

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

1448

PRINTED: 01/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505525	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2013
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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - LACEY	STREET ADDRESS, CITY, STATE, ZIP CODE 4524 INTELCO LOOP SE LACEY, WA 98503
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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INITIAL COMMENTS

This report is the result of an unannounced Quality Indicator Survey conducted at Manorcare Health Service of Lacey on 12/16/13, 12/17/13, 12/18/13, 12/19/13, and 12/20/13. A sample of 28 residents was selected from a census of 45. The sample included 23 current residents, and the records of 5 former and/or discharged residents.

The Survey was conducted by:

- ██████████, MS
- ██████████, MSW
- ██████████, BSS
- ██████████, RN, MSN
- ██████████, PhD, RN, MS, MSN, APFNS
- ██████████, RN, BSN

The Survey team is from:

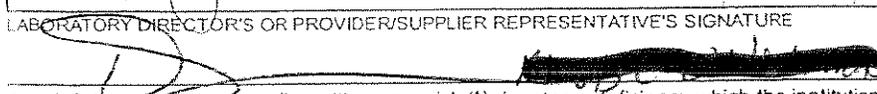
Department of Social & Health Services
Aging & Long Term Support Administration
Residential Care Services, District 3, Unit C & D
P.O. Box 45819
Tumwater, WA 98504-5819
Telephone: 360.664.8429
Fax: 360.664.8451


Residential Care Services 1-3-14
Date

F 000

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the dates indicated.

RECEIVED
JAN 16 2014
DSHS/ADSA/RCS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 1/16/2014
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 279 SS=D 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 observation, interview and record review, the facility failed to use the results of assessments to develop, review and revise the comprehensive care plan for 1 of 16 sampled residents (Resident #129) reviewed for care plans. This failure prevented the development of measurable goals for care provided and failed to describe appropriate services to be furnished to the residents to improve/maintain their health status and/or prevent decline.

Findings include:

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F 279:

Manor Care Lacey strives to develop a comprehensive care plan for each resident that includes measurable objectives to meet a resident's, medical, nursing, and psychosocial needs as identified in the comprehensive assessment.

Comprehensive assessment and care plan review has been completed on 1/5/14 by the IDT for Resident #129 and the care plan has been updated as appropriate.

Residents residing in the facility have the potential to be affected by this practice. Residents care plans will be updated as identified in the comprehensive assessment.

Licensed staff were educated on 1/10/14 on the development of care plans that describe appropriate services and goals to improve/maintain health status consistent with findings from the comprehensive assessment.

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Resident #129 was admitted from the hospital to the facility on [REDACTED]/13 with multiple medical diagnoses including: significant [REDACTED] of [REDACTED] pounds, [REDACTED], [REDACTED] affecting her [REDACTED] and her [REDACTED] [REDACTED] (the loss of the ability to produce [REDACTED] or [REDACTED] [REDACTED]), [REDACTED], [REDACTED], [REDACTED] history of [REDACTED], multiple [REDACTED] [REDACTED] and [REDACTED]. The Resident received specialized rehabilitation therapy services ([REDACTED], [REDACTED] and [REDACTED]) daily.

The resident incurred 22 falls between October 31 and December 11, 2013. The fall risk care plan, initiated 10/11/13, indicated Resident #129 had a history of and was at risk for falls due to balance/poor coordination, unsteady gait, inability to [REDACTED], [REDACTED] of [REDACTED] side, [REDACTED], [REDACTED] problems (had [REDACTED] only) and expressive [REDACTED].

The plan indicated the resident will: "transfer with a mechanical lift...use call light appropriately to call for assistance ... verbalize frustration and needs to the fullness of her ability to help alleviate tensions and prevent agitation ...if found sitting on floor redirect back to appropriate resting place."

Excerpts from the 22 fall assessments reviewed indicated that interventions did not meaningfully address identified problems. For example: on 11/22/13 at 9:00 p.m., "Found on floor next to bed; fidgeting with catheter. Licensed Nurse in room 20 minutes prior to the fall, administering medications for discomfort related to the catheter. Continues to complain of discomfort related to the catheter while on floor. Will advise to offer pain pills frequently to control pain and discomfort. No change to plan."

F 279 ADNS or designee will conduct random care plan audits weekly times 4 weeks and monthly times 3 months to ensure that appropriate interventions and goals are in place. Audits will be forwarded to the QAPI committee for review and recommendations.

On-going compliance will be ensured by ADNS or designee.

