

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

PRINTED: 04/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

1410

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 03/21/2013
NAME OF PROVIDER OR SUPPLIER  MANOR CARE OF TACOMA WA, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 5601 S ORCHARD STREET TACOMA, WA 98409	
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Manor Care Health Services - Tacoma on 3/21/13. A sample of 8 residents was selected from a census of 105. The sample included 5 current residents and the records of 3 former and/or discharged residents.</p> <p>The following complaint was investigated as part of this survey:</p> <p>#2774056</p> <p>The survey was conducted by:</p> <p>██████████, R.N. ██████████, R.N.</p> <p>The survey team was from:</p> <p>Department of Social &amp; Health Services Aging &amp; Disability Services Administration Residential Care Services, Distric 1, Unit A Rock Pointe Tower 316 W. Boone Avenue, Suite 170 Spokane, Washington, 99201-2351</p> <p>Telephone: (509) 323-7302 Fax: (509) 329-3993</p> <p><i>[Signature]</i> Residential Care Services      Date 4/2/13</p>	F 000	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p>
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE Administrator	(X6) DATE 4-8-13

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=D

483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES

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.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, the facility failed to identify, monitor, and intervene in a timely manner to prevent and/or promote healing of pressure sores for 2 of 5 residents at risk for pressure sores (#1, 2), in a sample of 8. Findings include:

1. Resident #1, per record review, had a [REDACTED], and was readmitted from the hospital on [REDACTED]/13 with an order for comfort care. The resident had no memory or behavior problems identified at the time of readmission. The resident required extensive assistance with transfers, bed mobility and did not walk.

According to the hospital transfer paperwork in the resident's record, the hospital identified [REDACTED] on both of the resident's [REDACTED] on 1/30/13. The record contained pictures of the heel wounds and a description by a wound specialist. The [REDACTED] heel was a 3 centimeter (cm) x 1.5 cm fluid filled [REDACTED]. The [REDACTED] was a 4 x 2 cm blood/fluid filled [REDACTED].

The 2/1/13 Nursing Transfer Summary from the hospital indicated the resident had [REDACTED] on

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Manor Care of Tacoma strives to monitor, identify and intervene in a timely manner to prevent and/or promote healing of pressure ulcers

Resident's #1 remains in the facility. Preventative measures, treatment orders and monitoring are in place. Resident #2 no longer resides in the facility

Residents currently in the facility were audited to ensure that preventative measures, treatment orders and monitoring are in place as indicated. New admissions will receive evaluation of skin conditions as well as skin risk assessments within the first 24 hours of their admission to ensure preventative measures, treatment orders and monitoring are in place as indicated.

Weekly audits will be done to ensure initial and weekly skin assessments are completed as indicated.

Findings of audits will be brought to QA for recommendations

Compliance will be ensured by DNS by 4/10/13

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F 314	<p>Continued From page 2</p> <p>both [REDACTED].</p> <p>Per review of the [REDACTED] 2013 treatment administration record and progress notes, a skin assessment scheduled for [REDACTED]/13 (day after admission) was not completed. There was no [REDACTED] assessment done to determine the presence and/or condition of the wounds to the [REDACTED] [REDACTED] as identified from the hospital transfer paperwork.</p> <p>Per review of the scheduled skin assessment and progress notes completed 2/9/13, a licensed nurse identified that the resident had an alteration in skin integrity with [REDACTED]. The [REDACTED] were described as approximately 2 cm in circumference and the [REDACTED] had blood/fluid type drainage. At that time a treatment intervention was put into place directing staff to "float" the resident's [REDACTED] (keeping them from direct contact on the bed). The facility did not implement an intervention or identify the wounds for 9 days.</p> <p>The [REDACTED] were not described again until 2/25/13 (16 days after the facility first identified them). Per review of the Skin Alteration Record and [REDACTED] Assessment form, the [REDACTED] was 1.8 x 1.8cm and the right heel was 1.5 x 2.3cm. Both [REDACTED] were described as macerated (softened), open areas with a small [REDACTED], clear drainage, and tender to palpation. The note identified the resident was non-compliant with nursing interventions, spent most of his time in bed and did not like his [REDACTED] elevated. The recommendations were for a betadine treatment and pressure reduction boots. An addendum was written to this assessment which documented the root cause of the [REDACTED] as multifactorial. The causes included [REDACTED], compromised [REDACTED], inadequate [REDACTED], [REDACTED] and [REDACTED].</p>	F 314			

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F 314	<p>Continued From page 3</p> <p>the resident limiting interventions allowed. The note identified the resident was non-compliant with pressure [REDACTED] and frequently kicked away pressure reduction attempts. According to the note those components as well as friction and pressure were contributing factors to the [REDACTED].</p> <p>The resident was observed intermittently on 3/21/13. He was in bed, with a pillow at his feet, and [REDACTED] directly on the mattress. Two pressure [REDACTED] were in a stationary chair in the room. A nursing assistant stated the resident would allow the boots to be put on and [REDACTED] floated, but would kick them off at times.</p> <p>The resident's heels were observed with a nurse supervisor on 3/21/13 at 2:50 p.m. The resident complained of pain when the legs were moved. The [REDACTED] had a red area approximately 4 cm long and 2 cm wide with a [REDACTED] area in the middle. The [REDACTED] had a circular red area approximately 3 cm with a small yellow [REDACTED] in the center.</p> <p>Eventhough the resident was identified as at risk for [REDACTED] and had multiple medical issues, the facility did not identify [REDACTED] on the resident's [REDACTED] at the time of admission or put preventative measures in place to prevent further breakdown for 9 days. Once the [REDACTED] were identified there was no ongoing monitoring to evaluate the effectiveness of the interventions or to track the healing of the [REDACTED] for another 16 days.</p> <p>When interviewed on 3/21/13 at 3:00 p.m., facility administrative staff was unable to provide further information regarding the delay in monitoring of the resident's heel wounds.</p> <p>2. Resident #2 was admitted to the facility in [REDACTED] 2012 with diagnoses that included</p>	F 314		

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F 314	<p>Continued From page 4</p> <p>██████████ and ██████████ Per record review, the resident required assistance with repositioning in bed &amp; transfers, and was at risk for ██████████ due to her impaired mobility.</p> <p>The Plan of Care directed staff to float the resident's ██████████ while in bed to reduce ██████████ and to monitor the resident's ██████████ during daily cares and report abnormalities to the licensed nurse. Per record review, the resident was to have weekly skin checks documented on the TAR (Treatment Administration Record). However, no skin checks were recorded for the month of November and the facility was unable to locate the resident's TAR for December.</p> <p>According to the record, the resident was discharged from the facility on 12/29/12 with no identified wounds or skin impairments. A physical therapist with a home health agency visited the resident on 12/30/12 and noted a wound on the resident's ██████████. On 1/3/13 a licensed nurse from the same agency assessed the wound as a ██████████ (partial thickness skin loss), measuring 2 x 3 centimeters. The physician was consulted and treatment orders were obtained.</p> <p>During an interview on 3/21/13 at 9:00 a.m., a caregiver in the resident's home stated the wound on the resident's ██████████ was present the day she was discharged from the facility and was noticed as soon as they got the resident home. The caregiver further stated that despite treatment, the wound was still not completely healed almost three months after discharge.</p> <p>When interviewed on 3/21/13 at approximately 3:00 p.m., administrative staff stated no wounds were identified on the resident's ██████████ while she was at the facility.</p>	F 314		