

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

PRINTED: 02/07/2013
FORM APPROVED
OMB NO. 0938-0391

14324

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372
---	--

(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>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Standard Survey conducted at Regency at Puyallup Rehabilitation Center on 1/23/13, 1/24/13, 1/25/13, 1/28/13, 1/29/13, 1/30/13, 1/31/13 and 2/1/13. A sample of 39 residents was selected from a census of 91. The sample included 33 current residents and the records of 6 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████ RN, BSN ██████████ RN, BSN, MSN ██████████ RN, MSN ██████████ RN, BSN ██████████, RN, BSN</p> <p>The survey team is from:</p> <p>DSHS - ADCA RCS - REGION 5</p> <p>Department of Social and Health Services Aging and Disability Services Administration Residential Care Services, District 3, Unit B 1949 South State Street, MS: N27-24 Tacoma, Washington 98405-2850</p> <p>Telephone: (253) 983-3800 FAX: (253) 589-7240</p> <p><i>Jean Perie</i> 2-7-13 Signature Date</p>	F 000	<p>F000 Initial Comments</p> <p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Puyallup Care and Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>F225</p> <p>Staff P was suspended from duty until the pending charge was removed from her record. She accomplished this action with the court. A new background check was obtained. She is now eligible for employment and has been reinstated to her job.</p>	2-28-13
-------	---	-------	---	---------

RECEIVED
FEB 19 2013
DSHS - ADCA
RCS - REGION 5

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kevin J. Fletcher</i>	TITLE Administrator	(X6) DATE 2/19/13
---	------------------------	----------------------

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.

MAR 20 2013

DSHS/ADSA

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372		
(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 225 SS=D	<p>483.13(c)(1)(ii)-(iii) STAFF TREATMENT OF RESIDENTS</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> <p>This REQUIREMENT is not met as evidenced</p>	F 225	<p>Residents, staff, and visitors have the potential for risk related to employees with disqualifying crimes on their background checks. The employee files were audited by the Human Resources Department, Staffing Coordinator, and Administrator to assure that there are no ineligible employees working.</p> <p>Measures to prevent recurrence:</p> <p>Re-education on review of background checks was provided to administrative staff on 2/1/13.</p> <p>Monitor for Corrective Action:</p> <p>The facility conducts background checks on hire and annually and these will be reviewed by trained staff to determine eligibility for employment.</p> <p>The Administrator will assure compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372	
(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 225	<p>Continued From page 2</p> <p>by: Based on interview and record review the facility failed to thoroughly review and follow up on an alleged violation prior to employment for one staff member (Staff P). This failure had potential to place other staff, residents and visitors at risk for being victims of a crime.</p> <p>Findings include:</p> <p>Staff P was hired by the facility on [REDACTED]/12.</p> <p>Review of the facility policy related to abuse revealed any potential employee with criminal history against a person or property will not be eligible for hire.</p> <p>Review of Staff P's personnel file revealed a criminal background check dated 11/8/12 revealed she had a charge listed on the DSHS Secretary's List of Crimes that would disqualified her from working in the facility. Tacoma Municipal Court records listed the charge as deferred.</p> <p>Staff P's personnel file also contained a letter from and attorney dated 7/16/12 that indicated Staff P had not been convicted in the case and may have it dropped completely on 10/16/12.</p> <p>During an interview on 1/28/13 Staff E confirmed that although Staff P's attorney indicated the charges may be dropped in October 2012, the background check that was ran in November 2012 confirmed Staff P still had criminal charges pending upon hire. Staff E confirmed the facility mistakenly thought the charges had been dismissed.</p>	F 225	<p>F242</p> <p>Corrective Action/s for residents identified to have been affected:</p> <p>Resident #214 was interviewed by Activity and Nursing staff on her preferences. Her plan of care was updated to include her preferred wake-up time. Staff who provide direct care to her were educated to the plan of care. The resident is satisfied with this outcome.</p> <p>Identification of residents with the potential to be affected:</p> <p>Other residents have the potential to be affected by this finding. Alert and oriented residents of the facility were interviewed regarding preferences for daily routine with no trend identified. Their preferences were incorporated into their plans of care whenever feasible.</p>	2-28-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372	
(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 225	Continued From page 3	F 225		
F 242 SS=D	<p>483.15(b) SELF-DETERMINATION AND PARTICIPATION</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to honor the choice for 1 of 3 Sampled Residents (#214) reviewed, the right to wake in the morning according to the residents preference. This failure placed the resident at risk for a diminished quality of life.</p> <p>Findings include:</p> <p>Resident #214 admitted to the facility on [REDACTED]-12 with diagnoses to include [REDACTED], [REDACTED], and [REDACTED].</p> <p>On 1-23-13 at 11:16 a.m., Resident #214 reported that the staff would wake her/him up between 6:00 a.m. and 6:30 a.m., and stated that it was earlier than s/he would like, but had to do it when the staff had time. Resident #214 stated</p>	F 242	<p>Measures to prevent recurrence:</p> <p>Staff were re-educated on incorporating residents' preferences into their plans of care.</p> <p>Residents and / or their families are interviewed about preferences with their initial and annual assessments. Interviewers have been educated on communicating preferences to the appropriate department and to incorporating them into each resident's routine. Preferences will be honored as much as possible.</p> <p>Monitor for Corrective Action:</p> <p>Resident and family interviews will be conducted monthly as a part of the QA process. These interviews help to identify residents who may not be satisfied with their daily routines or care. Findings of these interviews will be reviewed in the QA Committee meeting, with areas of concern identified and addressed.</p> <p>The Director of Nursing will assure compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372		
(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 242	Continued From page 4 that s/he told staff that s/he did not wish to get up that early, and according to the resident, staff said they needed to start at that time so they would have enough time to do their work. On 1-29-13 review of the record revealed a facility form titled "Resident Admission Profile" dated 12-23-12 which documented Resident # 214's usual rise time to be between 7 a.m. and 8 a.m. In an interview on 1-29-13 at 2:25 p.m., Staff G reported that the facility did not typically get the resident's up according to their usual rise time unless the resident had specifically stated they wished to get up at a later time. Staff G confirmed that the facility form titled "Resident Admission Profile" documented Resident #214's stated usual rise time was between 7 a.m. and 8 a.m. Staff continued to wake the resident between 6 a.m. and 6:30 a.m. although the resident specifically told staff that s/he did not want to get up that early. Failure to honor Resident #214 choices placed the resident at risk for diminished quality of life.	F 242	F250 Corrective Action/s for residents identified to have been affected: Resident #214 continues to have no evidence of psychosocial harm following her concern with being on a bedpan for too long. Identification of residents with the potential to be affected: Other residents have the potential to be affected by incomplete monitoring for psychosocial harm following events that could potentially cause psychosocial harm. Investigations of events occurring over the last 90 days, with potential for psychosocial harm, were reviewed by the Staff Development Nurse and Social Services Director to assure that residents were monitored by Nursing and by Social Services until psychosocial harm was ruled out or identified with follow-up measures taken. There were no residents identified to have incomplete monitoring and no psychosocial harm identified.	2-28-13	
F 250 SS=D	483.15(g)(1) SOCIAL SERVICES The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was	F 250			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013	
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372		
(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 250	<p>Continued From page 5</p> <p>determined that the facility failed to timely provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being for 1 of 3 Sampled Residents (#214) reviewed following an allegation of abuse/neglect. This failure placed the resident at risk for undue anxiety, fear or other psychosocial concerns.</p> <p>Findings include:</p> <p>Resident # 214 admitted to the facility on [REDACTED]-12 with diagnoses to include impacted [REDACTED], [REDACTED] and [REDACTED].</p> <p>On 1-23-13 at 11:29 a.m., Resident #214 reported that s/he had been left on the bedpan for about an hour and a half.</p> <p>Review of the facility's investigation dated 1-3-13 revealed an undated comment note made by social services at the bottom of the investigation report which read, "there appears to be no signs or symptoms of psychosocial harm, will continue to monitor weight, sleep, and participation."</p> <p>During an interview on 1-30-13 at approximately 3:30 p.m., Staff H stated that residents are monitored two weeks after suspected abuse or neglect has occurred. Staff H reported that before the two week evaluation, social services informally monitor the residents by looking at them for behavior changes. After two weeks, an evaluation is made, and a change such as weight loss is reviewed for possible psychological harm.</p> <p>There was no evidence to show that social services identified possible problems and linked</p>	F 250	<p>Measures to prevent recurrence:</p> <p>Social Services and Nursing staff were re-educated on monitoring residents for psychosocial harm following an incident. Residents with care concerns, who are involved in resident to resident altercations, or who are alleged to be victims of abuse or neglect will be placed on alert and monitored for psychosocial harm until signs of harm are ruled out. Social Services will follow-up with residents for any latent evidence of psychosocial harm.</p> <p>Monitor for Corrective Action:</p> <p>Residents with the potential for psychosocial harm following an occurrence will be identified by the Staff Development nurse as a part of the monthly QA process. Records will be reviewed to assure that monitoring for psychosocial harm is completed. Findings will be reported to the QA Committee for 3 months to identify the need for further education and/or intervention.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372	
(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 250	Continued From page 6 goals to psychosocial well-being for Resident #214, or that interventions were implemented to assist the Resident #214 to maintain the highest practicable physical, mental, and psychosocial well-being following an allegation of neglect/abuse. Failure to provide medically related social services for Resident #214 placed the resident at risk for unmet psychosocial needs.	F 250	The Director of Nursing or Designee will assure compliance.	2-28-13
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures;	F 272	F272 Corrective Action/s for residents identified to have been affected: Resident #43 was assessed by nursing for ability to provide his own catheter care and found able to competently do so. He was provided with supplies. His ability to provide his own catheter care will be periodically re-assessed, and he will be encouraged to continue to participate in his care as much as he desires and is able. Identification of residents with the potential to be affected: Other residents who perform procedures independently have the potential to be affected. Interviews were conducted by nurse managers with care staff on each unit and each shift to determine if other residents are performing treatments that might otherwise be performed by nursing. Identified residents will be assessed for ability and desire to perform these procedures and provided with	

