

1011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505325	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/31/2013
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NAME OF PROVIDER OR SUPPLIER ISLAND HEALTH & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 835 MADISON AVENUE NORTH BAINBRIDGE ISLAND, WA 98110
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Quality Indicator Survey conducted at Island Health and Rehabilitation Center on 1/22/13, 1/23/13, 1/24/13, 1/25/13, 1/29/13, 1/30/13 and 1/31/13. A sample of 34 residents was selected from a census of 47. The sample included 29 current residents and the records of 5 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████, RN, BSN, MSN ██████████, RN, BSN, MBA ██████████, BSS ██████████, RN, BSN</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Disability Services Administration Residential Care Services, District 3, Unit A 1949 South State Street, MS: N27-24 Tacoma, Washington, 98405-2850</p> <p>Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p><i>John Pease</i> 2-6-13 Signature Date</p>	F 000	<p>This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report.</p> <p>RECEIVED FEB 25 2013 RCS REGION 1</p>	3/7/13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mark Cunningham</i>	TITLE Administrator	(X6) DATE 2/20/13
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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 156 SS=F	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>	F 156	<p>F- 156 (F)</p> <p>I. How the nursing home will correct the deficiency as it relates to the resident:</p> <p>Center will display all required advocacy information on each hall of the building including North, South and West halls where the information will be readily accessible to residents and visitors.</p> <p>II. How the nursing home will act to protect residents in similar situations:</p> <p>Center has reviewed placement of information for all residents in the building to ensure that the advocacy information will be easily accessible by those on other halls and by visitors.</p> <p>III. Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <p>The required information will be permanently posted to the North, South, and West halls to ensure ongoing compliance.</p>	3/7/13
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F 156	<p>Continued From page 2</p> <p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's</p>	F 156	<p>IV. How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <p>Center will monitor compliance with the required posted advocacy information for a minimum of the next three scheduled QA meetings to ensure that ongoing compliance is sustained.</p> <p>V. Dates when corrective action will be completed: Mar 7, 2013</p> <p>VI. The title of the person/s responsible to ensure correction:</p> <p>Administrator, Director of Nursing or Designee</p>	3/7/13

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F 156	<p>Continued From page 3</p> <p>policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of information posted in the facility, it was determined that the facility failed to display all required State and advocacy information. This prevented residents, families and visitors from having contact information for State and resident advocacy groups available if needed.</p> <p>Findings include:</p> <p>Throughout all days of survey between 1/22/13 and 1/25/13 and 1/29/13 thru 1/30/13, facility posted information was located on the right side of the wall North Hall beyond the fire doors. The location of current posted information was not in a location visible to all residents and visitors. Residents and visitors who resided or visited on the South Hall or the West Hall may not have travelled the North Hall to see the information.</p>	F 156		3/7/13	

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F 156	Continued From page 4 Current information posted did not contain the following information: - Address of the State survey and certification agency - Name address and telephone number of the Medicaid fraud control unit - Address for the State ombudsman program - Names, addresses and telephone numbers of all state client advocacy groups for those with mental illness and developmental disabilities - A statement that a resident may file a complaint with the state certification agency regarding abuse, neglect, misappropriation of resident property in the facility, and non-compliance with advance directive requirements. On 1/30/13 at 1:40 p.m. Staff A confirmed the facility had not posted any further additional information.	F 156		3/7/13	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse	F 157	F- 157 (D) I. How the nursing home will correct the deficiency as it relates to the resident: Physician was informed of Resident # 38's low blood pressure. Center staff followed physician orders as delivered.		

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F 157	<p>Continued From page 5</p> <p>consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined licensed staff failed to timely notify the physician when they did not administer medication to treat hypertension as ordered or when blood pressure measurements were below identified facility parameters for 1 of 10 Sampled Residents (#38) reviewed for notification regarding medication use. This prevented the physician from being timely involved in making decisions related to medication use or had the potential for Resident #38 to experience an unfavorable event related to a potential adverse medication reaction of missed doses.</p> <p>Findings include:</p>	F 157	<p>II. How the nursing home will act to protect residents in similar situations:</p> <p>Facility will review its residents for timely notification to physicians per facility policy and the use of the SBAR tool. Facility will follow up with timely notification to physician and implement any updated orders.</p> <p>III. Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <p>Reeducation will take place with staff regarding timely notification to physicians per facility policy and SBAR tool in order to ensure that the physician may become timely involved in making decisions concerning the resident.</p> <p>IV. How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p>	3/7/13	

