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

1434

PRINTED: 05/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505211		C 04/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PUYALLUP NURSING AND REHABILITATION CENTER	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	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Standard Survey conducted onsite at Puyallup Nursing and Rehab Center on 4/29 & 4/30/2013. The sample included 7 residents out of a census of 79. The sample included 6 current residents and the record of 1 former resident. The following are complaints investigated as part of this survey: #2786620 The survey was conducted by: [redacted], RN, MSN RECEIVED MAY 16 REC'D DSHS - ADSA RCS - REGION 5 The surveyor is from: Department of Social and Health Services Aging and Disability Services Residential Care Services, District 3, Unit B 1949 S. State Street Tacoma, WA 98405-2850 Telephone: (253) 983-3800 Fax: (253) 589-7240 5/7/13 Residential Care Services Date	F 000	**F000 Initial Comments** "This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Puyallup Nursing and Rehabilitation Center** does not admit that the deficiencies 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." **F279** **Corrective Action/s for residents identified to have been affected:** A review was conducted to assure that Residents #2, 3, 4, 5, and 6 are up to date on monitoring of their pacemakers. Care plans have been developed for further monitoring of the pacemakers.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/16/2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 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. 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). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a comprehensive care plan was developed for 5 of 5 residents with a pacemaker (Residents #2, 3, 4, 5 & 6). This failure placed the residents at risk for unmet care needs related to pacemaker monitoring. Findings include: 1. Review of Resident #3's admission nursing assessment revealed the resident had a	F 279	**Identification of residents with the potential to be affected:** Other residents with pacemakers have the potential to be affected. On 5/14/2013, an audit was conducted to assure that all residents with pacemakers are identified, have care plans, and have up-to-date monitoring of pacemaker function. Care plans and monitoring are up to date for the identified residents. **Measures to prevent recurrence:** Nursing staff have been re-educated on the policy for management of pacemakers and assuring that pacemaker care plans are developed in a timely manner. Education was conducted by the Staff Development nurse on 5/13/13 and 5/14/2013.	

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F 279	Continued From page 2 [redacted] which was identified on the body diagram. Review of the resident's comprehensive care plan did not reveal a care plan related to the [redacted]. A facility data collection form [redacted]" which requested, in part, information to include type, model, date of insertion, frequency of monitoring, was blank. Interview with Staff C on 4/30/13 at 11:25 a.m. revealed it was the care manager's responsibility to obtain the information and develop a care plan. Staff C stated Resident #3 had been a resident in the facility for over a month and the [redacted] information/care plan should have been completed by now. 2. Review of Resident #6's admission nursing assessment revealed he admitted with a [redacted] which was identified on the skin assessment body diagram. There was no evidence of a care plan for the [redacted]. There was no evidence of the facility [redacted] data collection form. During interview on 4/30/13 at 10:45 a.m., Staff G stated the [redacted] data collection form was not used on her unit and the care manager was responsible for obtaining the information and developing the care plan. Staff G stated she had not yet obtained the information or developed the resident's care plan. The resident admitted 15 days prior to the interview date. 3. Expanded record review of residents with a [redacted] revealed Residents # 2, 4, & 5 were noted on admission assessment to have a [redacted]. There was no evidence in the record of a care plan for ongoing monitoring of the	F 279	**Monitor for Corrective Action:** Audits of the records of newly admitted residents will be conducted by the RCM or the DNS to assure that residents with pacemakers have been identified and that care plans have been developed at the time of admission. Findings will be reported to the Quality Assurance Committee monthly for 3 months to identify the need for further intervention or education. The DNS will assure compliance. **F282** **Corrective Action/s for residents identified to have been affected:** Resident #1 no longer resides in the facility.	

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F 279	Continued From page 3 [redacted] or initial information about the [redacted] documented on admission as per facility policy and procedure. Review of facility policy "[redacted]" dated 02/13 revealed, in part, the facility required staff to obtain information about a resident's [redacted] on admission to include manufacturer, model, lead type, rate and insertion date. In addition, a procedure was outlined that required staff to develop a care plan with interventions for monitoring specific signs and symptoms of potential [redacted] failure. During exit interview at 11:45 a.m., administrative staff was informed the above residents did not have care plans developed and did not have initial information about the device recorded in their records.	F 279	**Identification of residents with the potential to be affected:** Other residents who are care planned to have mats placed at bedside to assist in preventing injuries from falls have the potential to be affected. An audit of residents who are care planned to have mats at bedside was conducted to ensure that all care plans and care directives were in place and up-to-date. **Measures to prevent recurrence:**	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a plan of care was followed for 1 of 3 residents (Former Resident #1) reviewed for falls. The resident did not have mats placed on the floor next to the bed as per the plan of care. The resident fell and sustained a laceration above her eye.	F 282	The Staff Development will provide retraining to direct care staff on checking and following care directives. Retraining will be provided to licensed nursing staff on monitoring the use of safety devices. The training will be provided 5/20 through 5/23/2013. A checklist of devices is in use and was reviewed to assure that bedside mats were included. These checklists are used by staff rounding the unit to assure that care planned devices are in place.	

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F 282	Continued From page 4 Findings include: Record review revealed Resident #1 admitted to the facility during 2012 with medical diagnoses including [redacted], [redacted] and [redacted]. The resident had a documented history of falls in the facility. Review of the resident's care directives (instructions for care providers) updated 4/24/13 revealed an order for a mat on each side of the resident's bed. Record review revealed Resident #1 had non-injury falls from bed on 4/24/13 and 4/26/13. Review of facility investigations for these falls revealed the resident's care plan was followed at the time of the falls. Review of facility investigation dated 4/25/13 revealed Resident #1 fell at 1:55 p.m. while trying to get out of bed. According to the facility's investigation, the resident was found right next to the bed. Facility investigation revealed Staff H forgot to place the fall mats after assisting the resident to bed. During interview on 4/30/13 at 8:35 a.m., Staff A confirmed Resident #1's care plan was not followed on 4/25/13.	F 282	**Monitor for Corrective Action:** Rounds, at random times, will be conducted by RCMs or designee to ensure that care directives are followed. Any breach in the plan of care will be corrected, with education provided to the involved caregiver, at the time of rounding. Rounds will continue until this specific issue is resolved. Staff education on fall prevention and fall intervention continues. Fall investigations include monitoring for trends in root causes and the use of devices. Trends will be reviewed by the Quality Assurance Committee quarterly to determine the need for further intervention and education. The Director of Nursing will assure compliance.	6/4/2013