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F 279	<p>Continued From page 3</p> <p>On 12/4/13 at 8 p.m., the resident was "found on the floor; denies hitting her head. Complains of hip pain. Cannot state what happened due to expressive , encourage patient to request pain medication prior to reaching an intolerable pain level."</p> <p>On 12/8/13 at 5:15 p.m., "Found on floor. denied hitting head and denied any pain. Pain medication for complaints of hip pain. Call light was placed but not used by resident..."</p> <p>On 12/11/13 at 5 a.m., "Again discovered on the floor... feet still in bed wrapped in sheets. alert agitated. assisted to w/c [wheelchair] to hallway for quiet activity. Encourage resident to verbalize frustration and needs to the fullness of her ability to help alleviate tensions and prevent agitation."</p> <p>On 12/18/13 at 2:30 p.m. Resident #129 was observed in bed on her back. The resident's call light was near her hand. She was calling out "ow, ow, ow" and pulling at the sheet with her hand. She repeated "ow, no, and yes" to questions but without enough verbal and non-verbal indications to demonstrate understanding of the questions. She could not use her hand to demonstrate use of the call light to get help.</p> <p>At approximately 4:30 p.m., when asked about the call light location and need for a call light accommodation, Licensed Nurse (LN) A, the Assistant Director of Nursing (ADON) and Nursing Assistants (NA)s B and C agreed the resident's light should be on her side, not her affected . The ADON stated she would try to get an accommodation call light for the resident</p>	F 279		

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F 279 Continued From page 4
 and agreed the light should not be placed on her [redacted] side.

On 12/19/13 at 9:00 a.m., Resident #129 was observed to have an accommodation call light located near her [redacted] hand. When asked if she could demonstrate the use of the call light, she said: "yes" yet she made no attempt to locate it. When handed to her, she held the call light in her [redacted] hand and moved it around in the air. She was not able to demonstrate the use of the accommodation call light and appeared frustrated with attempts to assist her to use the light. She did not speak to voice her frustration. The care plan indicated the resident ... "will use call light appropriately to call for assistance."

On 12/19/13 at approximately noon, NAA stated Resident #129 seemed more uncomfortable when in the wheelchair.

During interview with a family member on 12/23/13 at 10:00 a.m., she stated the resident seemed to have more pain when in the wheelchair. The record indicated on October 30, 2013, Resident #129 had developed a pressure ulcer on her [redacted] buttock.

On 12/19/13 at approximately 3:00 p.m., interdisciplinary team (IDT) members NAs A and B, LN A, the Assistant Director of Nursing (ADON), LN C, Physical Therapist (PT) A, Occupational Therapist (OT) A, and Speech Therapist (ST) A, who cared for Resident #129 on a consistent basis, stated there were no specific suggestions from IDT members or the pharmacist to prevent repeated falls other than a slide-resistant pad placed on top of her wheelchair cushion.

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Review of the revised care plan, dated 12/5/13, indicated the facility determined Resident #129 "Places self on floor by pulling self out of bed or attempts to scoot out of wheelchair related to attention seeking/manipulative behaviors" without evidence of IDT involvement to evaluate the appropriateness and effectiveness of previously identified fall prevention interventions.

F 279

F 285 483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR
SS=D

A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.

A nursing facility must not admit, on or after January 1, 1989, any new residents with:

- (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission;
 - (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
 - (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.
- (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority

F 285

F 285:

Manor Care Lacey strives to ensure the Pre-Admission Screening and Resident Review (PASRR) assessments are accurately completed prior to admission to the facility.

Resident #21 PASRR has been reviewed and updated as appropriate to ensure accuracy.

Residents admitted to the facility have the potential to be affected by the practice. Residents PASRR assessments have been reviewed and updated as appropriate to ensure accuracy of assessments.

1/15/14

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<p>5. Continued From page 6</p> <p>has determined prior to admission--</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>For purposes of this section:</p> <p>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).</p> <p>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR) assessments were accurately completed prior to admission to the facility for 1 of 3 Sampled Residents (#21) reviewed for PASRR's. Failure to ensure PASRR's were accurately completed placed residents at risk for not receiving timely and necessary services to meet their mental health (MH) and/or developmental disability (DD) care needs.</p> <p>Findings include:</p> <p>The 2012 State PASRR form indicated: "Hospital staff members will initiate the PASRR process and when necessary, coordinate services with the designated MH PASRR evaluator or program</p>	F 285	<p>Social Services staff members (<i>employees at ManorCare of Lacey responsible for ensuring a complete and accurate PASRR is provided prior to admission</i>) were educated on 12/20/2013, re: how to properly complete PASRR assessments.</p> <p>Medical Records or designee will conduct random PASRR audits weekly times 4 weeks and monthly times 3 months. Audits will be forwarded to the QAPI committee for review and recommendations.</p> <p>Administrator or designee to ensure compliance.</p>		

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F 285 Continued From page 6
has determined prior to admission--
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.