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F 157	<p>Continued From page 6</p> <p>Refer to F 329 for information related to use and monitoring of daily administered [REDACTED] administered to treat high blood pressure, and for additional information related to facility policies for monitoring for potential adverse side effects of this medication.</p> <p>On 1/25/13 at 9:02 a.m. Resident #38 sat in a motorized wheelchair in front of the nursing station. Staff O reported the resident frequently left the building on outings in the wheelchair.</p> <p>A entry record Minimum Data Set tool dated [REDACTED] 12 identified Resident #38 admitted to the facility on [REDACTED] 12. An annual assessment dated 12/10/12 identified the resident had current diagnoses that included [REDACTED], [REDACTED], [REDACTED], [REDACTED], had [REDACTED] and used a wheelchair.</p> <p>The facility followed an interactive tool (SBAR) that directed staff to immediately notify the physician when resident systolic blood pressures (SBP, the top number of blood pressure readings that measured pressure on the arteries when the heart pumped blood) were below 90 mm Hg and when the pulse was below 55 beats per minute.</p> <p>Medication records for November 2012, December 2012 and January 2013 all contained frequent circled licensed staff initials when documenting administration of [REDACTED]. On 1/30/13 at approximately 10:00 a.m., Staff K reported circled initials meant staff did not administer the medication but held it.</p> <p>The November 2012 medication record identified licensed staff circled their initials 14 times</p>	F 157	<p>Nurse management or designee will monitor compliance by performing periodic chart audits to ensure timely notification is taking place per facility policy. Center will promptly resolve any non-compliant findings. This plan of correction will be monitored for a minimum of the next three scheduled QA meetings to ensure that ongoing compliance is sustained.</p> <p>V. Dates when corrective action will be completed: Mar 7, 2013</p> <p>VI. The title of the person/s responsible to ensure correction:</p> <p>Director of Nursing, RCM, Administrator or Designee</p>	3/7/13	

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F 157	<p>Continued From page 7</p> <p>between 11/1/12 and 11/30/12. On 11/1/12 Resident #38's SBP was 86 and on 11/22/12 the resident's blood pressure was 88/58, below facility parameters which required physician notification. On two occasions, 11/9/12 and 11/29/12, staff documented the resident was out of the facility and did not have initials to indicate the resident received the medication on those days.</p> <p>On 1/29/13 at approximately 2:30 p.m. Licensed Staff M reported staff should have reported the low blood pressures to the physician in November (2012) and did not provide further evidence it had been done.</p> <p>During December 2012, staff circled their initials nine times and during January 2013 staff circled their initials 14 times between 1/1/13 through 1/26/13 to indicate they did not administer the medication on those days. During three days between 1/22/13 through 1/24/13, staff documented the resident was out of the facility and the record did not identify staff had administered the medication those days.</p> <p>On 1/26/13 staff documented the resident's blood pressure measured 85/54, below facility protocol parameters. On 1/29/13 at 9:58 a.m. Staff M reported Staff K contacted the physician on 1/26/13 due to a low blood pressure and the physician reduced the dose of [REDACTED] from 50 mg to 25 mg a day.</p> <p>On 1/29/13 at 2:30 p.m. Staff B reported the facility interactive tool indicated for staff to notify the physician when the SBP was below 90 mm Hg and resting pulse was less than 55 beats per</p>	F 157		3/7/13

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F 157	Continued From page 8 minute and provided no further evidence the physician had been notified prior to 1/26/13. Licensed staff failed to inform the physician according to facility parameters, when Resident #38's SBP measured below 90 twice in November 2012, or when they held and did not administer [REDACTED] an additional 36 times between 11/1/12 and 1/25/13. Failure to inform the physician timely when and why staff held the resident's [REDACTED] and when blood pressures were low, prevented the physician from having a more timely opportunity to intervene to determine if changes to the resident's medication regimen were needed earlier. Refer to F 514 for failure to document and complete records related to medication administration.	F 157		3/7/13
F 164 SS=F	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any	F 164	F- 164 (F) I. How the nursing home will correct the deficiency as it relates to the resident: Resident care delivery guides will be relocated to the inside of resident closets to ensure privacy. Resident # 78 was interviewed to identify signs of discomfort, embarrassment or complaint if present. Resident # 78 is satisfied with all aspects of care received at the Center.	