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372
---	--

(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 272	<p>Continued From page 7</p> <p>Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assess 1 of 1 Sampled Resident (#43) reviewed for hospice and self-directed care. The facility failed to conduct an accurate assessment of the resident's ability to care for his indwelling Foley catheter placing the resident at risk for unmet needs and complications of infection.</p> <p>Findings include:</p> <p>Refer to F-309</p> <p>Resident #43 had resided in the facility for 8 months with multiple medially disabling conditions including a [REDACTED] that required an indwelling [REDACTED] (a [REDACTED] through the [REDACTED] into the [REDACTED]). Resident #43 started hospice services in January 2013.</p> <p>A Minimum Data Set (MDS-an assessment tool) dated 1/08/13, documented the resident had an [REDACTED]</p> <p>Resident #43's care plan dated 1/20/13 documented the resident had a [REDACTED]</p>	F 272	<p>the necessary supplies, support, and education to do so.</p> <p>Measures to prevent recurrence:</p> <p>Nursing staff were re-educated on the policy and procedure for self-medication (to include self treatment administration).</p> <p>Monitor for Corrective Action:</p> <p>Direct care staff from each unit will be interviewed, at the time of the quarterly MDS, to assure that the plan of care continues to accurately reflect the care that the resident is receiving and the level of assistance needed. Interviews will be conducted by MDS nurses and Resident Care Managers.</p> <p>The Director of Nursing will assure compliance.</p>	
-------	---	-------	---	--

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372	
(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 272	<p>Continued From page 8</p> <p>██████████ The resident's ██████████ care plan documented he was to receive ██████████ care each shift and as needed by staff.</p> <p>On 1/30/13 at 2:50 p.m., LN C stated Resident #43 did all of his daily ██████████ except to empty the ██████████. Both LN A and LN B said they were not aware Resident #43 was doing his own care and Resident #43 had not been assessed to do self-██████████. There was no assessment for self-directed care regarding the resident's ██████████ when Resident #43 did his ongoing ██████████ while residing in the facility.</p> <p>On 1/31/13 at 11:00 a.m., the Director of Nursing Services (DNS) said Resident #43 should have been assessed for ██████████ and referred to therapy when he was observed by nursing assistant staff to do his own care.</p> <p>The DNS said staff were to refer to the facility policy for "Self-Medication Program" in relationship to Resident #43 needing an assessment for self-directed care. The policy documented, in part, "Patients will be assessed as possible candidates when the condition warrants or the patient expresses a desire for self-care."</p>	F 272	<p>F279</p> <p>Corrective Action/s for residents identified to have been affected:</p> <p>Resident #93 was consulted to determine her wishes for repairing or replacing her dentures. She was seen in the facility by a dentist on 2/4/13, and new dentures have been ordered. Her care plan has been updated with current information on her dental status.</p> <p>A care plan for management of diabetes was developed for Resident #61. He had no complications in his care related to diabetes care. He has discharged home and is no longer a resident of the facility.</p> <p>Resident #17 is no longer a resident of the facility.</p> <p>Resident #214 was assessed for symptoms of urinary tract infection. There were none found. Her care plan was updated with interventions for prevention of urinary tract infection.</p>
F 279 SS=E	<p>483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment</p>	F 279	

2-28-13

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372		
(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 279	<p>Continued From page 9</p> <p>to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and 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 interview and record review it was determined that the facility failed to develop a care plan with measurable goals and interventions for 4 of 26 Sampled Residents (#s 17, 61, 93, & 214) reviewed in the stage 2 review. This failure placed residents at risk of unmet needs.</p> <p>Findings Include:</p> <p>Resident #93 Resident #93 admitted to the facility on [redacted] 12 from the hospital after having a fall at home.</p> <p>Review of Resident #93's admitting Minimum</p>	F 279	<p>Identification of residents with the potential to be affected:</p> <p>Other residents have the potential to be affected by failure to develop a comprehensive care plan for dentures, diabetes, and acute infections. Care plans were reviewed for residents who have dentures to assure that current information is available on the care plan. Care plans of diabetic residents were reviewed to assure that goals and interventions for management of diabetes are included on the care plan. Care plans for residents who had infections in the month of January and February 2013 were reviewed to assure that plans of care with measurable goals and interventions were developed for management of the acute condition.</p> <p>Measures to prevent recurrence:</p> <p>Nursing staff were educated on developing care plans for dental status, diagnoses, and acute conditions. Education was</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372	
(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 279	<p>Continued From page 10</p> <p>Data Set (MDS) assessment dated 9/17/12 was assessed as having no natural teeth. Review of the Care Area Assessments (CAAs) revealed "dental" was marked as a care area to be assessed, with a documented note that her dentures were broken.</p> <p>During an interview on 1/31/13 at 7:45 a.m. Staff R reported when a dental CAA is triggered the information is carried through to a nutrition care plan. Staff R reviewed Resident #93's medical record and confirmed the nutrition care plan did not include any information related to dental care or dentures.</p> <p>Further record review revealed an Activities of Daily Living (ADL) care plan that noted Resident #93 had broken dentures. The care plan did not have any goals or interventions related to the dentures listed.</p> <p>Failure to develop a care plan specific to identified dental issues placed Resident #93 at potential risk of continuing with broken dentures which affected her food texture and nutritional state.</p> <p>RESIDENT #61 Resident #61 admitted to the facility on [REDACTED]/12 with diagnosis to include [REDACTED].</p> <p>Review of Resident #61's medical record revealed there was no care plan with goals and interventions that addressed [REDACTED].</p>	F 279	<p>conducted on 2/21/13 by the DNS and the Staff Development nurse.</p> <p>Monitor for Corrective Action:</p> <p>Care plans will be developed with the initial MDS assessment and reviewed by each participating discipline each quarter. Care plans will also be reviewed with changes in condition to assure that goals and approaches remain appropriate.</p> <p>The Director of Nursing will assure compliance.</p> <p>F281</p> <p>Corrective Action/s for residents identified to have been affected:</p> <p>Resident #43 was assessed by nursing for his ability to provide his own catheter care, found competent to do so, and provided with the necessary supplies and oversight. He was assessed for signs and symptoms of a urinary tract infection and none are present.</p>	2-28-13