For purposes of this section:
(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1).
(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure Pre-Admission Screening and Resident Review (PASRR) assessments were accurately completed prior to admission to the facility for 1 of 3 Sampled Residents (#21) reviewed for PASRR's. Failure to ensure PASRR's were accurately completed placed residents at risk for not receiving timely and necessary services to meet their mental health (MH) and/or developmental disability (DD) care needs.

Findings include:
The 2012 State PASRR form indicated: "Hospital staff members will initiate the PASRR process and when necessary, coordinate services with the designated MH PASRR evaluator or program

12/20/14

F 285 Facility staff responsible for ensuring a complete and accurate PASRR is provided prior to admission, have been educated on ? Prior to admission PASRR assessments will be reviewed by facility staff to ensure accuracy.

Medical Records or designee will conduct random PASRR audits weekly times 4 weeks and monthly times 3 months. Audits will be forwarded to the QAPI committee for review and recommendations.

Administrator or designee to ensure compliance.

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manager to complete Level II evaluations (a comprehensive evaluation conducted by a mental health professional to determine if residents require MH or DD services) prior to admission to nursing facilities." The form further indicated: "The nursing facility (NF) is responsible for assuring the form is complete and accurate at the time of, or before, admission. The NF must maintain and update this form as necessary."

1) Resident #21 was admitted to the facility from the hospital on [REDACTED]/13 with multiple medical diagnoses including acute [REDACTED], [REDACTED], [REDACTED] disease ([REDACTED]), [REDACTED] and [REDACTED] disorder. The hospital PASRR dated 11/4/13 was incorrect and failed to indicate [REDACTED] and [REDACTED] or to identify any advanced categorical determinations (ACD) that would have exempted the resident from receiving a Level II evaluation. The facility's failure to verify the accuracy of the PASRR form delayed care and services to the resident for approximately six (6) weeks, until the surveyor inquired of the status of the PASRR.

On 12/19 and 12/20/13 at approximately 2:00 p.m., review of the PASRR's with the Social Services Director revealed s/he was new to the facility and not aware of previous practices and s/he would review the PASRR process to ensure accuracy.

F 285

F 314

F 314 483.25(c) TREATMENT/SVCS TO SS=G PREVENT/HEAL PRESSURE SORES

Based on the comprehensive assessment of a

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resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review the facility failed to ensure 1 of 3 sampled residents (Resident #129) that accurate assessments were conducted and interventions were implemented to provide timely necessary treatment and services to ensure a resident without a pressure ulcer at risk for developing pressure ulcers, or having a pressure ulcer did not develop one, and to promote healing when a pressure ulcer developed. received timely treatment to promote wound healing. This failure resulted in the development of a painful, ongoing pressure ulcer causing harm to the resident and placed the resident at risk of developing a serious infection to the underlying bone.

Findings include:

Resident #129 was admitted from a hospital to the facility on [REDACTED]/13. The resident had been hospitalized for over a month. Resident #129's diagnoses included [REDACTED] with [REDACTED] [REDACTED] ([REDACTED] of one [REDACTED] of the [REDACTED]) and [REDACTED] (the loss of the ability to produce [REDACTED] or [REDACTED]). The

F 314

F 314:

Manor Care Lacey strives to provide care and services that prevent the development of pressure sores unless the clinical condition demonstrates they are unavoidable and that a resident having a pressure sore receives care and services that promote healing, prevent infection, and prevent new sores from developing.

Resident #129 has been assessed and interventions were implemented to ensure the promotion of wound healing and management of pain. The wound is showing improvement.

Residents assessed to be at risk or who have actual skin breakdown have the potential to be affected by this practice. Residents were reassessed to establish current skin risk and appropriate interventions were placed for each resident. Care plans were revised when indicated.

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resident's history included a [REDACTED] accident [REDACTED] years prior, leaving her with several [REDACTED], including [REDACTED] on her [REDACTED]. Prior to [REDACTED]/13, Resident #129 lived alone and was independent with all activities of daily living.

The resident was treated at the hospital for an [REDACTED] [REDACTED] with [REDACTED]. She had a feeding tube placed at the hospital and continued to receive nutrition via the feeding tube at the facility until it stopped functioning in mid-December and the resident demonstrated she could tolerate taking food by mouth.