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F 164	<p>Continued From page 9 individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to store all resident clinical records in a location to ensure confidentiality was maintained on 3 of 3 Halls (North Hall, South Hall and West hall) and failed to maintain visual privacy during transport for bathing for 1 Sampled Resident (#78) of the 34 sampled residents who were included in the stage 2 review. This had the potential for all unauthorized staff residents and visitors to have access to view resident's confidential medical information and/or for Resident #78 to feel embarrassed due to bodily exposure.</p> <p>Findings include: RESIDENT RECORDS</p> <p>Throughout all days of survey between 1/22/13 to 1/25/13 and 1/29/13 through 1/31/13, a storage wall container on the North hall, South Hall and</p>	F 164	<p>II. How the nursing home will act to protect residents in similar situations:</p> <p>Care delivery guides will be relocated from all halls to the inside of resident closets for privacy of information. Staff members will be reeducated regarding the updated location of care delivery guides as well as the need to ensure resident dignity and privacy during transport from resident rooms to shower rooms.</p> <p>III. Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <p>Care delivery guide binders will be permanently replaced with the new system noted in this plan of correction. Floor nurses will reeducated to promptly resolve and then report observations of non-compliant shower transports in order to ensure that resident privacy and psychosocial well-being is respected.</p> <p>IV. How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p>	3/7/13	

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F 164	<p>Continued From page 10</p> <p>West Hall located by wall computers contained two separate three ring binders. Each binder contained plans of care for residents that lived on each hall. Resident care plans included specific guidance for nursing staff that identified levels of assistance required for care for activities of daily living, use of dentures, behaviors and incontinence status and other confidential information. Multiple visitors and residents were observed present in the hallways at various times, sometimes without the presence of staff.</p> <p>On 1/31/13 at 9:20 a.m., Staff K confirmed the notebooks stored in resident halls contained medical information for residents. Staff K also reported the medical information used to be kept inside resident closets and were moved to the halls. Staff K agreed the information was accessible to anyone in the hall who wanted to review it.</p> <p>Failure to safeguard resident clinical information in a location that prevented access by unauthorized individuals, had the potential to breach the Health Insurance Portability and Accountability Act (HIPAA) of 1996 Privacy and Security rules implemented to protect the privacy of individually identifiable health information. This had the potential to cause embarrassment to residents in the event confidential information was viewed by others.</p> <p>RESIDENT PRIVACY</p> <p>An admission Minimum Data Set (an assessment tool) dated 10/20/12 identified Resident #78 required extensive assistance from staff to</p>	F 164	<p>Non-compliant findings will be reviewed during in the Center's clinical meeting process. This plan of correction will be monitored for a minimum of the next three scheduled QA meetings to ensure that ongoing compliance is sustained.</p> <p>V. Dates when corrective action will be completed: Mar 7, 2013</p> <p>VI. The title of the person/s responsible to ensure correction:</p> <p>Director of Nursing, Resident Care Managers, Administrator or Designee</p>	3/7/13

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F 164	<p>Continued From page 11 transfer, bathe and for transportation within the facility in a wheelchair.</p> <p>On 1/30/13 at 7:05 a.m. on the North Hall, Staff H pushed Resident #78 down the hall in a shower chair (chair constructed with white PVC pipe on wheels) wearing only a hospital gown. The resident did not have any socks or shoes on and both legs were uncovered. The full length of the outer portion of the resident's left thigh remained exposed while being pushed down the length of the hall to the shower room.</p> <p>During an interview at this time, Staff H reported she had only worked in the facility a few weeks.</p> <p>On 1/30/13 at 9:50 a.m. Resident #78 was aware he/she wore a hospital gown while being pushed down the hall to the shower room.</p> <p>On 1/3/13 at approximately 11:00 a.m. Staff B reported residents should be covered during transport to the shower room.</p> <p>Failure to provide adequate clothing or draping for Resident #78 during transport in a common area exposed unnecessary body parts during provision of services.</p>	F 164		3/7/13
F 329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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</p>	F 329		

