

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  11/07/2014
NAME OF PROVIDER OR SUPPLIER  AVAMERE HERITAGE REHABILITATION OF TACOMA			STREET ADDRESS, CITY, STATE, ZIP CODE 7411 PACIFIC AVENUE TACOMA, WA 98408		
(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><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Avamere Heritage Rehabilitation of Tacoma on 11/03/14, 11/04/14, 11/06/14, and 11/07/14. A sample of 32 residents was selected from a census of 64. The sample included 25 current residents and the records of 7 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>Jonathan Berliner, RN, MSN Sonya Mae Conway, MSW Nancy Fretland, RN, MSN Candice Mohar, PhD, RN, MSN</p> <p>The survey team is from:</p> <p>Department of Social &amp; Health Services Aging &amp; Long Term Support Administration Residential Care Services, District 3, Unit C &amp; D P.O. Box 45819 Tumwater, Washington 98504-5819</p> <p>Telephone: 360.664.8429 Fax: 360.664.8451</p> <p><i>[Signature]</i> 11/21/14 Residential Care Services Date</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE  
*[Signature]* Administrator 12-3-14

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: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/07/2014
NAME OF PROVIDER OR SUPPLIER  AVAMERE HERITAGE REHABILITATION OF TACOMA			STREET ADDRESS, CITY, STATE, ZIP CODE 7411 PACIFIC AVENUE TACOMA, WA 98408	
(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 166 SS=D	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure grievances were acted upon in a timely manner for 1 of 3 current sampled residents (#74) reviewed for personal property. This failure created a potential for lack of resolution to residents' grievances.</p> <p>Findings include:</p> <p>On 11/4/14 at 12:16 p.m., Resident #74 reported he was missing a "nice pair of clippers, a Norelco razor and trifocal glasses." He stated he had reported the missing items to the nurses on the 400 hall and was told they were looking for the items. He indicated these items had been missing since June and there had been no attempts to reimburse him. The resident also complained he had been missing his dentures since May.</p> <p>On 11/6/14 at 5:05 p.m., the Social Services Director (SSD) said she was not aware of the resident's complaint of missing items. She provided the facility Grievance Communication Form that she initiated on 11/06/14 to follow up.</p> <p>On 11/07/14 at approximately 11:00 a.m., the SSD indicated she had not followed up on the resident's complaint of missing dentures. She</p>	F 166	<p>Cited Res: Rsd #74 had his grievance completed and an investigation was completed. All missing items reported were replaced by the facility.</p> <p>Like Rsd: Rsd's that have missing items will be encouraged to fill out a grievance form or be assisted in completing one out by staff.</p> <p>System Review/Education: Staff have been re-educated on assisting residents to complete a grievance form when they voice a concern or have missing items.</p> <p>SSD has received education on continued follow up to provide assistance with residents' dental needs.</p> <p>Monitoring: Grievances will be reviewed in am stand up, to ensure timely resolution and follow up with resident. Monthly report will be submitted to QA committee for further review and recommendation.</p>	

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/07/2014
NAME OF PROVIDER OR SUPPLIER  AVAMERE HERITAGE REHABILITATION OF TACOMA			STREET ADDRESS, CITY, STATE, ZIP CODE 7411 PACIFIC AVENUE TACOMA, WA 98408	
(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 166	Continued From page 2 provided information that showed the resident was evaluated for dentures on 4/05/14. When asked about the delay, she said the forms were submitted to the dentist's office and she thought the dentist's office would follow up with the facility when the dentures were ready.	F 166	Responsibility: Social Services and Administrator. Date of compliance 12/10/2014.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.  Clinical disagreement does not constitute a material and false statement.	F 278	Cited Rsd: Rsd #64's MDS was corrected and submitted at time of survey. Rsd #4's MDS was corrected and submitted on 12/1/2014.  Like Rsd: Facility will ensure that MDS accurately reflect resident conditions and/or status.  System Review/Education: MDS nurse was re-educated on MDS coding and ensuring correct coding on 11/13/2014.  Monitoring: Routine audits will be completed x' 1 month and then monthly audits will be conducted ongoing by DNS/designee to ensure MDS accuracy. Addendum: Will be brought to monthly QA meeting beginning December 2014	

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/07/2014
NAME OF PROVIDER OR SUPPLIER  AVAMERE HERITAGE REHABILITATION OF TACOMA		STREET ADDRESS, CITY, STATE, ZIP CODE 7411 PACIFIC AVENUE TACOMA, WA 98408	
(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)
F 278	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, it was determined the facility failed to ensure the Minimum Data Set (MDS), an assessment tool, accurately reflected the resident's condition and/or status for 2 of 17 current sampled residents (#64 &amp; 4) reviewed for nutrition and hydration. This failure prevented the staff from accurately identifying, treating and/or preventing decline in residents' status, and placed residents at risk for unmet care needs.</p> <p>Findings include:</p> <p>1) Resident #64 was admitted to the facility on [REDACTED] with diagnoses including hip fracture, heart disease, hemorrhage and altered mental state.</p> <p>The resident's MDS, dated [REDACTED], indicated the resident had severe cognitive impairment, required extensive assistance with eating, and had not had weight loss or gain with a mechanically altered diet.</p> <p>The resident's MDS, dated [REDACTED], indicated the resident was on a prescribed weight loss regimen.</p> <p>The Registered Dietitian Assessment, dated 09/19/14, documented "diet is appropriate and tolerated. Intake is variable, but appears adequate at this time." The recommendation was to continue with "diet and POC" (plan of care).</p> <p>The resident's care plan was updated on 10/24/14 for an "unplanned/unexpected weight loss related to cognitive impairment and poor</p>	F 278	See Page 3