The Minimum Data Set (MDS), an assessment tool, dated 10/17/13, documented Resident #129 was alert and usually able to understand others. She had difficulty communicating or finishing thoughts but was able to make herself understood if prompted or given time. The resident was non-ambulatory and dependent on facility staff for extensive assistance with all activities of daily living, including extensive assistance of two persons for transfers and bed mobility.

Resident #129 experienced a [REDACTED] pound weight loss during hospitalization, approximately 18% of her body weight which put her at risk for skin breakdown. The facility did not identify the recent weight loss on the MDS (10/17/13) which indicated the resident had not experienced weight loss of 5% or more in the last month or 10% or more in the last 6 months.

The MDS (10/17/13) documented Resident #129 was at risk of developing pressure ulcers but did not currently have any pressure ulcers or other ulcers, wounds or skin problems.

F 314 Nursing staff were educated on the prevention, assessment and treatment of pressure ulcers on 1/10/14 and 1/14/14.

ADNS or designee will conduct random audits of skin condition and interventions to validate appropriate interventions for residents. Findings of audit tools will be forwarded to QAPI committee for review and recommendation.

ADNS or designee is responsible for ongoing compliance.

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According to "Decubitus [pressure] Ulcers Treatment & Management," (Revis & Geibel, Medscape, 10/12/12), "The hip and buttock regions account for 67% of all pressure sores with ischial tuberosity, trochanteric, and sacral locations being most common" and "the commonly encountered ischial tuberosity ulcer" is caused by prolonged sitting.

The hospital record indicated that on 10/9/13 Resident #129 received a wound nurse consult for "pink blanchable area over previous scar on [REDACTED] buttock." The resident's "buttock/peri area" was documented by the Certified Wound Ostomy Nurse to have "light pink/red skin over buttock near anus no open areas" related to incontinence and "associated dermatitis."

On 10/10/13, the Assistant Director of Nursing (ADON) documented Resident #129 arrived at the facility via stretcher and noted old scarring, including scarring to the [REDACTED]. The note stated, "Wears a brief and has incontinence of bowel with history of loose stools," and reported "skin intact."

On 12/18/13 at 9:45 a.m., when asked about Resident #129's pressure ulcer, the ADON said when the resident was admitted, she had dense scar tissue on her [REDACTED] which eventually "turned purple and opened up. ...It wasn't clear to us what was going on." The ADON said the Wound Team (Director of Nursing Services (DNS), the ADON and Licensed Nurse (LN) C The Advanced Registered Nurse Practitioner (ARNP) served an as-needed advisory role). The ADON stated the team was "not sure if it's a pressure ulcer because it's not over a boney

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F 314	<p>Continued From page 11 prominence."</p> <p>The ADON further stated facility staff did not document stages of pressure wounds except when performing MDS assessments, using the Resident Assessment Instrument (RAI).</p> <p>The facility "Skin Practice Guide" (SPG) included the Pressure Ulcer Prevention Pathway (PUPP) which indicated documentation for an identified pressure ulcer should include location, length, width, depth and identify wound stage.</p> <p>The PUPP defined "tunneling" as a canal or passage under the wound surface that travels in one direction. "Undermining" was defined as tissue destruction underlying intact skin along margins of a wound; it can travel in more than one direction.</p> <p>The facility pressure ulcer monitoring tool, "Pressure Ulcer Healing Chart (PUHC)" did not measure wound depth or identify wound stages. The PUHC measured length x width in squared centimeters and indicated the presence of slough (loose, light colored necrotic tissue) or eschar (dense, dark colored necrotic tissue). Additional wound assessment information was documented in the progress notes but did not include wound staging.</p> <p>Assessments of Resident #129's [redacted] buttock were documented in the progress notes as follows:</p> <p>The first indication of redness to Resident #129's [redacted] buttock was on 10/19/13, when staff documented, resident "has a red spot on right sacral area. Applied [redacted] [skin protectant</p>	F 314		

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paste] and relieved pressure with reposition [every 2 hours.] The resident "denies any pain or discomfort at this time."

On 10/20/13, [REDACTED] applied to buttock with red blanchable area noted. Frequent repositioning performed, however, patient removes pillows used for repositioning and support."

On 10/21/13, "[Resident] has reddish spot on her lower back. She was repositioned off of it and [REDACTED] was placed on it."

From 10/22 through 10/26/13, there were no notes addressing the reddened area on Resident #129's buttock.