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F 329	<p>Continued From page 12</p> <p>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.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to identify adequate indication for use of a psychoactive medication for 1 of 10 Sampled Residents (#1) and failed to consistently and adequately monitor use of a blood pressure medication for 1 of 10 Sampled Residents (# 38) reviewed for medication use of the 34 sampled residents who were included in the stage 2 review. This had the potential for Resident #1 to receive an unnecessary medication or for Resident #38 to experience an unfavorable result from receipt of medication given in the presence of a potential adverse reaction.</p>	F 329	<p>F- 329 (D)</p> <p>I. How the nursing home will correct the deficiency as it relates to the resident:</p> <p>Resident # 1 was reviewed for proper diagnosis of antipsychotic medication and was found to be appropriate by psychiatrist under updated diagnosis. Resident # 38 was reviewed for notification of MD, proper usage of the Interact Tool for BP and pulse parameters, and to ensure that if medication is held, LN will initial and circle in MAR and add note for clarification.</p> <p>II. How the nursing home will act to protect residents in similar situations:</p> <p>Resident #1: Center residents who are currently receiving antipsychotic medications will be reviewed for a qualifying condition or diagnosis. Non-qualifying findings will be brought to the resident's physician for review and direction to ensure resident safety, as well as to verify state and federal regulations are followed.</p>	3/7/13
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F 329	<p>Continued From page 13</p> <p>Findings include:</p> <p>RESIDENT #1 On 1/29/13 at 3:50 p.m. Resident #1 was alert and oriented in bed in his/her room. The resident commented about animals observed in the courtyard through a window, interacted with licensed staff and accepted medications offered.</p> <p>A Face sheet identified Resident #1 recently admitted to the facility on [REDACTED]/12 following hospitalization. A hospital History and Physical (H&P) dated 10/29/12 documented the resident lived in a community setting prior to hospitalization and "passed out and was down on the floor for a few seconds." The H&P identified multiple medical conditions that included [REDACTED] and a [REDACTED] history.</p> <p>The H&P also documented the resident had mildly hypotensive (low blood pressure) with a systolic blood pressure (SBP) of 80. Systolic blood pressure is the force of blood in the arteries as the heart beats. Medications the hospital listed the resident took included use of an [REDACTED] medication prescribed 50 mg three times a day and 150 mg in the evening.</p> <p>A later hospital transcription dated [REDACTED]/12 documented Resident #1's discharge diagnoses included personality disorder, not otherwise specified. None of the diagnoses listed in the hospital transcription or at the time of admission included a qualifying condition or justification that identified why the resident required use of an [REDACTED] medication.</p>	F 329	<p>Resident 38: Center residents in similar situations will be reviewed for proper usage of the Interact Tool for BP and pulse parameters, proper notification to physician when needed, and to ensure that if medication is held that LN will initial and circle in MAR and add note to back of MAR or other appropriate documentation.</p> <p>III. Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <p>Resident #1: Antipsychotic medications will be reviewed for validation of proper diagnosis. Discrepancies noted during or following admission will be notified to the resident's following physician at the Center. Physician orders with updated diagnoses or changes will be documented and implemented. Resident # 38: LNs will be reeducated on proper usage of the Interact Tool for BP and pulse parameters, proper notification to physician when needed, and to ensure that if medication is held that LN will initial and circle in MAR and add note for clarification.</p> <p>IV. How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p>	3/7/13
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F 329	<p>Continued From page 14</p> <p>Upon admission, [REDACTED]/12, the physician ordered for staff to continue administration of the [REDACTED] medication.</p> <p>A pharmacy consult report dated 11/13/12 documented the resident did not have an appropriate associated diagnosis in the medical record for use of an [REDACTED] medication. The recommendation requested reevaluation for continued use or to consider a dose reduction. The physician response indicated no change in medication until a mental health evaluation was obtained.</p> <p>A mental health evaluation dated 11/26/12 documented reasons for the consult included resident "inconsistency with conflicting stories, is difficult and time consuming with staff" and refused care. The consult did not identify a specific diagnosis or justification for continued use of the [REDACTED] medication. Mental health recommendations included an increase in dose of the medication to 100 mg three times a day. January 2013 Physician Orders identified the physician ordered the increase in dose of medication on 11/27/12.