

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

PRINTED: 09/18/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/11/2013
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NAME OF PROVIDER OR SUPPLIER AVAMERE SKILLED NURSING OF TACOMA	STREET ADDRESS, CITY, STATE, ZIP CODE 3625 EAST B STREET TACOMA, WA 98404
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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 Avamere Skilled Nursing of Tacoma on 9/10/13 & 9/11/13. The sample included 5 residents, 5 current staff members, and 2 former staff members. Facility census was 64.</p> <p>The following are complaints investigated as part of this survey:</p> <p>#2866472 #2847063 #2863950 #2866800 #2861861</p> <p>The survey was conducted by: [REDACTED] 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 P.O. Box 45819 MS: N27-24 Olympia, WA 98504-5819</p> <p>Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p><i>[Signature]</i> 9/18/13 Residential Care Services Date</p>	F 000	<p>"Avamere Skilled Nursing of Tacoma's Plan of Correction shall stand as a written credible assertion of substantial compliance with the Federal and State requirements for skilled nursing facilities participating in the Federal Medicare or applicable State Medicaid programs."</p> <p>"Please note that nothing set forth in this document or any other communication in writing or otherwise (including, but not limited to any accompanying exhibits) is to be or should be construed to be an admission by Avamere Skilled Nursing of Tacoma, of the validity or accuracy of any of the deficiencies cited by the SURVEYING ENTITY relative to the survey, certification and enforcement effort at issue. Further, please note that any and all documents transmitted or otherwise provided by Avamere Skilled Nursing of Tacoma in relation to this Plan of Correction, as well as any and all other communications in writing or otherwise by or on behalf of Avamere Skilled Nursing of Tacoma are and shall be construed to be WITHOUT PREJUDICE to the rights, remedies, claims, defenses of Avamere Skilled Nursing of Tacoma, at law and/or inequity, all of which are not waived and all of which are reserved and retained by, and for and on behalf of Avamere Skilled Nursing of Tacoma.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE ADMINISTRATOR	(X6) DATE 9-27-13
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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 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F 225	<p>F 225</p> <p>Corrected:</p> <p>Resident #1 and #2 Accident and Investigation Are completed. Staff involved have a background Check completed and in personnell file.</p> <p>All staff have colpieted Background check</p> <p>Requests on file.</p> <p>Staff have been educated on the procedure related to abuse</p> <p>Allegations and investigations</p> <p>DNS to verify investigations have been completed Thoroughly.</p> <p>Administrator to ensure compliance</p>	9-27-13

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F 225	<p>Continued From page 2</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 thoroughly investigate 2 of 5 Sample Residents (#'s 1 & 2) allegations of abuse/neglect. Additionally, The facility allowed Staff C to continue working unsupervised during an investigation to rule out abuse and/or neglect. These failures placed residents at risk for continued abuse and/or mistreatment.</p> <p>Findings include:</p> <p>RESIDENT #1 Observations on 9/10/13 at 11:30 a.m. revealed Resident #1 was able to use her scooter for locomotion around the facility but would ask for staff assistance if she needed to be transferred in or out of her scooter.</p> <p>Review of the facility incident log revealed Resident #1 had reported an allegation involving Staff C on 7/10/13. Resident #1 had reported Staff C was assisting her out of bed and told her to get up or they would leave her in bed all day.</p> <p>Review of the facility investigation revealed there was no documentation to evidence the investigator reviewed background checks on the facility staff involved.</p> <p>During an interview on 9/11/13 at 8:50 a.m. Staff B confirmed when she does an incident investigation that involves abuse and/or neglect she reviews the employee's personnel file, including the background investigation. Staff B then confirmed she did not review Staff C's background check with this incident investigation.</p>	F 225		