There was no documentation on 10/27/13 related to the reddened area on Resident #129's buttock, or references to repositioning to relieve pressure on the area, until a note at 10:00 p.m. which stated, "[Resident] has a quarter size erythemic [reddened] area on buttocks that is being treated with [REDACTED] skin protectant and repositioning [every 2 hours]." The record indicated the resident had signs and symptoms of pain requiring pain medication.

On 10/30/13 at 7:45 a.m., the DNS documented, "Right buttock assessed this am by skin team. Scar tissue to [REDACTED] buttock with superficial skin opening to center previously noted purple area. ...ARNP made aware. ...care plan updated to turn side to side to tolerance."

At 1:36 p.m., the DNS documented, "Area to [REDACTED] buttock measures 2 x 1.5 cm [centimeters] to

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purple area. Entire scar area measures 5 cm."

On 11/1/13, the DNS documented, "Scar site continues to digress despite intervention. Area now measures 3 cm in circumference. Tissue to wound is thin yellow slough covering, with purplish color to 2 cm of wound bed. Scant bleeding noted during assessment. APM continues, therapy to provide gel cushion to wheelchair once available. Patient has roho cushion currently on wheelchair. Right buttock wound not on pressure point in sitting position, area not on bony prominence. Scar decline likely related to poor skin integrity and compromised circulation."

On 11/12/13, the DNS documented, "Area measures 2.5 cm x 1.5 cm. thin trace of black tissue ...entire wound bed covered by slough."

On 11/18/13, the DNS documented, "Area measures 3.2 x 2.3 area covered with thin yellow slough, eschar trace remains ...minimal drainage."

On 11/19/13, the ADON documented, "Patient continues to have an open pressure ulcer to [redacted] buttock, continues to be 2.5 cm x 1.5 cm with a greater depth of 0.5 cm yet area is improving. ...Patient denies pain at site. ...Patient is noted to remove positioning pillows and scooting self to back at times for comfort."

On 11/26/13, the wound measured 3.2 x 2.7 cm with slough covering the entire base, eschar present, and 2 cm undermining. Dressing had moderate drainage.

On 11/27/13, the wound dressing was "saturated

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F 314	<p>Continued From page 14</p> <p>heavily with serosanguinous discharge. ... Wound base was covered with yellow slough except for an area of eschar. ... swelling and light pink area developing around outer upper right edge. ... [Resident] expressed discomfort during dressing change."</p> <p>On 11/28/13, the wound was 4 cm x 3.5 cm x 1 cm deep with tunneling present and a "light amount of foul smelling drainage."</p> <p>On 11/30/13, the wound bed was yellow, had a "foul odor," the dressing was "saturated with drainage," and the resident stated the wound was painful during the dressing change.</p> <p>On 12/2/13, the ADON documented, "Pressure ulcer to [redacted] buttock ... 100% covered in yellow slough. Area measures 3.5 x 3 cm with a 1.5 cm depth. 1.5 cm undermining present at 5 o'clock."</p> <p>At 1:19 p.m., "[Resident] has been agitated today and states the ulcer in her buttocks hurts when ... dressing changed ... there is an odor to the wound and the drainage is yellow in color. Pt has been up in her wheelchair for meals and when in bed repositioned frequently."</p> <p>At 2:42, the ADON documented, "Received new order for wound consult. Certified wound nurse to be contacted and appt made."</p> <p>On 12/9/13, the DNS documented, "Area measures 2.5 x 3 cm x 2.5 in depth at center, wound undermining..." Orders were received for a wound device (wound vac which applies negative pressure to the area) to be applied. The wound device was implemented by staff at the facility on 12/11/13.</p>	F 314		

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On 12/11/13 at 4:59 p.m., the ADON documented "wound to [redacted] buttock (Stg III for MDS purpose)... Wound measures 2.5 cm x 2.5 cm with a 1.5 cm depth and a 4cm undermining 11 o'clock to 1 o'clock. 25% yellow slough at wound base."

On 12/18/13, the ADON documented "...wound continues to be improving with increased granulation tissue at base. Measure 2.2 x 2.2 cm with a 1.5 cm depth and 4 cm undermining 10-2 o'clock yet undermining appears to be filling in at edges. Serosang drainage in the wound vac canister ... Stated 'ow' when foam dressing was first placed yet no further pain."

<Pressure Ulcer Treatment Orders>

On 10/30/13: [redacted] to [redacted] buttock scar area. Cover with Mediplex dressing. Change daily. End date 11/7/13:

On 11/7/13: [redacted] to [redacted] buttock pressure area. Cover with [redacted] bordered foam dressing. Change daily and as needed. End date 11/12/13.