ASR

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372		
(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 279	<p>Continued From page 11</p> <p>During an interview on 1/28/12 at 10:15 a.m. Staff R reported the facility does have specific care plans for ██████ residents. Staff R reviewed Resident #61's medical record and confirmed there was no care plan related to ██████</p> <p>Review of other Sampled Residents in stage 2. revealed care plans for Alteration in ██████ with interventions in place to avoid complications related to ██████ and ██████ use.</p> <p>Failure to develop a care plan with specific interventions and goals place Resident #61 at potential risk for not receiving care to avoid complications and for delay in identification of complications related to ██████ dependent ██████</p> <p>RESIDENT #17 Resident #17 was admitted to the facility on ██████-12 with multiple diagnoses to include ██████, ██████, and ██████.</p> <p>The Minimum Data Set (MDS) an assessment tool dated 12-16-12 identified that the resident developed a ██████</p> <p>The Care Area Assessment (CAA) dated 12-20-12 identified the resident to have multiple risk factors to include ██████ and ██████.</p> <p>Review of the record did not reveal that a plan of care with measurable goals and interventions related to the development of the ██████ ██████ had been developed for this resident.</p> <p>In an interview on 1-25-13 at 11:27 a.m., Staff J reported that the process used for a resident who</p>	F 279	<p>Identification of residents with the potential to be affected:</p> <p>Other residents have the potential to be affected. Nursing staff were re-educated to the policy for obtaining timely urine samples for residents suspected of having urinary tract infections. Nursing staff were educated on the procedure for obtaining urine samples from a closed urinary catheter system. Education occurred on 2/21/13 and was conducted by the Director of Nursing and Staff Development nurse.</p> <p>Measures to prevent recurrence:</p> <p>Residents who provide self-care (medication or treatments that would otherwise be provided by nursing) will be identified through staff interviews and assessed for ability to provide self-care and provided with the supplies, education, and oversight needed.</p>	

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372	
(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 279	Continued From page 12 develops a [REDACTED] is to update the care plan to show that it is a new or a recurrent [REDACTED]. Staff J confirmed that the care plan related to the development of the [REDACTED] had not been updated for Resident #17. Failure to develop a plan of care with measurable goals and interventions placed Resident #17 at risk for further health complications RESIDENT #214 Resident #214 admitted to the facility on [REDACTED]-12 with multiple diagnoses to include [REDACTED], [REDACTED] and [REDACTED] The MDS dated 1-4-13 identified that the resident developed a [REDACTED] In an interview on 1-30-13 at 1:22 p.m., Staff K confirmed that a care plan with measurable goals and interventions related to the development of the [REDACTED] had not been developed for Resident #214. Failure to develop a plan of care with measurable goals and interventions placed Resident #214 at risk for further health complications.	F 279	Monitor for Corrective Action: The Staff Development nurse or Designee will audit the records of residents who are diagnosed with urinary tract infections to assure that diagnostic labs were obtained within a reasonable amount of time after they were ordered. Findings will be reported to the QA Committee for 3 months to identify trends and need for further education. The Director of Nursing will assure compliance.	
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was	F 281		

KSP

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372
---	--

(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 281	<p>Continued From page 13</p> <p>determined the facility failed to meet professional standards for 1 of 1 Sampled Resident (#43) reviewed for hospice services and self-directed care. This failure placed the resident at risk for lack of consistent monitoring regarding his catheter care and delayed treatment when the resident developed a [REDACTED].</p> <p>Findings include:</p> <p>Refer to F-309</p> <p>According to Fundamentals of Nursing, Lippincott, Williams, & Wilkins, 7th Edition 2011, page 559: Focused assessments are completed to assess specific problems that occur in patients. The information is used to formulate nursing diagnoses that require nursing care and monitoring of the patient. Page 326: Documentation is the record of pertinent interactions with the patient- assessing, diagnosing, planning, implementing and evaluating. Nursing interventions are documented as closely as possible to their execution. Indicate in each entry the date and time of pertinent observations and interventions. Note problems as they occur in an orderly, sequential manner.</p> <p>Resident #43 had resided in the facility for 8 months with multiple medical disabling conditions including a [REDACTED] that required an indwelling [REDACTED] (a [REDACTED] through the [REDACTED] into the [REDACTED]). Resident #43 started hospice services in January 2013.</p>	F 281	<p>F309</p> <p>Corrective Action/s for residents identified to have been affected:</p> <p>Resident #43 is free of signs and symptoms of a urinary tract infection. He has been interviewed by Activity, Nursing, and Social Service staff about preferences, concerns, pain, and any unmet physical or psychosocial needs. Resident #43 stated that he feels that his needs are being adequately addressed by the facility. His care plan has been reviewed and updated. Nursing staff has been educated on following the plan of care and honoring his choices when providing care. He will be interviewed monthly as a part of the QA process for the next 3 months and quarterly thereafter, if no problems are identified. He has been encouraged to report any problems that develop, and has been supplied with the names and locations of staff who will address concerns.</p>	2-28-13
-------	--	-------	---	---------

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372	
(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 281	<p>Continued From page 14</p> <p>On 1/10/13 Resident #43's chart record documented the facility received an order to obtain a [REDACTED] after the resident complained of [REDACTED] and back pain indicating a possible [REDACTED].</p> <p>By 1/17/13 a lab report confirmed Resident #43 had a [REDACTED] that required treatment with antibiotics.</p> <p>On 1/30/13 at 1:30 p.m., Licensed Nurse A (LN A, the unit manager) said she had been told Resident #43 had refused to allow one of the night nurses to get the UA on 1/11/13 when he would not let the nurse change the [REDACTED]. There was no plan in place to address obtaining the urine sample for another 5 days other than changing the [REDACTED].</p> <p>On 1/30/13 at 1:40 p.m., LN B said she notified the resident's physician when the resident refused to have his [REDACTED] changed but she had not documented her call. LN B said she had discussed the matter with the contracted hospice nurse but had not documented the information.</p> <p>Resident #43's chart had no documentation regarding monitoring him when staff did nothing more to obtain a [REDACTED] sample from 1/11/13 through 1/15/13 when the [REDACTED] was changed. The chart notes indicated he had pain and felt</p>	F 281	<p>Identification of residents with the potential to be affected:</p> <p>Other residents of the facility have the potential to be affected. Residents of the facility (or their families) were interviewed on quality of care. Any concerns identified were immediately addressed. There were no trends identified.</p> <p>Measures to prevent recurrence:</p> <p>Staff were re-educated on honoring residents' preferences when planning and providing care. Education was provided on February 19, 2013.</p> <p>Monitor for Corrective Action:</p> <p>Quality of care / quality of life interviews will be conducted monthly as a part of the QA process. Ten percent of the population will be interviewed each month. Immediate need concerns will be addressed at the time of the interview. Trends will be reviewed</p>	