</p> <p>On 1/31/13 at 8:25 a.m., following inquiry regarding clarification of adequate indication for use of the [REDACTED] medication, Staff B reviewed Resident #1's medical record and did not locate information that justified use. Staff B reported staff nurses should obtain diagnoses for all medications and their indications for use at the time of admission. On 1/31/13 at 1:00 p.m. Staff L also reported nursing was responsible to clarify the indication of use of medications with physicians.</p>	F 329	<p>Resident # 1: Nurse management or designee will perform an admission audit within one week of admission. Antipsychotic medications will be reviewed for proper diagnosis. Noted items will be resolved at the time of the audit and brought to QA for follow up as needed. Resident # 38: Nurse management, or designee, will perform periodic audits for no less that one month following the LN inservice to ensure ongoing compliance, and may be extended if deemed necessary. Noted items will be resolved at the time of the audit. This plan of correction will be monitored for a minimum of the next three scheduled QA meetings to ensure that ongoing compliance is sustained.</p> <p>V. Dates when corrective action will be completed: Mar 7, 2013</p> <p>VI. The title of the person/s responsible to ensure correction: Director of Nursing, Resident Care Managers, LNs, Administrator or Designee</p>	3/7/13
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F 329	<p>Continued From page 15</p> <p>On 1/31/13 at 8:45 a.m. Staff B contacted the mental health professional and obtained additional health history information from the mental health provider.</p> <p>At the time of admission and during medication review during survey, Resident #1's medical record did not contain an adequate diagnosis and justification for use of the [REDACTED] medication that met federal guideline criteria that staff administered since admission on [REDACTED]/12. Staff did not obtain further mental health history from the mental health provider until inquiry by the surveyor, two months after Resident #1's admission.</p> <p>This placed Resident #1 at risk for unnecessary medication use or adverse response to medication such as [REDACTED] (low blood pressure and fainting during changes of position).</p> <p>RESIDENT #38 On 10/25/12 the physician directed staff to administer a medication to treat high blood pressure ([REDACTED] 50 mg daily to Resident #38. The "Nursing 2013 Drug Handbook" identified potential adverse reactions to [REDACTED] included low pulse and low blood pressure.</p> <p>A physician order dated 6/6/12, directed staff to monitor the resident's pulse every Thursday. The physician orders did not identify specific parameters for blood pressure or pulse the physician wanted monitored in relation to use of</p>	F 329		3/7/13
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F 329	<p>Continued From page 16 this medication.</p> <p>Review of Medication Administration Records (MAR) for November 2012, December 2012 and January 2013 contained marked off dates for staff to monitor pulse weekly. Staff did not document they monitored Resident #38's pulse three out of 13 times they marked on the MAR to indicate to check it on 11/29/12, 12/27/12 and 1/17/13.</p> <p>When asked what parameters were used to monitor effects of [REDACTED] multiple staff provided different responses:</p> <p>On 1/29/13 at 9:58 a.m., Staff M reported she took Resident #38's blood press: and pulse daily before administering [REDACTED] and would hold the medication if the pulse was below 60 or the systolic blood pressure (SBP) was below 90.</p> <p>On 1/24/13 at 2:55 p.m. with Staff N and on 1/30/13 at approximately 10:00 a.m. with Staff K, both staff reported they checked Resident #38's pulse and blood pressure daily before administering [REDACTED]. Both staff reported they would hold the medication if the resident's SBP was less than 100 or the pulse less than 60.</p> <p>On 1/29/13 at 2:30 p.m. Staff B reported the facility followed a printed interactive tool (SBAR) as a monitoring tool for use of [REDACTED] when the physician did not identify specific parameters. Staff B reviewed the guidelines with the surveyor and reported when the systolic blood pressure measured below 90 mm Hg and when the pulse was below 55 beats per minute, staff should hold the medication and contact the physician. The SBAR did not identify how often to check the</p>	F 329		3/7/13
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F 329	<p>Continued From page 17 blood pressure and/or pulse.</p> <p>Licensed staff frequently circled initials during days of the month on MARs during November 2012, December 2012 and January 2013 for a total of 37 out of 83 times to indicate [REDACTED] was held (not given) on those days. Resident #38's SBP measured below 90 on 11/1/12 and on 11/22/12. The record did not contain evidence staff identified if the resident experienced any symptoms of low blood pressure during any days they circled it was not given although the resident's SBP measured below identified facility parameter levels.</p> <p>Staff did not identify consistent parameters to use to monitor Resident #38's blood pressure medication. Staff frequently held the blood pressure medication and administered it intermittently for 3 months, without notifying the physician even in the presence of a potential adverse reaction of a low blood pressure on two days.</p> <p>Refer to F 157 for failure to notify the physician when staff held the medication and when blood pressure fell below parameter levels staff. Refer to F 514 for failure to maintain completed medication record documentation.</p>	F 329		3/7/13
F 371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p>	F 371		

