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

1403

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505183		C 07/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVAMERE HERITAGE REHABILITATION OF TACOMA	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	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Standard Survey conducted onsite at Avamere Heritage Rehab of Tacoma on 7/15/14. The sample included 9 residents out of a census of 60. The sample included 8 current residents and the records of 1 former resident. The following are complaints investigated as part of this survey: #3020322 #3020569 #3021603 #3022495 The survey was conducted by: Donna J. DeVore, RN, MSN 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 Telephone: (253) 983-3800 Fax: (253) 589-7240 D Longer-Shimer 7/21/14 Residential Care Services Date	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Bill Bailey — Administrator — 7-28-14

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.

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F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to insure ongoing assessment and monitoring of injuries for 2 of 2 residents (#'s 1 & 2) reviewed for injuries sustained during a fall. Failure to provide ongoing assessment and monitoring of injuries placed residents at risk for delayed healing and/or infection. Findings include: All interviews took place on 7/15/14. Review of a facility investigation dated 6/24/14 revealed Resident #1 fell from bed during care. Initial assessment, in part, identified "a small cut on the resident's [redacted] forehead with no bleeding". Review of nursing notes dated 6/24/14 revealed documentation of the residents fall at approximately 5:30 p.m. included "Resident was not complaining of a headache but had a small cut on the [redacted] side of forehead, not bleeding, no signs of infection". There was no further description of the cut or potential treatment of the area.	F 309	1. Resident #1's abrasion to the [redacted] side of resident's forehead was re-assessedand documented in the medical record. Resident #2's abrasion to the [redacted] side of resident's chin was re-assessed and documented in the medical record. 2. Incident reports from the previous two weeks were reviewed by the IDT for accuracy, and concerns were addressed as needed. 3. Licensed Staff were re-educated that injuries must be documented and added to the medical record to ensure that injuries will be treated per orders and monitored until resolved.	

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F 309	Continued From page 2	F 309	Continued from Page 2	
	Review of nursing progress notes dated 6/25/14 at 2:50 a.m. revealed documentation "no changes to laceration on [redacted] forehead". There was no further evidence of assessment or monitoring as of the date of survey.		4. Incidents are reviewed at daily stand up meeting to review that treatments and/or monitoring orders for skin impairments are present. Staff will conduct a weekly meeting to review that incidents have been addressed thoroughly and concluded. Findings from that meeting will be brought to the Quality Assurance for continued compliance and monitoring.	
	2. Review of a facility investigation dated 6/25/14 revealed Resident #2 fell during a Hoyer lift transfer. Initial assessment, in part, revealed the resident had a small, about 1.5 inches, superficial cut beneath the resident's [redacted] side of his chin.		per phone conversation with Anna Brown DNS 8-11-14 10:10am BIC 7-28-14 DNS is responsible for ensuring plan of correction.	
	Review of nursing progress notes dated 6/25/14 revealed the resident fell at approximately 3:30 p.m. Documentation reflected the assessment as written above in the facility's investigation.			
	Further review of nursing progress notes revealed no further evidence of assessment, monitoring and or potential treatment of the cut as of the date of survey.			
	At approximately 1:45 p.m., Staff F (Staff Development) was informed about the above. Staff F stated she would review treatment records for Residents #1 & 2 to check for documentation of monitoring.			
	During exit interview at 2:15 p.m., Staff B (director of nursing) stated there was no further documentation available for the injuries noted for Residents #1 & 2. Staff B stated it was the responsibility of the nurse that completed the incident reports to initiate monitoring of the injury via the residents treatment record.			
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 3 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. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interview, the facility failed to ensure adequate supervision to prevent accidents for 2 of 2 Residents (#'s 1 & 2) reviewed for falls with injuries. The facility failed to provide adequate supervision to ensure Resident #2 was safely transferred with a Hoyer lift. During transfer, Resident #2 sustained harm (blunt head injury) when the lift tipped and the resident fell, hitting his head on the footboard. The resident additionally sustained a cut on his chin. Resident #2 subsequently transferred to the emergency room for evaluation. The facility failed to provide adequate supervision to ensure a care plan that required attendance of 2 staff in the room during care was followed for Resident #2. The resident rolled from bed during care provided with 1 staff in the room. The resident sustained a cut on her forehead and pain in her arm and shoulder. The resident suffered harm from the pain and limited movement experienced after the fall which required pain medication. Findings include:	F 323	1. Resident #2 was re-assessed by the DON for his transfers to ensure transfers are being done correctly. Resident #1's Care Plan was reviewed by DON for accuracy. 2. Residents with care plans for 2 person "care in pair" were reviewed by DON for accuracy. IDT reviewed care plans for those Residents who use Hoyer lifts for transfers to ensure accuracy. 3. Staff were re-educated on following the resident's Care Plans, and on Abuse and Neglect. Nursing Staff were re-educated by the DME representative for safety, proper sling placement, and proper Hoyer lift operation. 4. Staff Development Coordinator will audit Hoyer transfers weekly for 4 weeks, then monthly for 3 months and reports will be submitted to the Quality Assurance Committee with findings. Audits will be done for residents that are 2 person "care in	