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372
---	--

(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 281	<p>Continued From page 15 anxious. However, there was no monitoring of complications from possible infection.</p> <p>On 1/30/13 at 2:50 p.m., LN C stated Resident #43 did all of his daily [REDACTED] except to empty the [REDACTED]. Both LN A and LN B said they were not aware Resident #43 was doing his own care.</p> <p>There was no assessment for self-directed care or monitoring of self-care completed by staff when Resident #43 did his ongoing [REDACTED] while residing in the facility.</p> <p>On 1/31/13 at 11:00 a.m., the Director of Nursing Services (DNS) said Resident #43 should have been assessed for [REDACTED] care and referred to therapy when he was observed by nursing assistant staff to do his own care.</p> <p>The DNS said the staff did not have to change the catheter to get a [REDACTED] sample. Staff should have referred to the facility Lippincott Nursing Practice Manual to obtain the sample in a timely manner.</p>	F 281	<p>by the QA Committee to identify any changes needed.</p> <p>The Director of Nursing will ensure compliance.</p> <p>F309</p> <p>Corrective Action/s for residents identified to have been affected:</p> <p>Resident #82 is no longer a resident of the facility.</p> <p>Identification of residents with the potential to be affected:</p> <p>Other residents with declines in condition have the potential to be affected. Residents with declines in condition over the last month were identified through staff interviews and physician order review. Records were reviewed to assure that families and physicians were made aware of declines in condition. Documentation was reviewed to assure that the declines were assessed and documented accurately. Care plans were reviewed to assure that identified problems, goals, and interventions are appropriate.</p>	2.28.13
F 309 SS=G	<p>483.25 QUALITY OF CARE</p> <p>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</p>	F 309		

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013	
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372		
(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 309	<p>Continued From page 16 accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide the necessary care and services to identify, implement and ensure timely treatment was provided for 1 of 1 sampled resident (#43) reviewed for hospice services. This failure resulted in actual harm when Resident #43 had delayed treatment for a [REDACTED] with noted increased pain and anxiety. The facility also failed to correlate assessment findings as end of life changes that required a more thorough assessment to address the resident's physical, mental and psychosocial needs for 1 of 1 sampled resident (#82) reviewed for care and services related to death issues. Failure to correlate assessment findings with end of life for Resident #82 resulted in unmet physical, mental and psychosocial needs.</p> <p>Findings include:</p> <p>RESIDENT #43 Resident #43 had resided in the facility for 8 months with multiple medically disabling conditions including a [REDACTED] that required an indwelling [REDACTED] (a [REDACTED] through the [REDACTED] into the [REDACTED]). Resident #43 started hospice services in January 2013.</p> <p>A Minimum Data Set (MDS-an assessment tool) dated 1/08/13, documented the resident had a</p>	F 309	<p>Measures to prevent recurrence:</p> <p>Licensed nurses were educated on identifying residents with declines in condition and determining, with input from the resident, the family, and the physician, the goals and interventions needed for managing the decline. Licensed nurses were re-educated on maintaining communication with the resident, family, and physician as the resident's condition changes. Education was provided by the Director of Nursing and the Staff Development nurse on 2/21/2013.</p> <p>Monitor for Corrective Action:</p> <p>Residents who have declines in condition will be identified each month by the Resident Care Managers and will have progress notes, care plan, and physician progress notes reviewed to assure that all notifications and monitoring are complete. Trends will be</p>	

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372
---	--

(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 309	<p>Continued From page 17</p> <p>Brief Interview of Mental Status (BIMS) score 15 of 15 indicating he had no cognitive impairments. He was listed as being able to understand conversation, he had clear speech and staff had no difficulty understanding him.</p> <p>Resident #43's care plan dated 1/20/13, documented the resident had a [REDACTED]. The resident's [REDACTED] care plan documented he was to receive [REDACTED] ([REDACTED]) care each shift and as needed by staff. On 1/30/13 at 2:50 p.m., LN C stated Resident #43 did all of his daily [REDACTED] except to empty the [REDACTED]. Refer to F-tag 272.</p> <p>A mental health consultation dated 12/20/12, documented Resident #43 had clear cognition with significant medical issues, suffering from anxiety and depression due to his significant loss of independence.</p> <p>On 1/10/13 Resident #43's chart documented the facility received an order to obtain a [REDACTED] after the resident complained of [REDACTED].</p> <p>A chart note dated and timed 1/11/13 at 5:00 a.m., documented Resident #43, "refused to have Foley changed to obtain [REDACTED]. Resident #43 requested pain medication for pain in his back and legs on a scale of 10 (highest level of pain) ... possibly related to [REDACTED]."</p> <p>The [REDACTED] was not obtained until 1/15/13 when the</p>	F 309	<p>reported to the QA committee for 3 months to identify the need for further training.</p> <p>The Director of Nursing will assure compliance.</p> <p>F315</p> <p>Corrective Action/s for residents identified to have been affected:</p> <p>Resident #214 has had her catheter discontinued and her cast has been removed. She is free of signs and symptoms of a urinary tract infection and is voiding without problem.</p> <p>Identification of residents with the potential to be affected:</p> <p>Other residents with catheters in place have the potential to be affected. Other residents with catheters were reviewed to assure that the catheter is medically justified and that they have been</p>	2-28-13
-------	--	-------	---	---------

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013	
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372		
(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 309	<p>Continued From page 18 resident had his scheduled [REDACTED] change for the month.</p> <p>On 1/17/13 a lab report documented Resident #43 had a [REDACTED]. An antibiotic was started on 1/18/13, nine days after the initial order to obtain a [REDACTED] sample was received by the facility to treat the infection.</p> <p>On 1/30/13 at 2:00 p.m., Resident #43 was observed in his bed. He was alert and able to complete an interview regarding his care. Resident #43's [REDACTED] and port for collecting a [REDACTED] sample were observed.</p> <p>Resident #43 said on 1/11/13 around 4:00 a.m., a licensed nurse came to his room and said she was going to change his [REDACTED] because she had to get a [REDACTED] sample.</p> <p>Resident #43 said he told the nurse he was in pain after being awakened, he needed pain medication and to sleep. He was not going to have his [REDACTED] changed at 4:00 a.m. Resident #43 stated he did not know why the nurse insisted on changing the entire [REDACTED]. The resident demonstrated the location of the port and said staff could have cleansed the port with an alcohol wipe and aspirated a sample of [REDACTED].</p> <p>Resident #43 said he purchased his own brand of [REDACTED] and equipment he had used at</p>	F 309	<p>educated to the purpose, risks, and benefits of using the catheter.</p> <p>Measures to prevent recurrence:</p> <p>Nursing staff have been re-educated to the policy for using urinary catheters. Education was provided on 2/21/2013 by the DNS and the Staff Development nurse.</p> <p>Monitor for Corrective Action:</p> <p>Residents with urinary catheters will be reviewed by the Resident Care Managers monthly to assure the policy for urinary catheters is being followed, with correction of any problem found and a monthly report to the QA Committee for 3 months. The QA Committee will determine the need for further education and monitoring.</p> <p>The Director of Nursing will assure compliance.</p>	

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013	
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372		
(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 309	<p>Continued From page 19</p> <p>home to provide his own care for years. Resident #43 said he did his own [REDACTED] in the facility with aseptic technique.</p> <p>Resident #43 said his pain medication was increased when he had symptoms of a [REDACTED]. He also reported he felt anxious when the nurse told him his physician had ordered the Foley to be changed for a [REDACTED] sample. It was an invasive procedure and he was already on a schedule to have the [REDACTED] changed once a month not during the middle of the night. Resident #43 stated he never refused to have a [REDACTED], rather, he refused to have his entire [REDACTED] changed at 4:00 a.m.</p> <p>On 1/30/13 at 1:30 p.m., Licensed Nurse A (LN A, the unit manager) said she had been told Resident #43 had refused to allow the nurse to get the [REDACTED] on 1/11/13. LN A said she had not spoken to Resident #43 directly nor talked with the night nurse who reported the resident's alleged refusal. There was no plan in place to address getting the urine sample for another 5 days.</p> <p>On 1/30/13 at 1:40 p.m., LN B said she was she was aware Resident #43 "refused" to have the [REDACTED] changed on 1/11/13. LN B said she notified the resident's physician but she had not documented her call. LN B said she had also discussed the matter with the contracted hospice nurse but had not documented the information. LN B said there was no other plan or option to get the UA except to wait until 1/15/13 when Resident</p>	F 309	<p>F325</p> <p>Corrective Action/s for residents identified to have been affected:</p> <p>Resident #93 has had her diet upgraded per the Speech Therapist's recommendations. She has been fitted for new dentures and they are ordered. Her current dentures have been returned to the facility, and she continues to refuse to wear them. She is managing a mechanical soft diet texture without difficulty. She reports that she has no mouth pain and her oral mucous membranes are free of redness or lesions on assessment. Her weight has decreased by 1.9% in 30 days and 3.2% in 90 days. She is reviewed weekly by the Nutrition Committee, with continued interventions for weight stabilization, as she allows.</p>	2-28-13