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  11/07/2014
NAME OF PROVIDER OR SUPPLIER  AVAMERE HERITAGE REHABILITATION OF TACOMA			STREET ADDRESS, CITY, STATE, ZIP CODE 7411 PACIFIC AVENUE TACOMA, WA 98408		
(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 278	<p>Continued From page 4</p> <p>food intake" with interventions including supplements.</p> <p>Record review showed the resident's weight dropped from 144 pounds on 09/13/14 to 107 pounds on 10/24/14.</p> <p>The physician's orders showed a supplement was ordered on 10/10/14 and a more calorie enriched supplement was ordered on 10/24/14.</p> <p>On 11/06/14 at 5:32 p.m., LNA stated supplements were ordered when the weight loss was identified. The resident was not eating during this time. The resident's portion size was also increased, and his diet was changed to give the resident multiple opportunities to eat. LNA stated the weight loss was a sudden change for the resident.</p> <p>When asked about the MDS documentation of the resident being on a prescribed weight loss regimen, LNA stated the MDS, dated 10/30/14, was not accurate.</p> <p>At 5:46 p.m., LNB stated the MDS, dated 10/30/14, was not accurate. The MDS should have reflected the resident had weight loss and was not on a prescribed weight loss regimen. The resident "was coded incorrectly."</p> <p>2) Resident #4 was readmitted to the facility on [REDACTED] with diagnoses including heart disease, arthritis, dementia, anxiety, depression, lung disease, kidney disease, muscle problems, obesity, skin ulcer, and edema.</p> <p>The resident's MDS, dated [REDACTED], indicated the resident was able to make needs known, was</p>	F 278	See Page 3		

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/07/2014
NAME OF PROVIDER OR SUPPLIER  AVAMERE HERITAGE REHABILITATION OF TACOMA			STREET ADDRESS, CITY, STATE, ZIP CODE 7411 PACIFIC AVENUE TACOMA, WA 98408	
(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 278	Continued From page 5 alert and oriented, and was dehydrated.  The resident's MDS, dated 11/05/14, indicated the resident was not dehydrated.  The resident's care plan did not document concerns regarding hydration.  On 11/07/14 at 10:39 a.m., Licensed Nurse (LN) A stated the resident was not dehydrated at the time of readmission on [REDACTED]. LN A indicated she verified with the resident's readmission paperwork and did not find any documentation indicating the resident was dehydrated.  At 10:50 a.m., LN B stated she was unable to find any documentation in the history and physical or readmission paperwork indicating the resident was dehydrated. LN B said the resident's MDS assessment paperwork did not show the resident was dehydrated at the time of assessment.	F 278	See Page 3	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  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.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and	F 279	Cited Rsd: Rsd #74 was reassessed to ensure that he is not having any issues with his dentition. Paperwork was submitted by the dentist on 10/3/14 and is awaiting approval from Medicaid to replace Rsd's dentures.  Like Rsd: Residents that have no teeth or dentures will be re-assessed to ensure that there are no issues with pain or eating. Care plan will be developed as indicated.	

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

PRINTED: 11/21/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505183	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/07/2014
NAME OF PROVIDER OR SUPPLIER  AVAMERÉ HERITAGE REHABILITATION OF TACOMA			STREET ADDRESS, CITY, STATE, ZIP CODE 7411 PACIFIC AVENUE TACOMA, WA 98408	
(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)	(X6) COMPLETION DATE
F 279	<p>Continued From page 6</p> <p>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 observation, interview and record review, the facility failed to develop a comprehensive care plan for 1 of 17 current sampled residents (#74) reviewed for care planning. This failure placed residents at risk of not having their dental care needs met in a timely manner.</p> <p>Findings include:</p> <p>On 11/04/14 at 11:00 a.m., Resident #74 was observed without teeth. When asked if he had mouth or facial pain, he stated he did. He said his dentures were taken because the bottom denture needed some work and the dentures had been missing since June.</p> <p>According to the resident's Minimum Data Set (MDS), an assessment tool dated [REDACTED], the resident required a plan be developed for his dental care.</p> <p>On 11/7/14 at 11:00 a.m., the Social Services Director stated the resident had been to the dentist's office on 4/5/14 and thought the dentist's office would follow up with the facility. Review of the resident's comprehensive care plan did not include dental care.</p>	F 279	<p>System Review/Education: Residents will be re-assessed quarterly for dental concerns; any residents with concerns will be referred to the dentist.</p> <p>Residents who have dental services in process will be monitored to ensure this process is being completed. Care plans will be modified as warranted.</p> <p>Monitoring: SSD/ Resident Care Managers will bring a list to the regular QA meeting of all residents that are in need for dental services, or have dental services in process to follow up on to ensure those services are being completed and care reflects follow up.</p> <p>Responsibility: Resident Care Managers and Social Services will ensure ongoing compliance. DOC 12-10-14</p>	