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F 371	<p>Continued From page 18</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure staff washed hands in the kitchen after handling contaminated dishes and before handling sanitized dishes and failed to maintain the kitchen floor in clean condition. This had the potential to cross contaminate clean dishes used to serve food to residents.</p> <p>Findings include:</p> <p>INADEQUATE HAND WASHING On 1/30/13 beginning 1:00 p.m. the surveyor observed the dishwashing process from the noon meal. One staff conducted dishwashing procedures and moved between handling dirty dishes on one side of the dishwasher and cleaned dishes on the other side.</p> <p>Staff C handled dishes facility residents ate from with ungloved hands and scraped leftover food and napkins that remained on meal trays. After rinsing dirty dishes, Staff C placed them inside racks and pushed the racks into the dishwasher. Staff repeated this process multiple times throughout observations.</p> <p>Once, after pushing the dishwasher rack that contained soiled dishes into the dishwasher, Staff</p>	F 371	<p>F- 371 (F)</p> <p>I. How the nursing home will correct the deficiency as it relates to the resident:</p> <p>Staff C has been reeducated on proper hand washing. The kitchen floor has been professionally deep cleaned twice and sealed.</p> <p>II. How the nursing home will act to protect residents in similar situations:</p> <p>Staff C has been reeducated on proper hand washing. And the facility will reeducate other staff members on proper hand washing. The kitchen floor has been professionally deep cleaned twice and sealed.</p> <p>III. Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <p>Staff will be reeducated regarding proper hand washing and the need to maintain a cleaning schedule for the kitchen floor. The kitchen floor will be cleaned daily by the kitchen staff, deep cleaned quarterly by the housekeeping staff, and professionally as needed.</p>	3/7/13	