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372	
(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 309	<p>Continued From page 20</p> <p>#43 had his scheduled [REDACTED] change.</p> <p>On 1/30/13 at 1:45 p.m., the hospice nurse said the resident was known to "pull apart" his [REDACTED] and "might not trust it would be clean". The hospice nurse had no other options to obtain the UA except to wait another 5 days for the scheduled catheter change.</p> <p>During further interview with LN B She reprted she had never observed or noted Resident #43 pulling apart or handling his [REDACTED] to cause contamination.</p> <p>The DNS said she did not know why staff would insist on changing the entire [REDACTED] to get a [REDACTED] sample. The DNS said nursing staff were to refer to the facility Lippincott Manual of Nursing Practice for guidance in getting a [REDACTED] sample for residents with [REDACTED] other than changing the entire [REDACTED].</p> <p>The Manual documented staff were to, "Clamp the drainage tubing below the aspiration port for a few minutes to allow [REDACTED] to collect, cleanse the aspiration port with 70% alcohol and insert a sterile needle to obtain the [REDACTED]..."</p> <p>Record review of a current physician order originally dated 8/14/12, documented to change Resident #43's [REDACTED] on the 15th of each month and "Do not wake resident for [REDACTED]"</p>	F 309	<p>Identification of residents with the potential to be affected:</p> <p>Other residents have the potential to be affected. Dental assessments have been completed by the Resident Care Managers to assure that residents who have dentures in need of refitting, repair, or replacement are referred for dental care. Diet orders have been reviewed by Dietary, Nursing, and Rehab to assure that residents evaluated by a Speech Therapist are receiving the recommended diet texture and that a physician's order for the correct diet is in place.</p> <p>Measures to prevent recurrence:</p> <p>Re-education of nursing and therapy staff has been conducted. Residents who have weight loss trends or significant weight loss will be referred to the dietician and to the Nutrition Committee and a review of potential contributors to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372		
(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 309	<p>Continued From page 21</p> <p>change." There was no order from the physician, directing staff to obtain a [REDACTED] by changing the entire [REDACTED].</p> <p>Record review of physician orders dated 1/11/13 documented Resident #43 had his pain medication increased from every 4 to 6 hours as needed to every two hours as needed.</p> <p>According to Medication Administrator Records (MARs) dated between 1/11/13 and 1/15/13, Resident #43 requested and received 23 doses of the pain medication during the time he was waiting for the UA to be obtained. From 1/20/13 to 1/24/13 his requests for the same pain medication was reduced to 13 doses after he received treatment for his infection.</p> <p>The facility further failed to assess or implement a plan regarding the resident's ability to do [REDACTED] care to ensure he was able to complete this care without complications or risk of infection.</p> <p>The facility failed to obtain a physician ordered [REDACTED] sample for 6 days when Resident #43 had pain and discomfort from a [REDACTED] that required antibiotic therapy.</p> <p>RESIDENT #82 Resident #82 admitted on [REDACTED]-12 with multiple diagnoses to include [REDACTED], [REDACTED] and [REDACTED]. The resident had a physician's order for multiple medications to include a blood</p>	F 309	<p>the weight loss will be conducted, to include a review of dental status and diet recommendations. The physician and family will be notified of the weight loss.</p> <p>Monitor for Corrective Action:</p> <p>Weight loss data will be gathered each month and reported to the QA committee. Residents who have persistent weight loss will be identified and interviewed / reviewed for the root cause of the weight loss and any unrecognized contributing factors.</p> <p>The Director of Nursing will assure compliance.</p> <p>F329</p> <p>Corrective Action/s for residents identified to have been affected:</p> <p>Residents #40, 118, 98, and 5 have had postural blood pressures checked and documented. Any adverse findings have been reported to the physician, per the policy. Resident #61 has been discharged from the facility. Resident #59 had labs drawn to monitor medication</p>	2-28-13	

KSP

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372	
(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 309	<p>Continued From page 22 thinner and a heart medication.</p> <p>According to the records the resident was bedridden at home for 4-5 months and had deteriorated a couple of weeks prior to going to the emergency room. After the residents hospital stay, s/he admitted to the nursing home for skilled physical therapy, occupational therapy and speech therapy. The plan was for the resident to discharge home with spouse and son after the nursing home stay.</p> <p>Record review revealed that on the dates of 12-22-12 through 12-24-12 the resident had blood pressures between 98/50 and 98/60. A nursing note dated 12-23-12 with a time of 10:00 p.m., documented the resident to be combative with staff during a.m. care.</p> <p>Further review of the record revealed a nurse's note dated 12-25-12 with a time of 3:30 a.m., documented that the resident had diminished lung sounds at the bases and a nurse note dated 12-15-12 at 8:00 p.m. documented that the residents lung sounds were clear. A nurses note dated 12-25-12 with a time of 2:00 p.m., documented that the resident had diminished lung sounds at the bases with slight lower lobe crackles and was agitated, anxious, and moaning.</p> <p>A nurse note dated and timed for 12-28-12 at 4:30 p.m., documented that a care conference was held with the family. The note documented that the resident had a decline in condition, and would be comfort care. Record review revealed that the resident [REDACTED] on [REDACTED]-12.</p>	F 309	<p>blood levels. . Resident #74's antibiotic dosage was confirmed with the original order. She received the correct dosage of medication throughout her IV antibiotic therapy. Her infection resolved and she has discharged to her assisted living facility.</p> <p>Identification of residents with the potential to be affected:</p> <p>Other residents have the potential to be affected. The company policy for monitoring of postural blood pressures monthly for residents taking anti-psychotic medications has been introduced. Records for residents on anti-psychotics have been reviewed to assure that a baseline postural check has been documented and that monthly postural checks are scheduled. An audit of lab orders and lab result reports was completed to assure that residents had their ordered labs completed. Missing labs were ordered and completed. Physician orders were reviewed by the Resident Care Managers and the Director of Nursing to assure that orders were complete.</p>	

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372	
(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 309	Continued From page 23 In an interview on 1-3-13 at 9:24 a.m., Staff L stated that she spoke to the physician about the residents decline in condition prior to receiving comfort care orders. Staff L was unable to provide documented evidence that the physician was notified and unable to provide a documented plan of care related to the residents change of condition prior to 12-28-12. Staff L was also unable to provide documented evidence that the family was made aware of the resident's end of life changes prior to 12-28-12. Staff L stated that the resident was "clearly" end stage prior the care conference and request for comfort care. Although the resident had experienced low blood pressures over several days with lung sound changes, anxiety and combativeness, staff did not correlate assessment findings as end of life changes that required a more thorough assessment in an effort to address the resident's physical, mental and psychosocial needs until six days after the first noted change in condition. Failure to correlate assessment finding to end of life changes placed Resident #82 at risk of not having optimal end of life care and services.	F 309	Measures to prevent recurrence: Nursing staff have been educated on the policy for postural blood pressures for residents who are on anti-psychotics and the parameters for notification of the physician of significant postural drops. Labs are reviewed monthly by the consulting Pharmacist. As needs for labs for monitoring of medications are identified, letters to physicians requesting orders are generated. The pharmacist reviews the charts to assure that the labs were then completed. Education was provided to nurses on following the pharmacy recommendations in a timely manner and notifying the Resident Care Manager or the Director of Nursing and the physician of any lab that could not be obtained. Nursing staff were re-educated on following the 5 Rights when administering medication (Right resident, Right time, Right medication, Right dose, Right route). Nursing staff were re-educated to obtain a clear and	
F 315 SS=D	483.25(d) ██████████ INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling ██████████ is not ██████████ unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder	F 315		

