STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505269	A. BUILDING _____ B. WING _____	11/19/2013

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PACIFIC SPECIALTY & REHAB CARE	1015 NORTH GARRISON ROAD VANCOUVER, WA 98664

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0314	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure 1 of 4 sampled residents (#1) at risk for developing pressure ulcers, or having a pressure ulcer received timely treatment to promote wound healing. The facility failed to identify resident #1's pressure ulcer, notify the physican and provide appropriate necessary treatment. This failure resulted in actual harm to the resident as the pressure ulcer worsened requiring hospitalization and specialty services of a wound clinic. Findings include: Resident #1 was admitted to the facility 9/10/13. She had [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS - tool used for assessment by the facility) resident #1 was alert and oriented and totally dependent on staff to meet her daily needs to include bed mobility and transfers. Document review indicated on 9/10/13 when she was admitted the skin of her buttocks was red with a rash. Progress note written 9/13/13 on night shift stated, Slight redness noted on coccyx area, patient to be turned every 1-2 hours and barrier cream to be applied. On 9/13/13 resident #1 was sent to the hospital for respiratory problem and returned to the facility on [DATE]. According to the SNF Discharge Orders/Nursing Report sent from the hospital to the facility with Resident #1 on 9/15/13 Resident #1 had a Stage III (full thickness of skin, serosanguineous -blood colored - drainage) pressure ulcer on her buttocks. The pressure ulcer, according to the transfer paperwork was 1cm x 1.5cm and was to be covered with allyven (dressing used to cover wounds). A skin assessment was completed when resident #1 was readmitted to the facility on [DATE], according to the assessment there was slight redness to residents' buttocks. There was no evidence the facility recognized the pressure ulcer and there were no orders written for treatment. Review of the progress notes and treatment sheets did not indicate there was any identified skin issue for the resident except some excoriation in the groin which was treated with dimethacone (cream for minor skin irritations and [MEDICATION NAME] powder (used for skin irritations and yeast). Weekly skin assessments between 9/10/13 and 10/15/13 indicated there were no skin issues. Progress note written night shift 10/11/13 stated, Patient had skin wounds on/near coccyx area. Treated with cream and 4x4 allevyn. Diarrhea appears to be causing skin damage. There was no doctors' order found or any indication in the documentation to indicate the physician was made aware of the wounds. There was no documentation to support there was any assessment of the wounds completed. Progress note written 10/11/13 dayshift stated, .buttocks and coccyx area red and excoriated; cleaned and protective cream applied. Again there was no mention of wounds or assessment being done or physician notified of any change in condition. According to the treatment sheet the weekly skin assessment was not completed on 10/22/13. On 10/29/13 the skin assessment box on the treatment sheet indicated there was a skin issue. There was however, no documentation of what the skin issue was, what was done about it and/or if the physician was notified. 10/30/13 day shift progress note, .residents' sacrum with black eschar noted with excoriation around the black eschar. Progress note written 10/30/13 written at 12:45p.m. TO (telephone order) to discontinue current treatment to coccyx (there was no evidence of any prior order); new order cleanse area with normal saline, pat dry, apply skin prep to eschar (slough), cover with pad, change every day, turn resident every hour and refer to wound healing center. Progress note written 10/30/13 at 2:50pm indicated the residents' buttocks were assessed. The wound measured 4cm x 4cm on sacrum, with black eschar covering the area. To right and below the sacrum there was an excoriated area 6.5cm x 4.5cm and to the left and below was 8.5xm x 6.5cm blanchable red area. There was no odors or drainage noted. When the facility assessed the resident prior to sending her to the emergency room they documented on the skin grid - pressure ulcer/[MEDICAL CONDITION] ulcer/other form, the pressure ulcer on her coccyx was unstageable and was 9cm x 8cm and pressure ulcer to the right anterior coccyx was unstageable and 11cm x 7cm. On 10/30/13 the family, according to the progress notes, insisted the resident be sent to the emergency room for treatment of [REDACTED]. Resident was taken to the emergency room and returned to the facility on [DATE]. Facility stated in their investigation, the pressure sore was present on admission to the facility. There was no evidence found in the documentation to indicate they were aware of the pressure ulcer prior to 10/30/13. There was no treatment or assessment completed of a pressure ulcer prior to 10/30/13. Resident did have care plan in place with interventions such as air flow mattress and turning every 1 or 2 hours but no other treatment or interventions were noted. In an interview with resident #1 on 11/19/13 she stated she did not have a pressure ulcer when admitted to the facility. She stated she did not always get turned and when the pressure ulcer developed staff did not do anything about it. Resident #1 stated she was now getting turned on a regular basis and going to the wound clinic for treatment. In an interview with the director of nurses on 11/19/13 she had no explanation as to why staff had not identified the presence of the pressure ulcer but believed it had developed in the hospital and was present according to hospital documentation when resident returned to the facility on [DATE]. She agreed the assessment of slight redness was not the same as a stage III pressure ulcer. She agreed the lack of assessment and appropriate treatment led to the worsening of the residents' pressure ulcer. She stated she had/was implementing interventions to prevent future episodes.
F 0314	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure 1 of 4 sampled residents (#1) at risk for developing pressure ulcers, or having a pressure ulcer received timely treatment to promote wound healing. The facility failed to identify resident #1's pressure ulcer, notify the physican and provide appropriate necessary treatment. This failure resulted in actual harm to the resident as the pressure ulcer worsened requiring hospitalization and specialty services of a wound clinic. Findings include: Resident #1 was admitted to the facility 9/10/13. She had [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS - tool used for assessment by the facility) resident #1 was alert and oriented and totally dependent on staff to meet her daily needs to include bed mobility and transfers. Document review indicated on 9/10/13 when she was admitted the skin of her buttocks was red with a rash. Progress note written 9/13/13 on night shift stated, Slight redness noted on coccyx area, patient to be turned every 1-2 hours and barrier cream to be applied. On 9/13/13 resident #1 was sent to the hospital for respiratory problem and returned to the facility on [DATE]. According to the SNF Discharge Orders/Nursing Report sent from the hospital to the facility with Resident #1 on 9/15/13 Resident #1 had a Stage III (full thickness of skin, serosanguineous -blood colored - drainage) pressure ulcer on her buttocks. The pressure ulcer, according to the transfer paperwork was 1cm x 1.5cm and was to be covered with allyven (dressing used to cover wounds). A skin assessment was completed when resident #1 was readmitted to the facility on [DATE], according to the assessment there was slight redness to residents' buttocks. There was no evidence the facility recognized the pressure ulcer and there were no orders written for treatment. Review of the progress notes and treatment sheets did not indicate there was any identified

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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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