On 11/12/13: Cleanse [redacted] buttock wound with normal saline. Cut Medihoney square to size of wound. Cover wound with Medihoney, cover site with Mediplex foam dressing. Change daily and as needed. End date 11/18/13.

On 11/18/13: Cleanse [redacted] buttock wound with normal saline. Cut mesalt square to size of wound and cover with foam bordered gauze. Change daily and as needed. End date 11/21/13.

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On 11/21/13: Cleanse [redacted] buttock wound with normal saline, apply isosorb paste to base of wound. Cover with foam bordered gauze every 2 days. End date 11/26/13.

On 11/26/13: Dakins ¼ strength wet to dry dressing to [redacted] buttock wound twice daily. Apply dressing to wound bed only, minimize contact with surrounding skin. End date 11/27/13.

On 11/27/13: Wet to dry dressing to [redacted] buttock wound. [Wet solution not identified.] Change twice daily and as needed. End date 12/2/13.

12/6/13: Dakins ¼ strength solution wet to dry to [redacted] buttock wound. Cleanse site with normal saline then pack with moistened Dakins to necrotic tissue only twice daily. End date 12/9/13.

On 12/9/13: Dakins ¼ strength solution. Apply to [redacted] buttock ulcer topically twice daily. Cleanse site with normal saline then pack lightly with moistened Dakins gauze. Apply to necrotic tissue only. End date 12/13.13.

On 12/9/13: Wound vac [Negative Pressure Wound Therapy (NPWT)] to [redacted] buttock wound. Change dressing Monday, Wednesday, Friday and as needed for dislodgement. Start date 12/11/13.

The facility Skin Practice Guide defined NPWT as the creation of a vacuum at a well-sealed wound site.

<Repositioning, Pressure Relief and Pain>

According to "Decubitus [pressure] Ulcers Treatment & Management," (Revis & Geibel,

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F 314	<p>Continued From page 17</p> <p>Medscape, 10/12/12), "Regardless of the choice of support surface, turning and repositioning the patient remain the cornerstones of prevention and treatment [of pressure ulcers] ...even in the presence of a specialty surface or bed."</p> <p>According to "Fundamentals of Nursing," (Wilkinson, Treas & Davis, 2010, page 850), frequent repositioning is "one of the most important interventions for preventing pressure ulcers" and patients at risk for pressure ulcers should be repositioned at least every two hours. Patients with little subcutaneous tissue "might need to be repositioned more frequently. At-risk individuals who are chair bound should be repositioned every hour or taught to shift their weight every 15 minutes." Use of support surfaces which redistribute body weight, such as specialty wheelchair cushions or alternating pressure mattresses, should be "coupled with an effective turning and repositioning schedule."</p> <p>The PUPP indicated the care plan for a resident with diminished mobility should include a "turn/reposition schedule."</p> <p>For Resident #129, neither the care plan nor the nursing assistant care directive identified a turn/reposition schedule or identified a specific frequency for repositioning.</p> <p>Resident #129's care plan for activities of daily living, dated 10/11/13, instructed staff to "Encourage and/or assist to reposition frequently."</p> <p>The care plan, for "an unstageable area to the [redacted] buttock," dated 10/30/13, stated, "Patient to be turned side to side to tolerance. Notify LN</p>	F 314		

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F 314	<p>Continued From page 18</p> <p>[licensed nurse] if patient refuses. Re-approach if refuses. ...Use pillows and/or positioning devices as needed."</p> <p>The undated care directive for nursing assistants instructed staff: "Turn and/or reposition frequently. Bridge patient when on back in bed to decrease pressure to [redacted] buttock wound. Encourage side to side to tolerance."</p> <p>There was no care plan for Resident #129 addressing resistance to repositioning and related need for education in order to assist the resident to make informed choices about care and help her understand the consequences of refusing repositioning. Nor was documentation located in the resident's medical record to indicate staff attempted to ascertain the resident's reason for resisting efforts to reposition her or offer alternative measures such as positioning devices.</p> <p>Random progress notes and nursing assistant care logs documented repositioning the resident off her [redacted] buttock. There was no documentation if the resident was consistently repositioned and/or when she refused repositioning.</p> <p>On 12/18/13 at 1:37 p.m., Resident #129 was observed lying on her back on top of the covers in bed. A thin pillow was placed a few inches under the resident's [redacted] side; her [redacted] sacral area (the region of the pressure ulcer) appeared to be making contact with the bed surface. On numerous occasions throughout each day of the survey, Resident #129 was observed lying on her back in bed. In most instances, one or two thin pillows were lying to one side or both sides of the resident and were never observed to support</p>	F 314		

