

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

1405

PRINTED: 02/28/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505264</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/21/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>AVAMERE SKILLED NURSING OF TACOMA</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3625 EAST B STREET TACOMA, WA 98404</b>
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(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
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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 Avamere Skilled Nursing of Tacoma on 11/21/13. The sample included 7 residents Facility census was 67.</p> <p>The following are complaints investigated as part of this survey:</p> <p>#2904882 #2901106 #2900354 #2902097 #2903138</p> <p>The survey was conducted by: <b>[REDACTED]</b>, 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> Residential Care Services Date 2/28/14</p>	F 000	<p style="text-align: center;">IDR AMENDED</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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 159 SS=D	<p><b>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</b></p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the</p>	F 159		
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F 159	<p>Continued From page 2</p> <p>SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to safeguard, manage and account for the personal funds of 1 of 4 Sampled Residents (#1) reviewed for personal funds. Additionally the facility failed to deposit funds of \$1,500.00 into an interest bearing account. This failure placed Resident #1 at risk for not being able to access his money and for loss of income through the collection of interest payments.</p> <p>Findings include:</p> <p>During an interview on 10/28/13 at approximately 2:00 p.m. Resident #1 reported Staff A had taken \$1,500.00 dollars cash from him. Resident #1 further reported he had tried a few times to retrieve the money from Staff A, however Staff A did not give him the money. Resident #1 reported Staff A told him that the money was used to pay bills for the resident and it was no longer available. Resident #1 was not able to recall the timeframe in which he had requested his money from Staff A.</p> <p>During an interview on 10/28/13 at approximately 2:15 p.m. Staff A confirmed he had received \$1,500.00 in cash from Resident #1. Staff A then reported he no longer had the money, he had</p>	F 159		
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F 159	<p>Continued From page 3</p> <p>deposited it into an interest bearing account for Resident #1.</p> <p>Review of a facility investigation revealed a paper towel that had been torn in half had a hand written note "received \$1500 4/12/13". The note had three sets of initials, Resident #1, Staff A, and Staff K.</p> <p>Review of Resident #1's personal funds account revealed from 4/12/13, when Resident #1 gave the \$1500.00 cash to Staff A, through 10/28/13, when Staff A was questioned regarding the whereabouts of the cash, there were no cash deposits made into the account. Although Resident #1 recieved direct deposits from his pension and social security, there was not an additional deposit made until 10/28/13 after Staff A reported he no longer had the money and had deposited the \$1500.00 cash into the resident's account.</p> <p>Review of the facility investigaiton revealed the deposit of \$1500.00 into Resident #1's account on 10/28/13 was made with funds from a personal check written from Staff A's personal checking account made payable to Resident #1.</p> <p>Further review of the facility investigation of Resident #1's personal funds revealed a statement dated 11/6/13 indicating that Staff L was aware that Staff A had \$1500.00 cash that belonged to Resident #1. Staff L stated that Staff A had reported to her he did not want to keep that much cash in his desk so he had removed it. The investigation did not indicate when the cash had been removed from the desk.</p> <p>Three facility staff members, Staff A, Staff K, and</p>	F 159		

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F 159	Continued From page 4 Staff L were aware Resident #1 had a large amount of cash in Staff A's desk. The \$1500.00 was not deposited into an interest bearing account for over six months. The resident was not able to access his money during the six month period Staff A was holding it for him.	F 159		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		
	<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>			

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F 225	<p>Continued From page 5</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> <p>This REQUIREMENT is not met as evidenced by: Based on observation interview and record review it was determined that the facility failed thoroughly investigate an incident for 1 of 7 Sample Residents (#2). Additionally, the facility failed to initiate interventions to prevent further potential abuse/exploitation while an investigation was in progress for 1 of 7 Sample Residents (#1). These failures placed residents at potential risk for further abuse and/or financial exploitation.</p> <p>Findings include:</p> <p><b>RESIDENT #1</b> During an interview on 11/21/13 at 3:45 p.m. Staff B reported that on 10/28/13 Staff L came to her with a concern related to a resident's personal funds account. Staff L had reported she knew Staff A had \$1500.00 cash that belonged to a resident and when a state investigator questioned him as to where the money was he reported it was in the resident's personal funds account. Staff A then gave Staff L a personal check written payable to Resident #1 and instructed her to deposit it into the resident's personal funds account immediately. Staff B reported at that time she instructed Staff L to call corporate Staff C and report the incident.</p>	F 225		