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F 371	<p>Continued From page 19</p> <p>C did not wash hands first before handling cleaned dishes to remove them from the rack and stack them.</p> <p>Twice, after handling dirty dishes, Staff C washed hands briefly with soap and water (for less than 8 seconds) and turned off the faucet to the sink with bare hands. Following brief hand washing, Staff C removed dishes from dishwasher racks that were just cleaned in the dishwasher.</p> <p>On 1/30/13 at 4:30 p.m., Staff D provided a copy of facility policy and procedures for hand washing that identified staff should conduct hand washing for a minimum of 20 seconds and use a paper towel to turn off faucets.</p> <p>KITCHEN FLOOR</p> <p>During initial tour in the kitchen on 1/22/13 at 11:32 a.m. and on 1/30/13 at 1:00 p.m., the kitchen floor material consisted of small dark colored tiles separated approximately 1/4 of an inch with light colored grout. The light colored grout contained a significant amount of darkened colored stains throughout the entire floor that included food preparation and dish washing areas.</p> <p>On 1/30/13 at 1:00 p.m., Dietary Staff D reported the stains in the grout did not clean although staff cleaned the floor daily. Staff D reported housekeeping services conducted a more thorough cleaning of the grout two to three times a year. After deeper cleaning, Staff D reported the grout still had stains and reported the grout had never been sealed.</p> <p>On 1/30/13 at 1:24 p.m. Staff E reported working</p>	F 371	<p>IV. How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <p>Dietary manager will bring any non-compliant observations regarding proper hand washing technique and the floor cleaning schedule to management's attention. Any findings will be corrected immediately and this plan of correction will be monitored for a minimum of the next three scheduled QA meetings to ensure that ongoing compliance is sustained.</p> <p>V. Dates when corrective action will be completed: Mar 7, 2013</p> <p>VI. The title of the person/s responsible to ensure correction:</p> <p>Dietary Manager, Maintenance Director, Housekeeping Supervisor, Administrator or Designee</p>	3/7/13	