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F 314	<p>Continued From page 19 repositioning off the pressure ulcer.</p> <p>At no time were positioning devices other than pillows observed.</p> <p>Observation of the mattress on Resident #129's bed revealed it was a motorized Joernes P.R.O. [Pressure Redistribution Optimization] ES2. It felt firm and dense when pressed manually. There were settings on the motor for comfort (1-5), mode (autofirm, therapy, and alternate) and cycle time (5, 10, and 15 minutes).</p> <p>The product information literature for the Joernes P.R.O. ES2 indicated the mattress had 15 adjacent horizontal air-filled sections for actively alternating pressure and was "appropriate for up to uncomplicated Stage III or Stage IV pressure ulcers based on individual patient assessment." The mattress could also be used without the motor and the alternating pressure function.</p> <p>The mattress literature further stated, "Patients should be turned and repositioned per an individual turning schedule or per facility policy."</p> <p>The mattress did not have a "low air loss" function which, according to the National Pressure Ulcer Advisory Panel Support Surfaces Initiative, 1/29/2007, "provides a flow of air to assist in managing heat and humidity (microclimate) of the skin."</p> <p>On 12/2/13, the ADON documented Resident #129 was "to receive air mattress today." No documentation was located to verify when the P.R.O. ES2 mattress, or any other specialty mattress, was placed on the resident's bed.</p>	F 314		
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F 314	<p>Continued From page 20</p> <p>On 12/18/13 at 10:29 a.m., Nursing Assistant (NA) C said, "When we lay [Resident #129] down we lay her on one side." NA C said staff lay the resident on alternate sides, using pillows to keep her off her back but the resident pulls the pillows out and ends up on her back.</p> <p>On 12/18/13 at 2:25 p.m., Physical Therapist (PT) B and the surveyor examined Resident #129's wheelchair. PT B stated it was a standard wheelchair with no tilt function for pressure relief, with a standard cushion having no special pressure relieving properties. PT B said the resident was currently receiving therapy to assist with self-propelling. When asked, PT B said she was unaware of any plans to procure a wheelchair with a tilting function.</p> <p>On 12/19/13 at 11:48 a.m., NAA, said Resident #129 liked to be up in her wheelchair around people and spent a fair amount of time in her wheelchair each day. NAA said when the resident was in bed staff tried to lay the resident on her side using a pillow for repositioning, or on her back with one pillow under each side to "bridge the resident off her coccyx."</p> <p>NAA said Resident #129 often expressed pain by saying "ow, ow, ow." NAA said the resident was able to communicate pain location when staff asked yes/no questions citing different body areas. NAA said the location the resident identified most often was the [REDACTED] buttock. NAA said, "We say, 'bottom?' and she says yes."</p> <p>On 12/19/13 at 9:00 a.m., during medication observation with LNA, Resident #129 was observed in her wheelchair near the medication cart in the hall. The resident was grimacing and</p>	F 314		

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F 314	<p>Continued From page 21</p> <p>repeatedly said "ow." LN A asked Resident #129 if her bottom hurt and the resident said yes.</p> <p>LN A said, "Sometimes she is very clear and can say where it hurts. We also observe behaviors like facial grimacing or a furrowed brow." LN A said staff ascertained pain location by asking yes/no questions and said, "The area that seems to cause the most discomfort is her bottom. ...She is so thin and can't reposition herself."</p> <p>On 12/23/13 at approximately 10:00 a.m., during a telephone interview, Resident #129's Family Member (FM) said that during her stay at the facility, Resident #129 had 3 different beds. The FM said the resident started with a regular non-air mattress with no motor, then an air mattress with a motor, then a non-air mattress with bolsters to prevent falls, then back to the air mattress with a motor "because of the wound on her bottom." The FM could not recall the dates when the mattress changes occurred.</p> <p>The FM further stated, "They try to reposition her in bed but she won't stay. It really aggravates the wound when she's in the wheelchair. She says 'ow,ow, ow.' We ask, 'Is your bottom sore?' and she indicates that it does. She can usually answer correctly."</p> <p>Resident #129's Medication Administration Record for December 1-19, 2013 revealed the resident received the following medication for pain:</p> <p> 500 mg every 6 hours from 12/1 to 12/17/13 and 650 mg every 6 hours from 12/18 to 12/19/13.</p>	F 314		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505525	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2013
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - LACEY		STREET ADDRESS, CITY, STATE, ZIP CODE 4524 INTELCO LOOP SE LACEY, WA 98503	
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F 314	<p>Continued From page 22</p> <p>██████████ 50 mg as needed: 1-2 times on December 2, 4, 5, 10, 11, 13, 14, 15; and 3 times on December 1, 3, 6, 7, 8, 9, and 12. On December 9-11 she also received ██████████.</p> <p>Beginning 12/16/13, Resident #129 received ██████████ 25 mg routinely every 4 hours, and 25 mg as needed for "increased pain" which she received on December 17, 18, and 19.</p> <p>On 12/19/13 at 3:30 p.m., in reference to resident #129's ██████████ buttock ulcer, the DNS said, "We didn't think it could be a pressure wound because it's not in the usual area. We are treating it as a pressure ulcer but it's a wound anomaly to me."</p> <p>When asked how the settings on the motor for the resident's mattress were determined or monitored, the DNS said the settings were standard and did not require monitoring. The DNS was unable to identify how the settings were determined or where the "standard" settings were documented.</p> <p>The RAI definitions of pressure ulcer stages included:</p> <p>Stage III: Full thickness tissue loss. Bone, tendon or muscle is not exposed. Slough may be present and may include tunneling.</p> <p>Stage IV: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present and often includes tunneling.</p> <p>On 12/20/13 at 9:34 a.m., during a dressing change, with two surveyors, the DNS, the ADON and the ARNP present, the pressure ulcer on Resident #129's ██████████ buttock was observed to be</p>	F 314	