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F 225	<p>Continued From page 3</p> <p>Failure to thoroughly review the employee's personnel record resulted in Staff C who had not been cleared to work unsupervised being allowed to continue working with residents.</p> <p>RESIDENT #2 Observations on 9/10/13 at 12:00 p.m. revealed Resident #2 frequently asked staff for assistance with locomotion in her wheelchair but was able to move the chair by herself.</p> <p>During an interview on 9/10.13 at 11:45 a.m. Resident #2 reported she had an incident with Staff C and it had been resolved. Resident #2 reported Staff C no longer worked there, and she was happy about that, however she was still afraid to be at the facility.</p> <p>Review of the facility's incident log revealed an allegation of Abuse was reported by Resident #2 on 8/21/13. Review of the incident revealed Resident #2 was attempting to get out of bed and Staff C had put her legs back on her bed and told her she could not get out of bed. Resident #2 reported he held her legs down so hard she thought they would break.</p> <p>Further review of the incident investigation revealed a written statement by Staff C in which he reported during the night on 8/21/13 Resident #2 had requested to get out of bed and into her wheelchair. Staff C had told Resident #2 not to get out of her bed. The statement indicated Resident #2 was moving her legs out of the bed trying to get up and he had to reposition her legs at least 5 times. Staff C wrote he went and got his medication cart and put it in front of Resident #2's door to ensure she did not get out of the</p>	F 225		

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F 225	<p>Continued From page 4 room.</p> <p>During an interview of 9/10/13 11:30 a.m. Staff B reported the incident was not substantiated, and it was not the reason Staff C had been terminated. When asked if Resident #2 had the right to get out of bed, even if it meant falling, Staff B confirmed the resident had a right to get out of bed. When asked if Staff C confined Resident #2 to her room by placing the cart in front of the door, Staff B reported she thought the staff member had made a poor decision.</p> <p>Review of Staff C's personnel file on 9/11/13 revealed the facility had not received a background clearance.</p> <p>The facility had completed two investigations that involved allegations against Staff C of abuse. In both investigations the facility had failed to review and identify Staff C had never been cleared to work unsupervised.</p> <p>STAFF C Review of an incident titled "Alleged Abuse" dated 8/21/13 at 5:10p.m. revealed on 8/21/13 Resident #2 reported to staff that at 11:00 p.m. on 8/20/13 Staff C had hurt her when putting her legs back into her bed and then would not allow her to get out of bed.</p> <p>Further review of the investigation revealed Resident #2's physician was notified on 8/21/13 at 6:52 p.m.</p> <p>Review of facility staff records revealed Staff C worked the night shift on 8/21/13, meaning he did not leave the facility until the morning of 8/22/13. During an interview on 9/11/13 at 8:45 a.m. Staff</p>	F 225		

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F 225	Continued From page 5 D confirmed Staff C's last shift at the facility was night shift on 8/21/13. Further review of the investigation revealed a statement from Staff C was not received until 8/22/13, meaning the facility was still conducting their investigation on 8/22/13. The facility was made aware of an allegation of abuse against Staff C on 8/21/13. The facility allowed Staff C to work with residents on the night shift on 8/21/13 even though the allegation had not yet been confirmed or ruled out. This failure placed residents at potential risk for further mistreatment by a staff member.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to implement their written policies and procedures that prohibit mistreatment, neglect and abuse of residents for 2 of 7 staff (Staff C & Staff G) reviewed for criminal background inquiries. This failure placed residents at potential risk for receiving care from a staff member with a criminal history. Findings include:	F 226	F226 Corrected: All background checks submitted for thoses staff identified Have been received. Both staff were qualified to work as per the Sec. List of DSHS (3-13 version). Staff responsible for conducting the initial And ongoing Background Checks have been Educated regarding the process oand the procedure. An ongoing list of Initial background checks and ongoing Background checks submitted for completion Hes been established. This list will be audited The three (3) months and the results brought to the QA Committee for review and futner discussuon if necessary Administrator to ensure compliance	9-27-13