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F 323	Continued From page 4	F 323	Continued from Page 4	

Observations and interviews were conducted on 7/15/14.

1. On 6/25/14 Resident #2 was observed sitting in his room in the wheel chair, having just transferred from bed with the Hoyer lift. The sling was under the resident and was centered; staff repositioned the resident for comfort. The resident was not able to provide information specific to the fall incident.

Record review revealed Resident #2 admitted to the facility during 6/2013 with medical diagnoses including traumatic [redacted] and [redacted] related to trauma, [redacted] and hemiplegia and atrial fibrillation (irregular heart rate) for which the resident took a blood thinning medication. The resident was at risk for bleeding related to use of blood thinning medication.

Review of a facility investigation dated 6/25/14 revealed during Hoyer lift transfer from bed to wheel chair at approximately 3:30 p.m., while the lift was being moved over the wheel chair, it tipped and the resident fell approximately 3 feet to the floor, hitting his jaw on the footboard of the other bed in the room. The investigation indicated one staff member was able to intervene and cushion the resident's head; however, slight impact was still made.

Review of nursing progress notes dated 6/25/14 revealed at approximately 5:00 p.m., Resident #2 was diaphoretic and complaining of a headache. Following assessment and physician notification, the resident was transferred to the emergency room for evaluation.

pair" weekly for 4 weeks then monthly for 3 months for continued compliance. Findings will be submitted to the QA committee for review.

Per phone conversation with Anna Brown DNS 8.11.14 at 10:10am
BIC 7-28-14
DNS responsible for ensuring plan of correction

JM

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F 323	Continued From page 5 Review of the emergency room report dated 6/25/14 revealed a CT scan of the head was negative for internal bleeding and no fractures were noted on a CT scan of the cervical spine. The physician's clinical impression was documented as blunt head injury. The physician noted the need in the facility for strict head injury precautions due to the blunt head injury and anti-coagulation (on blood thinning medications). Review of a witness statement by Staff E dated 6/25/14 revealed she went into Resident #2's room to ask for help with another resident. Staffs C and D (certified nursing assistants) were transferring Resident #2 with the Hoyer lift. Her statement indicated the transfer could have been more organized; the sling was not attached in sync with the other side and the Hoyer was too high. Staff C operated the lift and approached the resident's wheel chair from the side and the lift hit the wheel chair. The resident started rocking side to side and then the lift tipped over. Staff E stated she observed the resident hit the right side of his head and face on the footboard and the lift landed on the resident. During survey, interview with Staff E at 2:35 p.m. verified her statements as above. Staff E reiterated the sling was not attached equally on both sides and the Hoyer was up too high. She stated Staff C went in sideways with the lift next to the wheel chair instead of straight on; the lift bumped the wheel chair and tilted the Hoyer over. Review of witness statement dated 6/25/14 by Staff D revealed she was behind the resident's wheel chair to guide him in the sling to the proper position. She indicated she was taken by surprise when she suddenly saw the back of Resident #2	F 323		

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coming at her very fast. She grabbed the sling handles and held the resident as steady as she could; the lift was on its side. Staff D guided the resident to the floor, noting he was at a slant and clipped his jawline on the footboard.

Review of witness statement written by Staff C (certified nursing assistant) revealed she was operating the lift and was opening the legs of the lift as she was pulling it out from underneath the bed; as she approached the wheel chair, the legs closed, the lift tilted and the resident fell.

