stated the physician assessed the resident's wound on 7/17/12 and identified it as a boil and/or abscess and recommended a wound clinic evaluation for possible incision and drainage.</p> <p>Review of a hospital record dated [REDACTED]/12 revealed Resident #1 was admitted to the hospital on [REDACTED] 12 following evaluation of the pressure ulcer in the hospital's wound clinic. Documentation showed a diagnosis of a Stage III sacral pressure ulcer (full thickness skin loss including damage, or necrosis of, subcutaneous tissue) measuring 7 by 8 cm with 2 to 3 cm black eschar over the left side of the ulcer. A culture revealed the wound was infected; the wound was surgically debrided and a wound vacuum placed to promote healing.</p> <p>During interview on 9/6/12 at 12:20 p.m., Staff C and A (director of nursing) stated Resident #1 was not consistently compliant with turning and repositioning while in bed and the resident spent many hours out of bed in the wheel chair.</p> <p>Review of the resident's care plan revealed the issue of resident non-compliance was not included; there was no evidence risks were discussed with the resident and no evidence of</p>	F 314		

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F 314	Continued From page 5 interventions for increased pressure relief while the resident was in bed or in the wheel chair. During the above interview, Staffs A and C confirmed additional interventions for pressure relief for the bed and wheel chair were not implemented until after the further decline of the pressure ulcer noted on 7/14/12. An air loss mattress was obtained on 7/16/12 and a Roho wheel chair cushion was implemented on 7/17/12. During interview in another facility on 8/31/12 at 11:05 a.m., Resident #1 recalled her stay in the named facility. She recalled the "sore hurting some" for two weeks but then it changed to "stinging" the day before she went to the hospital. Resident #1 did not recall not wanting to turn when she was in bed; she did not recall being told it was not good for the sore to sit in the wheel chair for long periods until a therapist at the hospital told her to raise herself up and down in the chair to relieve pressure. Resident #1 stated she made the appointment for the wound clinic independent of the facility.	F 314		