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F 226	<p>Continued From page 6</p> <p>Review of the facility policy entitled "To prevent, investigate, report abuse and/or neglect" revealed the following procedures;</p> <ol style="list-style-type: none"> 1. all employees of the facility must complete a criminal background check b. if the result of the criminal background check is delayed the supervisor or designee will monitor the employee until the background check is complete. The facility shall keep a list of "uncleared employees" solely for the purpose of monitoring employees until clearance is received. <p>STAFF C</p> <p>Review of Staff C's personnel record revealed that he/she had been hired on 4/10/13. Further review of Staff C's personnel file revealed a form dated 4/10/13 which was to be completed by all employees which gave authorization for a criminal background check to be obtained by the facility. At the bottom of the form was a box label "19. REQUIRED: YOUR SIGNATURE." The form had never been signed by Staff C to allow the facility to inquire a criminal background check. There was not a criminal background check in Staff C's employee file.</p> <p>During an interview on 9/11/13 at 8:40 a.m. Staff H confirmed she processes all of the employee background checks and it typically takes 8 business days to receive background clearance once submitted. Staff H also confirmed the facility had not received a criminal background check for Staff C since he/she had been hired in April 2013, therefore, he was considered "uncleared."</p> <p>Review of the facility's "Criminal Background Check Uncleared Employee List" which identified staff members who the facility had not received</p>	F 226		

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F 226	<p>Continued From page 7</p> <p>background clearances for. The list had instructions which directed that all uncleared employees must be actively monitored at all times until cleared. The list defined active monitoring as knowing where the employee was at all times, what they were doing, monitoring their actions and being in the same building at all times, no exceptions.</p> <p>During an interview on 9/11/13 at 8:45 Staff H reported monitoring the staff members listed on the uncleared list meant the facility would monitor the list in order to ensure the background was received. Staff H reported the book of uncleared employees was kept in the human resources office and other staff did not have access to it. Staff H confirmed the scheduler did not have a copy of the list or the department heads.</p> <p>During an interview on 9/10/13 at 11:30 a.m. Staff B reported it was hard to monitor the staff who worked on the night shift. Staff B further reported that sometimes a department head would occasionally, but not even weekly, come into the facility on night shift. Staff B confirmed Staff C worked the night shift. Staff B confirmed Staff C was the only licensed staff on the 300/400 wing.</p> <p>During an interview on 9/10/13 at 11:40 a.m. Staff B confirmed Staff C had worked full time on the night shift since being hired on 4/10/13 until his last shift on 8/22/13. Staff B further confirmed that Staff C had been named in two different allegations of abuse made by two different residents during the time he was employed at the facility.</p> <p>The facility did supply an authorization for background check pm 9/11/13 at 8:55 a.m. which</p>	F 226		

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F 226	<p>Continued From page 8</p> <p>had been signed by Staff C and dated 9/9/13, the date and time fax stamp was 9/10/13 at 5:00 p.m. When asked if Staff C had come to the facility on 9/9/13 to sign the authorization, Staff H confirmed he had not been in the facility since August 2013 and that she had altered the form.</p> <p>Staff C had been allowed to work with minimal supervision on the night shift for over four months and had two allegations of being rude and rough handling before leaving the facility. The facility's failed to obtain a background clearance in a timely manner and failed to monitor the staff member while waiting for the clearance.</p> <p>STAFF G Review of Staff G's personnel file revealed the first shift he/she worked at the facility was on 4/16/13 and his/her last shift was the evening shift of 5/18/13. Review of Staff G's time card with Staff revealed he/she had always worked the evening shift which was 2:00 p.m. until approximately 10:30 p.m.</p> <p>Further review of Staff G's personnel record revealed there was not a background clearance.</p> <p>During an interview on 9/11/13 at 8:50 a.m. Staff H reviewed the personnel file for Staff G and confirmed there was not background clearance. Staff B, who was present during the interview, reported Staff G was a registered nurse and therefore was supervising other staff during the evening shift.</p> <p>Staff G worked in the facility without background clearance for over one month.</p> <p>Failure to obtain background clearance for</p>	F 226		

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F 226	Continued From page 9 employees prior to having unsupervised access to residents placed residents, staff and visitors at potential risk for abuse and or neglect.	F 226			