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372		
(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 315	<p>Continued From page 24 function as possible.</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 ensure that 1 of 3 residents (#214) reviewed for indwelling catheters, were not [REDACTED] unless their clinical condition demonstrated the [REDACTED] was necessary. In addition, the facility failed to ensure care and services of an indwelling catheter to prevent [REDACTED] for this resident. This failure placed the resident at risk for deterioration of [REDACTED] function.</p> <p>Findings include:</p> <p>Resident #214 was admitted to the facility on [REDACTED]-12 with multiple diagnoses to include impacted [REDACTED] (a [REDACTED] into the [REDACTED] to [REDACTED]), and [REDACTED]</p> <p>Although the resident had a diagnosis of an [REDACTED] and there was no documented evidence of a post void residual to indicate [REDACTED] review of the record revealed a care plan dated 12-31-12 which documented, [REDACTED] related to [REDACTED], and a toe to hip cast to groin area, and resident cannot be safely placed on a commode or toilet.</p> <p>During an interview on 1-29-13 at approximately 10:30 a.m., Staff G reported that the resident had used the commode with assistants, and stated</p>	F 315	<p>complete order before administering a medication. Education was conducted on 2/21/13 by the Director of Nursing and the Staff Development nurse.</p> <p>Monitor for Corrective Action:</p> <p>Residents on anti-psychotic medication are reviewed monthly in the Psychotropic Committee meeting with a pharmacist present. At that time, the committee will assure that the postural blood pressure check was completed for the prior month and that appropriate physician notification occurred. A report will be made to the QA committee monthly times 3 months to determine the need for further education or intervention.</p> <p>The pharmacist provides a list of recommendations that have not received response each month. The Director of Nurses or designee will review this list each month to identify residents who continue to need labs. Any trend in failing to obtain labs, as ordered, will be reviewed in the QA Committee to determine further need for education and/or intervention.</p>		

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372
---	--

(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 315	<p>Continued From page 25</p> <p>that she had assisted the resident to the commode at least once. Staff G also reported that the resident was to have the [REDACTED] until the appointment with the orthopedic doctor. The resident had the appointment on 1-8-13, and Staff G was unable to provide documented evidence that the physician discussed the continued use of the [REDACTED]. Staff G also confirmed that there was no physicians order for the use of the [REDACTED] and confirmed that the resident did not have medical justification for the use of the [REDACTED].</p> <p>During an interview on 1-29-13 at approximately 11:00 a.m., Staff L stated that she had a conversation with the physician who stated if the [REDACTED] were removed, the resident would basically be voiding down the cast. The resident used the bed pan for bowel movements, and if used to urinate, gravity would allow the urine to go in the bedpan. Staff L was unable to provide documented evidence that the conversation took place with the physician and unable to provide a physician's order for the use of the [REDACTED]. Staff L confirmed that the resident did not have medical justification for the use of the [REDACTED].</p> <p>The facility's policy for the use of indwelling [REDACTED] for residents entering the facility with an indwelling [REDACTED] documents, "For residents without medical justification for indwelling [REDACTED] use, effort to remove the [REDACTED] will be made as soon as medically feasible."</p> <p>During an interview on 1-29-13 at 3:44 p.m., Resident #214 who had a Brief Interview of</p>	F 315	<p>Copies of new physician orders are supplied each weekday to the Resident Care Managers and will be reviewed for order completeness. Incomplete orders will be corrected and staff education completed, as need is identified.</p> <p>The Director of Nursing will assure compliance.</p> <p>F387</p> <p>Corrective Action/s for residents identified to have been affected:</p> <p>Resident #59 was seen by her physician on 1/6/13 and will continue to be seen on her regular schedule. Her physician has been notified of the missed visits.</p> <p>Identification of residents with the potential to be affected:</p> <p>Other residents have the potential to be affected. An audit was conducted by Medical Records to assure that residents had physician visits in compliance with regulations. Physician visits were brought up to date. The Medical Records department continues to track physician visits</p>	2-28-13

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372		
(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 315	Continued From page 26 Mental Status (BIMS) score of 15 indicating s/he had no cognitive impairments, stated s/he used the bedpan for bowel movements. Resident #214 also stated s/he wondered what would stop him/her from getting [REDACTED] after having the [REDACTED] in so long. When asked, the resident stated s/he did have pain where the [REDACTED] was at times, but not enough to have pain medication. The resident stated s/he had not been told of the risk and benefits of prolonged use of a [REDACTED]. The resident developed a [REDACTED] which review of the record revealed a physician's order dated 1-1-13 for [REDACTED] (an antibiotic) 250mg by mouth daily related to [REDACTED]. Failure to attempt removal of the [REDACTED] resulted in Resident # 214 to develop a [REDACTED], and placed the resident at risk for deterioration of [REDACTED].	F 315	and to notify physicians of upcoming visits. Regulatory guidelines are followed for scheduling of physician visits. Measures to prevent recurrence: The Medical Records department will continue to notify physicians monthly of needed visits. Visits will be tracked and second reminders sent out, as needed. Monitor for Corrective Action: Data on physician visits will be compiled and brought to the QA Committee monthly. The Medical Director will intervene with physicians who fail to provide visits per regulatory guidelines. The Administrator will assure compliance.		
F 325 SS=D	483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to take all measures to prevent weight loss for 1 of 3	F 325			

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372		
(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 325	<p>Continued From page 27</p> <p>(#93) Sampled Residents reviewed for nutrition. This failure had potential to place Resident #93 at risk for continued weight loss.</p> <p>Findings include: DENTAL CARE RELATED TO WEIGHT LOSS: Resident #93 admitted to the facility on 1/12/12 weighing 125 pounds. Review of Resident #93's medical record revealed her weight dropped to 114 pounds over the next three months. The weight loss of 8.8% in a three month period is considered severe weight loss.</p> <p>Observations throughout the survey revealed Resident #93 at meals in her room and had a pureed diet.</p> <p>During an interview on 1/23/12 at 11:45 a.m. Resident #93 reported she had a soft diet due to her dentures not fitting well. Resident #93 reported they had broken as a result of a fall and now they fall out when she tries to wear them.</p> <p>During an interview on 1/30/12 Staff F reported that prior to admitting to the facility Resident #93 lived at home and only wore her dentures to eat, confirming the resident did need her teeth to eat.</p> <p>Review of the admitting activities assessment dated 1/12/12 revealed documentation that indicated Resident #93 had mouth pain and was not able to eat.</p> <p>Review of the admitting nursing assessment dated 9/6/12 revealed Resident #93 had broken dentures.</p> <p>Review of Resident #93's medical record</p>	F 325	<p>F441</p> <p>Corrective Action/s for residents identified to have been affected:</p> <p>No resident is identified in this citation.</p> <p>Identification of residents with the potential to be affected:</p> <p>Residents have the potential to be affected by the failure to analyze infection control data. Infection control data for 2012 has been reviewed by the Staff Development nurse and the Director of Nursing and trends identified. This data is being utilized to identify areas that require education and increased monitoring.</p>	2-28-13	