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F 225	<p>Continued From page 6</p> <p>Review of the facility/corporate investigation of the incident revealed Staff C received the call from Staff L on 10/28/13 explaining what had happened. Further review revealed Staff A was not questioned about the incident until one week later on 11/4/13. The facility investigation indicated Staff A was not asked to leave the facility and not return until 11/5/13.</p> <p>During an interview on 11/21/13 at 5:15 p.m. Staff C confirmed she did not contacted Staff A regarding the incident until 11/4/13. Staff C reported she felt Staff A had not followed the corporation's policies of not intermingling resident money with personal money. Staff A then reported after reviewing state guidelines for the definitions of abuse/neglect she determined the incident to be potential financial exploitation of Resident #1. Staff A confirmed the incident was logged and the state abuse hotline was called on 11/5/13.</p> <p>During an interview on 11/21/13 at 5:25 p.m. Staff B and Staff C confirmed Staff A was a full time employee of the facility and was working on 10/28/13 when the concern was first identified, and continued to work until he was instructed to leave on 11/5/13.</p> <p>Failure to remove a staff member from the facility until an allegation of financial exploitation was investigated placed residents, visitors, and staff at potential risk for further financial exploitation.</p> <p><b>RESIDENT #2</b> Observations on 11/21/13 at 2:25 p.m. revealed Resident #2 had two nephrostomy tubes (a tube from the kidney through the skin to the outside of</p>	F 225		
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F 225	<p>Continued From page 7</p> <p>the body to drain urine) coming from his [REDACTED] and [REDACTED] side of his back.</p> <p>Review of the facility investigation dated [REDACTED]/13 revealed one of the nephrostomy tubes had been dislodged when staff had been assisting him from his wheelchair to his bed. The resident was sent to emergency room following the incident.</p> <p>Review of Resident #2's care plan dated 10/10/12 revealed there were interventions in place to avoid dislodging the nephrostomy tubes. Interventions included ensuring the resident was wearing an abdominal binder during transfers and ensuring the nephrostomy tube was brought to the front of the resident with the bag between his legs during transfers.</p> <p>Further review of the facility investigation revealed a paragraph entitled "Incident Description" in which there is a statement "The CNA (certified nursing assistant) was not paying attention. The investigation included a statement from Staff J who was assisting Resident #2 at the time of the incident that indicated the nephrostomy tubes and bag were placed to the resident's side. The investigation did not indicate if the resident was wearing a binder at the time of the incident.</p> <p>During an interview on 11/21/13 at 2:30 p.m. Resident #2 reported he was not wearing a binder at the time of the incident. Resident #2 further reported he had not worn an abdominal binder in months.</p> <p>Further review of the facility investigation revealed a statement by the investigator "root cause: nephrostomy tube was placed on the bed</p>	F 225		

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F 225	Continued From page 8 to assist with transfer, but became caught and dislodged." The facility investigation concluded with a statement "care plan was being followed at the time of the incident. No additional interventions needed."  During an interview on 11/21/13 at 3:45 p.m. Staff B reported she did not believe the care plan was being followed at the time of the incident as indicated in the investigation. Staff B further confirmed the facility should have looked at additional interventions to prevent further incidences of similar nature.	F 225		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  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 observation interview and record review it was determined that the facility failed to take appropriate measures to reduce the risk of	F 323		

