

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

PRINTED: 06/03/2014
FORM APPROVED
OMB NO. 0938-0391

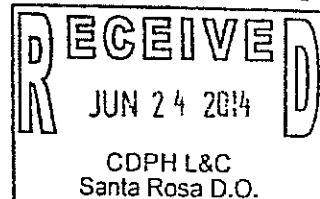
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055334	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/16/2014
NAME OF PROVIDER OR SUPPLIER PACIFIC REHABILITATION & WELLNESS CENTER, LP			STREET ADDRESS, CITY, STATE, ZIP CODE 2211 HARRISON AVENUE EUREKA, CA 95501	
(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	Continued From page 4 Management Staff K stated that staff is trained on how to use the emergency cart suction machine and it is possible that Licensed Staff I did not know the proper suctioning technique because she worked in central supply prior to working "the floor." Management Staff K stated that she monitored the training through returned demonstration but that there was no outline of education, and/or policy and procedure. According to "Fundamentals of Nursing," Third Edition, p. 821, Suctioning, "In clients who cannot cough effectively to expectorate mucus... To prevent this, you may have to suction airways." Under 'Suctioning Secretions From Airways' procedures, p. 827, "Nurses need to maintain skill in suctioning so that suctioning can occur quickly to maintain a patent airway..."	F 281	demonstration prior to completion of nursing orientation. On 6/13/2014 staff, all departments and shifts, was in-serviced by the Director of Nursing and Administrator on the importance of checking for completeness of orders and following facility policy and procedure titled Telephone Orders for Medication. This training reinforced that failure to follow these procedures could have resulted in residents having adverse reactions. Staff was also in-serviced on the importance of maintaining suctioning skills. This training reinforced that failure to maintain these skills could result in emergency services not being provided to residents timely. The Director of Nursing or designee will monitor the effectiveness of the teachings and monitors. Progress will be discussed at the monthly QA & A meeting by the Director of Nursing or designee until satisfactory compliance is met and sustained and or new recommendations will be made and acted upon by the Administrator. Corrective Action Date: 06/13/2014	6/13/14
F 309 SS-D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record reviews, the facility failed to provide the necessary care and services when there was not a timely assessment of a change in skin condition for 1 of 14 sampled residents (Resident 10). This failure resulted in Resident 10 receiving delayed	F 309		

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Event ID: W56N11

Facility ID: CA010000051

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240 D DEFINITION 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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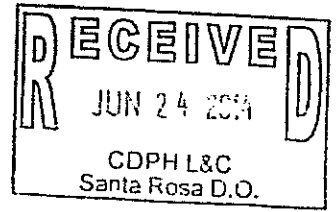
F 309	Continued From page 5 treatment for a skin condition. Findings: During the Residents' Group Meeting interview, on 5/13/14, at 9:30 a.m., Resident 10 stated that he had been experiencing burning pain on his back "for a few weeks" nursing staff had been notified. The treatment did not start until a few weeks after the resident had reported the concern. During a review of Resident 10's clinical record, on 5/13/14, at 11 a.m., there was no documentation regarding Resident 10's change in skin condition. During an interview, on 5/13/14, at 11:30 a.m., Licensed Staff G stated that Resident 10 reported "itching and pain" on his back. Licensed Staff G also stated that he notified Licensed Staff J (Wound Care Nurse). Licensed Staff G did not document Resident 10's change in skin condition in Resident 10's clinical records. During an interview, on 5/13/14, at 12:40 p.m., Licensed Staff J stated that he was not aware of any changes in Resident 10's skin condition. During an interview, on 5/14/14, at 10:30 a.m., Resident 10's responsible party stated that Resident 10 had been complaining of itchy rash on his back for about 2 weeks. Resident 10's responsible party stated, "I told CNA's, nurses, anyone at the nurses station because the rash was getting worst... he would scratch aggressively and sometimes causing the rash to open and bleed." Treatment assessment was not initiated until 5/12/14.	F 309	F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Resident 10 has had an itchy rash on back off and on for several years, per resident's spouse. Resident uses TAC and Benadryl at home as needed. Resident 10's Weekly Assessment Worksheet, dated 5/10/2014, had no rash noted. Resident 10's Weekly Assessment Worksheet, dated 5/13/2014, had red dots on upper back documented and was noted by the treatment nurse on 5/13/2014. Resident 10 started treatment for a rash on 5/13/2014. Resident 10 was apologized to by Director of Nursing for this delay in treatment and reassured he would get treatment on 5/13/2014. All facility residents were questioned as to their perception of comfort regarding skin (itching) on 6/13/2014 by Director of Nursing or designee; everyone expressing concern was checked for a skin treatment. If no skin treatment order existed a skin check would be completed and the residents' physician would be notified if needed. The Director of Nursing or designee will perform random resident interviews to ensure	
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F 309	Continued From page 6 During a review of Resident 10's clinical record, on 5/15/14, at 3:44 p.m., an unsigned Physician Telephone Order, dated 5/15/14, indicated, "To rash back: Apply TAC 0.1% (skin calming medicine) ointment topically (to skin) to affected area for 14 days and then re-evaluate." The facility policy and procedure titled, "Skin Wound Management," dated January 1, 2012, indicated, "All Nursing Staff is responsible for the prompt reporting of any skin related conditions to the Licensed Nurse. The Licensed Nurse will notify the Attending Physician promptly at the first occurrence of a pressure ulcer or other skin related problems." According to "Fundamentals of Nursing," Third Edition, p. 164, "Nursing assessment focuses on the gathering of data about a client's state of wellness, functional ability, physical status, strengths, and responses to actual and potential health problems." "The purpose of nursing assessment is to gather data about the client that can be used in diagnosing, identifying outcomes, planning and implementing care."	F 309	compliance that care and/or services are being provided. Staff will be in-serviced on 6/13/2014 by the Director of Nursing and Administrator regarding the importance of prompt reporting of changes in skin condition, how all nurses should promptly obtain a treatment order by notifying the physician of changes in skin condition, and facility policy and procedure "Skin Wound Management". This training reinforced that this failure could have result in residents not being treated timely. The Director of Nursing or designee will monitor the effectiveness of the teachings and monitors. Progress will be discussed at the monthly QA & A meeting by the Director of Nursing or designee until satisfactory compliance is met and sustained and or new recommendations will be made and acted upon by the Administrator. Corrective Action Date: 06/13/2014	
F 323 SS-E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		6/13/14

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