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372
---	--

(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 325	<p>Continued From page 28</p> <p>revealed a signed waiver to decline annual dental exams. During an interview on 1/29/13 at 9:50 a.m., Staff Q reported even if a resident signs the form the facility will re-offer a dental exam if the resident begins to have dental problems. Staff Q confirmed the form did not address denture exams.</p> <p>During an interview on 1/30/13 at 12:00 noon, Staff F confirmed the facility had not offered Resident #93 to have her dentures repaired or replaced.</p> <p>Review of Resident #93's admitting Minimum Data Set (MDS) assessment dated 9/17/12 revealed Resident #93 was assessed as having no natural teeth. Review of the care area assessments (CAA's) revealed the area of "dental" was marked as triggered, with a documented note that Resident #93's dentures were broken.</p> <p>Review of Resident #93's medical record revealed there was no care plan for dental/dentures.</p> <p>During an interview on 1/31/12 at 7:45 a.m. Staff R reported when "dental" is triggered in the CAAs the information is carried through to the nutrition care plan. Staff R reviewed Resident #93's medical record and confirmed there was not any information related to dental and/or dentures on the resident's nutrition care plan.</p> <p><RECOMMENDATIONS NOT FOLLOWED> Review of Resident #93's medical record revealed a speech therapy assessment dated 10/8/12 through 10/11/12. The therapist</p>	F 325	<p>Measures to prevent recurrence:</p> <p>Infection data will be gathered, summarized, and analyzed each month with a report made to the Quality Assurance Committee. Re-education was provided to the Staff Development nurse by the Director of Nursing on 2/1/2013. Weekly review of electronically logged infections will be conducted by the Director of Nursing. The electronic log also identifies trends as they develop. CASPER Report data will also be used to determine trends in infections.</p> <p>Monitor for Corrective Action:</p> <p>Monthly reports of infection data will be made to the Quality Assurance Committee. These reports will be prepared by the Staff Development nurse and will reflect trends, analysis of data, and need for education and intervention.</p>	
-------	--	-------	---	--

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013	
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372		
(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 325	<p>Continued From page 29</p> <p>recommended Resident #93 to be given a mechanical soft diet with thin liquids. The therapist indicated Resident #93 had demonstrated safe swallowing, and did not have risk of choking or aspiration.</p> <p>Observations throughout the survey revealed Resident #93 had eaten pureed food and thickened liquids at all meals.</p> <p>During an interview on 1/3/13 at 9:10 a.m. Staff S reported when a speech therapist makes a recommendation for a diet change they should fill out a change slip, one copy goes to the kitchen and copy goes to nursing staff. Staff S reviewed Resident #93's records and confirmed a diet change slip had never been completed.</p> <p>Review of the dietician notes revealed Resident #93 was assessed for continued weight loss on 10/9/12, 12/3/12, and 1/7/13. There was no documentation to evidence the dietician had noted the speech therapy recommendation for a diet change.</p> <p>During an interview on 1/3/13 at 9:10 a.m. Staff S confirmed the dietician should review speech therapy notes while doing assessments.</p> <p>Further record review revealed Nutrition Risk Review forms dated 12/31/12 and 1/22/13, indicating Resident #93 had been reviewed for weight loss. Both nutritional risk reviews indicate resident #93 was on a pureed diet. There was no documentation to evidence any of the staff had reviewed or followed through with the speech therapy recommendation for a mechanical soft diet.</p>	F 325	<p>The Director of Nursing will assure compliance.</p> <p>F520</p> <p>Corrective Action/s for residents identified to have been affected:</p> <p>No residents are identified in this citation.</p> <p>Identification of residents with the potential to be affected:</p> <p>Residents have the potential to be affected if Quality Assurance needs are not regularly identified and plans implemented.</p> <p>Measures to prevent recurrence</p> <p>Staff have been educated to continue to bring immediate need concerns to their direct supervisor. Staff have been educated that any staff member with a concern regarding quality of resident care should bring that concern to the Administrator, the Director of Nursing, the Staff Development</p>	2-28-13

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372	
(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 325	Continued From page 30 During an interview on 1/30/13 at 9:20 a.m. Resident #93 reported she would like to have soft foods such as pasta or scrambled eggs. Failure to develop a care plan that identified ill fitting dentures effecting Resident #93's food intake, failing to repair dentures, failing to follow diet recommendations and failing to identify all factors the effect nutrition placed Resident #93 at risk for actual and continued weight loss.	F 325	Coordinator, or to Social Services. Reported concerns will be addressed immediately, if needed, with trends brought to the QA Committee for discussion and corrective action. Tools have been provided to staff to assist them in this reporting process. Monitor for Corrective Action: Any pattern or trend in concerns brought to QA Committee will be identified and discussed in the QA Committee meeting. Corrective plans will be developed as the need is identified.	
F 329 SS=E	483.25(l)(1) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to monitor side effects of anti-depressant medications for 5 of 10 Sampled Residents (#'s 118, 98, 61, 5, & 40) reviewed for drug regimes, and failed to clarify a medication dose prior to administering the medications for 1 of 10 Sampled Residents (#74) reviewed for medication administration, and failed to consistently monitor medication blood levels for 1 of 10 Sampled Residents (#59) reviewed for	F 329	<i>Responsible Administrator and DNS</i>	2-28-13 2/22/13
			<i>3-8-13 8:00am Interview with Kelvin Fletcher - Reports all tags have BIC date 2-25-13 also reported responsible staff for F520. Kara Newk</i>	

KSF

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372	
(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 329	<p>Continued From page 31 unnecessary medication use .</p> <p>Findings include:</p> <p><MONITORING OF SIDE EFFECTS OF ANTI-DEPRESSANT MEDICATIONS> Review of the facility policy entitled Psychotropic Drug Monitoring: Orthostatic Hypotension revealed directives that all residents on antidepressant medications should have orthostatic blood pressure reading done on a routine basis to monitor side effects of orthostatic blood pressure drops.</p> <p>During an interview on 1/29/13 at 11:20 a.m., Staff DNS reported the facility does orthostatic blood pressure monitoring on residents who take antidepressants as they have a side effect of lowering blood pressure.</p> <p>RESIDENT #118 Resident # 118 admitted to the facility on [REDACTED]/11 from the hospital with a history of [REDACTED] and [REDACTED].</p> <p>Record review revealed a physician's order for [REDACTED] (an [REDACTED] medication) to be given daily at bedtime.</p> <p>During an interview on 1/29/13 at 10:30 a.m. Staff R confirmed Resident #118 was taking an [REDACTED] medication.</p> <p>Review of Resident #118's medical record revealed no documentation of orthostatic blood pressure monitoring.</p>	F 329		

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013	
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372		
(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 329	<p>Continued From page 32</p> <p>RESIDENT #98 Resident #98 admitted to the facility on [REDACTED] 12 with a diagnosis of [REDACTED] and [REDACTED].</p> <p>Review of Resident #98's medical record revealed he/she is taking two different antidepressants both two times daily.</p> <p>Further review of Resident #98's medical record revealed no documentation to evidence staff were performing orthostatic blood pressure monitoring.</p> <p>RESIDENT #61 Resident #61 admitted to the facility on [REDACTED]/12 from the hospital with a diagnosis to include [REDACTED].</p> <p>Review of Resident #61's medical record revealed a physician's ordered dated 12/7/12 for an [REDACTED] medication to be given daily. The medical record indicated Resident #61 had received the medication everyday since admit.</p> <p>Further record review revealed no documentation to evidence the facility staff had been monitoring Resident #61 with [REDACTED].</p> <p>RESIDENT #5 Resident #5 admitted to the facility on [REDACTED]/12 with diagnosis to include [REDACTED], [REDACTED] and [REDACTED] (a condition when a person faints related to the effects of drop in blood pressure).</p> <p>Review of Resident #5's medical record revealed a physician's ordered dated 10/25/12 for an [REDACTED] to be given every day.</p> <p>Review of facility incident log revealed Resident</p>	F 329		