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F 323	<p>Continued From page 9</p> <p>an accident when the resident's plan of care for 1 of 3 Sampled Residents (#2) was not followed. This failure caused Resident #2 to be sent to the emergency room to undergo a procedure he described as painful.</p> <p>Findings include:</p> <p>Resident #2 had a medical diagnosis to include [REDACTED] and [REDACTED] (a condition where urine does not drain from the kidneys to the bladder). Resident #2 had one nephrostomy tube (a tube from the kidney through the skin to the outside of the body to drain urine) from each kidney.</p> <p><b>NEPHROSTOMY TUBE CARE PLAN</b></p> <p>Review of the facility's incident log revealed one of Resident #2's nephrostomy tubes was accidentally pulled and disconnected during a transfer on 10/6/13. Review of the facility investigation revealed that staff members were moving the resident from his wheelchair to his bed using a slide board technique. While staff slid the resident into bed the right sided tube became caught on either the bed or the wheelchair, pulling it and causing to disconnect.</p> <p>Review of Resident #2's care plan dated 11/11/12 for nephrostomy tubes revealed interventions listed to prevent dislodgement of the tubes. The interventions listed included directives for staff to place an abdominal binder for all transfers to promote tube safety, notify the nurse if the resident refuses the binder.</p> <p>During an interview on 11/21/13 at 3:00 p.m. Staff D reviewed Resident #2's care plan and confirmed the resident was to wear a binder</p>	F 323		
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F 323	<p>Continued From page 10</p> <p>whenever being transferred. Staff D confirmed the directives in the care plan were current at the time of the incident. Staff D reported she was not aware Resident #2 had a binder.</p> <p>During an interview on 11/21/13 at 3:05 p.m. Resident #2 reported he was not wearing a binder at the time of the incident. Resident #2 further reported he had not even seen the binder in several months.</p>	F 323		
	<p>During an interview on 11/21/13 at 3:55 p.m. Staff E and Staff F who were both assigned to Resident #2 reported they were not aware he had a binder.</p> <p>During an interview on 11/21/13 at 4:05 p.m. Staff H, who was assigned to Resident #2's care, reported she was not aware he had a binder.</p> <p>During an interview on 11/21/13 at 4:00 p.m. Staff G reported she has been assigned to Resident #2's care and has not ever seen an abdominal binder.</p> <p><b>ACTIVITIES OF DAILY LIVING CARE PLAN</b> Review of Resident #2's care plan for activities of daily living dated 10/10/12 revealed the resident was to be transferred by using a sliding board. Interventions listed included directives for staff to place the resident's nephrostomy tubes in front of him and between his legs prior to the transfer.</p> <p>Review of the facility's investigation of the nephrostomy tube dislodgement on 10/6/13 revealed a statement from the staff member who was assisting the resident in the transfer. In the written statement Staff J indicated he had placed the collection "bag on the bed beside him</p>			

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NAME OF PROVIDER OR SUPPLIER  <b>AVAMERE SKILLED NURSING OF TACOMA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3625 EAST B STREET</b> <b>TACOMA, WA 98404</b>		
(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 323	<p>Continued From page 11 like we always do".</p> <p>During an interview on 11/21/13 at 2:27 p.m. Resident #2 reported staff usually put the tubes in front of him with the bag between his legs, but the day the tubes were dislodged they had put it beside him on the bed.</p> <p>During the same interview Residnet #2 confirmed he had been sent to the hospital to have new nephrostomy tubes placed. Resident #2 reported during the procedure the hospital staff had to place a "wire" onto his bladder which was painful for him.</p> <p>During an interview on 11/21/13 at 3:00 p.m. Staff D confirmed after the nephrostomy tubes were pulled during the transfer the resident had to be sent to the emergency room so new tubes could be placed. Staff D confirmed the placement of new tubes through the skin and into the kidneys placed Resident #2 at risk for pain and infection related to the procedure.</p> <p>Failure to follow the care plan during a transfer caused one of Resident #2's nephrostomy tubes to become dislodged. This avoidable accident resulted in Resident #2 being sent to the hospital where he underwent an invasive procedure to have the tube replaced.</p>	F 323		

IDR AMENDED