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F 314	<p>Continued From page 23</p> <p>located to the right of her sacrum. The ulcer measured 2 x 2 cm with a 1.5 cm depth and approximately 4 cm area of undermining in the direction of the resident's spinal column. Full tissue thickness loss was observed with a 1.0 cm area of yellow slough near the center of the ulcer. The wound vac canister contained a small amount of drainage.</p> <p>During the dressing change, the resident said "ow" three or four times. She was observed to be quite thin with little subcutaneous fat.</p> <p>Just prior to the dressing change, the resident was observed to be positioned on her back with two thin pillows: one on each side, placed partially under her back. The DNS said the pillows were to provide a "bridging" effect to keep the resident off her coccyx. When the surveyor noted that the ulcer was to the [redacted] of the coccyx and the pillow appeared to create, not relieve, pressure to the ulcer, the DNS agreed that might not be effective.</p> <p>When asked if the resident was on a specific schedule for repositioning, the DNS said, "No, we don't have turn schedules."</p> <p>The ARNP said, "We are calling this a wound, not a pressure ulcer," and said she did not think pressure was a factor because the ulcer was "not in a usual site for a pressure ulcer."</p> <p>On 12/24/13 at 1:20 p.m., four days after the survey team exited the facility on 12/20/13, the ADON sent an additional document to the surveyor by facsimile: a medical report from the Wound Care Clinic.</p> <p>The report, dated 12/24/13, signed by the</p>	F 314		

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NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES - LACEY	STREET ADDRESS, CITY, STATE, ZIP CODE 4524 INTELCO LOOP SE LACEY, WA 98503
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physician, indicated this was Resident #129's first visit to the clinic. The resident was accompanied by the ADON.

The report documented pressure ulcer measurements of 1.9 x 1.3 x 1.6 cm with 4.1 cm undermining and stated, "This patient has a stage 3, possible stage 4 ulcer of the [redacted] ischial tuberosity with possible osteomyelitis. ...There is necrotic tissue in the skin and subcutaneous tissue. There are calcium deposits in the wound itself in the area of the patient's prior scar. The wound extends down to the gluteus muscle..."

The wound was surgically debrided including "100% of the wound debriding skin, subcutaneous tissue, fascia, and muscle, and calcifications in the wound."

When the resident was admitted to the facility on [redacted]/13, her skin was intact. On 10/30/13, the resident developed a superficial pressure ulcer over her [redacted] ischial tuberosity (a bony prominence) which eventually progressed to a Stage 3.

Although facility staff identified the resident to be at risk for developing a pressure ulcer, they failed to accurately identify the type of wound, consistently implement and evaluate the effectiveness of interventions according to facility policy.

Although the resident was non-verbal and could not voice a reason for resistance to repositioning, the facility failed to ascertain the reason for resisting efforts to reposition or offer alternative measures. The resident's resistance to repositioning and turning was documented as

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F 314	Continued From page 25 early as 10/20/13. Additionally, staff failed to clearly identify the ulcer over the resident's [redacted] ischial tuberosity as a pressure ulcer, and did not identify that sitting in the wheelchair could specifically aggravate and worsen the ulcer. These failures resulted in the development of a painful, ongoing Stage 3 pressure ulcer causing harm to the resident.	F 314		