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372		
(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 329	<p>Continued From page 33</p> <p>#5 had three falls in facility while self ambulating.</p> <p>Review of Resident #5's medical record revealed no documentation to evidence staff had monitored ██████████ for the resident.</p> <p>Resident #40</p> <p>Resident #40 was admitted to the facility on ██████-11 with multiple diagnoses to include ██████████, ██████████ and ██████████.</p> <p>Record review revealed a physician's order for ██████████ to be given daily at bedtime, and ██████████ to be given daily (both ██████████ medications).</p> <p>During an interview on 1/31/13 at 1:54 p.m., Staff M confirmed Resident #40 was taking ██████████ medications, and confirmed that orthostatic blood pressure monitoring was not done for this resident.</p> <p>Review of Resident #40's medical record revealed no documentation of orthostatic blood pressure monitoring.</p> <p>RESIDENT #59</p> <p>Resident #59 was admitted to the facility on ██████-11 with multiple diagnoses to include ██████████, ██████████ and ██████████. Further review of the record revealed that the resident was taking several medications to include ██████████, Potassium (used to replace potassium loss when taking a ██████████).</p>	F 329		

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-G391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372		
(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 329	<p>Continued From page 34 and [REDACTED] (a medication used to treat high [REDACTED]).</p> <p>On 1-28-13 review of the record revealed that the resident had refused her medication on multiple days during the months of December and January. The resident refused Lasix six different days, refused potassium eight different days, and refused [REDACTED] four different days in the month of January. Refusing medication would cause fluctuations in blood levels. Further review of the record revealed that it had been over a year since the resident had lab work to monitor blood levels. Resident #59 last had labs to monitor blood levels 1-6-13.</p> <p>In an interview on 1-28-12 at 9:58 a.m., Staff K, reported that the resident had been refusing her medication and stated that resident's labs are reviewed every three -six months or yearly. Staff K confirmed that labs had not been done for this resident for over a year.</p> <p>Failure to consistently monitor blood levels placed the resident at risk of receiving medications in excessive dose which increased the risk for adverse side effects and less than optimal medication effectiveness.</p> <p><PHYSICIAN'S ORDER> Resident #74 Observations on 1/25/13 at 10:19 a.m. revealed Staff T administer an antibiotic intra-venously (IV) to Resident #74. Staff T reported she gave [REDACTED] 2 grams through the IV.</p> <p>Review of the January 2013 Medication Administration Record (MAR) revealed the</p>	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372	
(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 329	Continued From page 35. [REDACTED] was listed but did not specify the dosage. Review of Physician's orders revealed an order dated 12/31/12 which directed [REDACTED] in 100 milliliters of saline through the IV. The order did not specify the dosage of the antibiotic to be given. Failure to clarify an incomplete physician ' s order had potential for Resident #74 to receive the wrong dose of medication.	F 329		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to ensure that 1 of 10 Sampled Residents (#59) reviewed for timely visits with a physician. Failure to ensure that residents are seen by a physician at least every 60 days following their first 90 day stay at the nursing home, placed this resident at risk of	F 387		

[Handwritten signature]

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372		
(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 387	Continued From page 36 having unmet needs. Findings include: Resident #59 was admitted to the facility on [REDACTED]-11 with multiple diagnoses to include [REDACTED] and [REDACTED]. In an interview on 1-23-13 at 11:00 a.m., the Medical Doctor reported that she is not notified by medical records when residents are due to be seen by the physician according to the regulatory requirements, which caused some residents not to be seen timely. On 1/28/13, review of the record revealed two physician notes, one for 9-23-12 and one for 1-6-13. On 1-28-13 at 12:54 p.m., Staff O confirmed that physician visits for this resident occurred on 4/6/12, 4/30/12, 9/23/12 and 1/6/13. The facility's failure to ensure timely physician visits placed Resident #59 at risk of having unmet medical needs.	F 387			
F 441 SS=F	483.65(a) INFECTION CONTROL The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as	F 441			

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372		
(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 441	<p>Continued From page 37</p> <p>isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to consistently maintain an infection control program which mapped, trended and analyzed data concerning infections occurring in the facility, and thereby unable to effectively determine the effectiveness of infection prevention and control practices. Failure to maintain an effective infection control program could result in the development and spread of nosocomial infections.</p> <p>Findings include:</p> <p>On 1-29-13 review of the record revealed that the following:</p> <p>May 2012 mapping with no analysis of data</p> <p>June 2012 mapping with no analysis of data</p> <p>July 2012 mapping with no analysis of data</p> <p>August 2012, September 2012, and October 2012 no mapping, trending or analysis of data</p> <p>November 2012, infections logged with no mapping, trending or analysis of data</p> <p>December 2012 infections logged with no mapping, trending or analysis of data</p>	F 441			

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372		
(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 441	Continued From page 38 In an interview on 1-29-12 at 11:30 a.m., Staff F confirmed that the analysis for infection control is not done, and stated she is in the process of going through and writing reports and analysis of infections.	F 441			
F 520 SS=D	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to develop an adequate system to identify quality assurance needs and implement plans to correct deficiencies. This failure had potential to place residents at risk for diminished quality of care. Findings include: PRESSURE SORES The facility was cited F314 at a G level on 12/17/13. The facility submitted a plan of correction related to avoiding pressure sores with a compliance date of 1/21/13. When state surveyors entered the facility on 1/22/13, two residents were observed not receiving the care and interventions that were in place in their pressure ulcer care plans. The facility failed to implement the plan identified	F 520			

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372		
(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 520	<p>Continued From page 39 by the committee to correct the care and services related to pressure sores.</p> <p>REFER TO F441 The facility failed to consistently maintain an infection control program which mapped, trended and analyzed data concerning infections occurring in the facility, and thereby unable to effectively determine the effectiveness of infection prevention and control practices.</p> <p>During an interview on 1/31/13 at 12:00 noon the DNS reported the Quality Assurance Committee meets every month to identify QA needs and implement plans to correct deficiencies. The DNS reported she was unaware of how the QA committee failed to maintain the infection control program.</p> <p>REFER TO F325 During an interview on 1/31/12 at 12:00 noon the DNS reported the quality assurance committee was currently reviewing weight loss.</p> <p>Review of Resident #93's medical record revealed she was being assessed by the dietician and a nutrition risk committee to determine what measures should be in place to avoid further weight loss. It was never noted by any staff assessing Resident #93 that she needed her dentures repaired. The facility also failed to identify Resident #93 was receiving pureed food when she had been assessed and upgraded by speech therapy to receive mechanical soft foods.</p> <p>QA PROCESS During staff interviews certified nursing assistants (CNAs) reported if they had a</p>	F 520			

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

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505211	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/01/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT PUYALLUP REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 516 23RD AVE SE PUYALLUP, WA 98372		
(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 520	<p>Continued From page 40</p> <p>concerns they would report it to the medication nurse. When interviewing the medication nurse they reported if they had a concern they would report to the charge nurse. During an interview the charge nurse reported if she had a concern or had received report of a concern she would give the information to the Resident Care Manager (RCM). During an interview the RCM reported if she had a concern she would report the information to the QA nurse. All staff interviewed reported they do not attend the QA meetings.</p> <p>During an interview on 1/31/13 at 11:45 a.m. Staff F reported when concerns are brought to her attention from the staff, the issue is usually addressed on the floor and does not go to the QA meeting.</p> <p>During an interview on 1/31/12 at 12:00 the DNS confirmed this process and confirmed the CNAs, medications nurses, charge nurses and RCM's do not attend the QA meetings. The DNS also reported the facility should consider having the RCM's attend as they would be able to bring more information to the meetings and have more impact on the problem solving process.</p> <p>The failures to identify and correct quality of care issues had potential to compromise the care and services for all residents.</p>	F 520		