During interview on survey at 11:10 a.m., Staff C stated as far as she recalled, the lift was in good working order, the sling was attached correctly and the transfer was done properly. Staff C did not know why it would have tipped.

The investigator reviewed the incident investigation with Staff B (director of nursing) at 10:55 a.m. She stated two of three staff in the room involved in the transfer (Staffs C & D) stated they felt the transfer was done properly. Maintenance staff checked the machine and did not find mechanical problems.

Staff B stated immediate in-service education was started during the shift following the incident and continued until all staff were educated and able to demonstrate the proper technique. Staff B stated she knew something went wrong during the transfer in order for the lift to tilt and fall over.

2. Record review revealed Resident #1 admitted to the facility during [redacted] with medical diagnoses including vascular dementia with behaviors, blindness left eye and cataracts.

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F 323	Continued From page 7 Review of the resident's care plan dated 4/15/2013 revealed a problem identified related to verbal and physical aggression and accusatory behaviors. One of the interventions care planned was to have two staff in the room with the resident for all care. On 7/15/14 at 7:55 a.m., Resident #1 was observed in her room walking from the bathroom using a seated walker. Staffs G & H (certified nursing assistants) were in the room walking with the resident. Staff assisted the resident to a chair using a gait belt. Interview with Staffs G & H revealed they had both cared for the resident previously and both stated she was care planned for two person care for as long as they could recall. During interview at approximately 8:05 a.m., Resident #1 stated she recalled falling out of bed and stated she hurt her shoulder, pointing to her right arm. The resident said her arm was not broken "but it might as well have been, they had to do 7 x-rays. The resident grimaced and held her shoulder as she talked about the x-rays done in her room. The resident stated she was not able to lift her arm up very far, demonstrating by lifting it approximately 3 inches from the chair arm. She stated "I use this arm to lift it" as she demonstrated lifting her right arm up with her left hand. Review of a facility investigation dated 6/24/14 revealed the resident fell from bed during care at approximately 5:30 p.m. The investigation revealed Staff I was assisting the resident in the room by herself; and, the resident was care planned for 2 staff related to behaviors and allegations against staff. The second staff,	F 323		

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F 323	Continued From page 8 according to the investigation report, was to serve as a witness. Staff I admitted to not following the care plan by providing care without a second staff in the room. Review of a witness statement by Staff I dated 6/24/14 revealed she asked Resident #1 to roll onto her left side and proceeded to wash her. Staff I told the resident not to move. As Staff I reached for a clean wash cloth, the resident moved her right leg over her left leg and rolled off the bed onto the floor. Review of a nursing progress note dated 6/24/14 revealed the resident complained of 9/10 pain in her right shoulder and right upper arm following the fall and also sustained a small cut on her [redacted] forehead. Review of x-ray results dated 6/24/14 revealed no evidence of fractures. Review of Resident #1's medication administration record (MAR) dated 6/2014 revealed prior to the fall on 6/24/14, the resident had not requested "as needed" pain medication (Tylenol 500 milligrams (mg) every 6 hours as needed for breakthrough pain) from 6/1 through 6/23/14. The resident received Tylenol 500 mg following the fall on 6/24, twice on 6/25 and on 6/26/14 for arm and shoulder pain. Review of nursing progress notes dated 6/25/14 revealed the resident was on alert for a new order for Vicodin 1 tablet for pain on a scale of 1 -5. The resident's right shoulder was noted with swelling and redness. Review of the MAR dated 6/2014 and 7/2014 revealed the resident received Vicodin 1 tablet for arm and/or shoulder pain on 6/26, 6/27, twice on	F 323		

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F 323	Continued From page 9 6/28, twice on 6/29, on 7/1, twice on 7/2, and on 7/3 , 7/4 , 7/7, 7/8 & 7/9. Review of physician orders dated 7/9/14 revealed an order for an increased dose of Vicodin two tablets for pain on a scale of 6-10. The resident received two tablets on 7/13/14 for right shoulder pain. During exit interview at 2:15 p.m., Staff B (director of nursing) concluded Resident #1's fall may or may not have occurred if a second staff was in the room as per the care plan.	F 323		