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F 371	Continued From page 20 at the facility since March 2013 and did not know what the cleaning schedule for the kitchen floor was. Staff D reported during the second week of December (2012), staff scrubbed the grout with a deck brush and a toothbrush using an acid base cleaner and reported the grout contained a lot of stains. Staff E reported the grout did not get sealed after deeper cleaning. When asked how the grout looked today compared to immediately following the deeper cleaning in December, Staff E reported it looked "more or less the same." On 1/30/13 at 1:40 p.m. the surveyor requested previous deep cleaning schedules for the kitchen floor from Staff A. The facility did not provide any further information.	F 371		3/7/13	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	F- 431 (E) I. How the nursing home will correct the deficiency as it relates to the resident: The Center performed an audit on all medications located in the medication refrigerator to ensure resident safety with no non-compliant findings. Center assessed Resident # 53 for pain to ensure resident safety and comfort.		

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F 431	<p>Continued From page 21</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure medications were stored under proper temperatures in accordance with manufacturer specifications and failed to consistently follow facility policy and procedure to ensure controlled medications were accurately recorded and reconciled on 1 of 3 medication carts. This had the potential for altered effectiveness of refrigerated medications and/or inaccurate count of controlled medications.</p> <p>Findings include:</p> <p>REFRIGERATED MEDICATIONS On 1/24/13 at 10:20 a.m. a thermometer located inside the medication refrigerator registered 34</p>	F 431	<p>II. How the nursing home will act to protect residents in similar situations:</p> <p>The Center performed an audit on all medications located in the medication refrigerator to ensure resident safety with no non-compliant findings. Residents with pain flow sheets will be reviewed for compliance to facility policy and any items noted will be followed up on.</p> <p>III. Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p> <p>Center will reeducate staff on proper temperature check procedure, documentation and notification for readings that are out of range. Refrigerator temp policy will be posted on the medication refrigerator. Center will reeducate LNs on proper documentation and medication count handoff.</p> <p>IV. How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p>	3/7/13
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F 431	<p>Continued From page 22</p> <p>degrees Fahrenheit (F). The refrigerator was filled with medications that included:</p> <ul style="list-style-type: none"> - A medication used to treat viral infections and certain cancers -15 vials and three different types of insulin and multiple insulin pens - A box that contained 14 single dose injections used to treat a neurological disease whose label identified to store the medication between 36 to 46 degrees F. - A vial of medication used to test for tuberculosis inside the refrigerator also identified to store medication between 36 to 46 degrees F. <p>A plastic sleeve on the outside door of the refrigerator contained a temperature log that recorded refrigerator temperatures taken by licensed staff. A note on the sleeve identified temperatures should remain below 41 degrees.</p> <p>On 1/24/13 at 10:20 a.m., when asked what temperature ranges medications should be stored at, Staff J confirmed temperatures should remain below 41 degrees F as identified on the plastic sleeve.</p> <p>On 1/24/13 at 10:36 a.m. Staff G reported the night nurse checked temperatures in the refrigerator and made adjustments when necessary. Staff G also reported if there was a problem with the temperature maintenance should be notified.</p> <p>Review of temperature logs for December 2012 and January 2013 identified for 25 continuous days between 12/22/12 and 1/20/13, temperatures recorded ranged between 28</p>	F 431	<p>Nurse management, or designee, will periodically review the medication temperature log for compliance to policy. As well as perform periodic audits of proper documentation and validate that a count of controlled medications has taken place before taking possession of keys to the medication cart. This plan of correction will be monitored for a minimum of the next three scheduled QA meetings to ensure that ongoing compliance is sustained.</p> <p>V. Dates when corrective action will be completed: Mar 7, 2013</p> <p>VI. The title of the person/s responsible to ensure correction:</p> <p>Director of Nursing, Resident Care Managers, Maintenance, Administrator or Designee</p>	3/7/13
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505325	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/31/2013
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NAME OF PROVIDER OR SUPPLIER ISLAND HEALTH & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 835 MADISON AVENUE NORTH BAINBRIDGE ISLAND, WA 98110
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F 431	<p>Continued From page 23</p> <p>degrees F to 34 degrees F. Only twice the document identified staff attempted to readjust temperatures on 1/1/13 and 1/12/13 but the temperatures were not corrected. Temperatures for 17 continuous days between 1/3/13 through 1/20/13 continued to register between 29 degrees F and 34 degrees F.</p> <p>On 1/24/13 at 10:48 a.m. Staff A reported the only policy the facility had regarding storage of refrigerated medications identified temperatures should not rise above 41 degrees. Later in the day, Staff A provided a copy of a long term care pharmacy policy that identified medications should be stored between 36 degrees F to 46 degrees F.</p> <p>Licensed staff could not identify and the facility did not have a policy and procedure on site that identified safe storage temperature ranges of medications. When refrigerated medications were stored for 25 days at potentially freezing temperatures staff did not take immediate corrective steps to correct to safe temperature storage ranges to maintain medication efficacy.</p> <p>MEDICATION RECONCILIATION On 1/25/13 at 8:21 a.m. Resident #53's pain flow sheet documented staff administered a controlled medication at 6:00 a.m. that morning. The resident's medication record did not indicate licensed staff administered the medication.</p> <p>At this time, when asked if the resident received the medication, Licensed Staff F reviewed the narcotic count book and reported it did not contain documentation staff on the previous shift</p>	F 431		3/7/13
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F 431	<p>Continued From page 24</p> <p>signed the book to indicate they administered the medication. When asked how staff reconciled the count of narcotics between shifts, Staff F reported controlled medications had not been counted with the nurse on the previous shift and hoped the license nurse was still in the building.</p> <p>On 1/25/13 at 10:30 a.m., following further inquiry, the Director of Nursing (DNS) reported licensed staff on the previous shift left the building. The DNS also reported he/she would have assisted with the medication count but staff did not report the count did not get done. The DNS reported licensed staff should have documented in three different locations when narcotic medication was given.</p> <p>On 1/25/13 at 11:00 a.m., Licensed Staff F reported she did not know the nurse from the previous shift left the building. Staff F also confirmed she already began medication administration and knew facility policy identified licensed staff should count controlled medications before taking possession of keys to the medication cart.</p> <p>On 1/25/13 at 11:01 a.m., the DNS provided a copy of the facility procedure for Controlled Drugs which indicated to "count All controlled drugs at each change of shift by one off-going and one oncoming licensed nurse or trained medication assistant."</p>	F 431		3/7/13
F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each</p>	F 514		

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F 514	<p>Continued From page 25</p> <p>resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to maintain complete records of medication administration for 1 of 10 Sampled Residents (#38) reviewed for medication use of the 34 sampled residents who were included in the stage 2 review. This prevented staff from having consistent, timely and adequate information necessary to determine if the resident experienced adverse reactions to medication use and delay notification of physician.</p> <p>Findings include:</p> <p>Refer to F 329 for failure to adequately monitor use of blood pressure medication [redacted] for Resident #38 and F 157 for failure to timely notify the physician when staff held the resident's medication and had low blood pressure.</p> <p>Physician orders dated 10/25/12 directed staff to administer [redacted] once a day, a medication to treat high blood pressure.</p>	F 514	<p>F- 514 (D)</p> <p>I. How the nursing home will correct the deficiency as it relates to the resident:</p> <p>Resident # 38 was reviewed for notification of MD, proper usage of the Interact Tool for BP and pulse parameters, and to ensure that if medication is held, LN will initial and circle in MAR and add note for clarification.</p> <p>II. How the nursing home will act to protect residents in similar situations:</p> <p>Center residents in similar situations will be reviewed for proper usage of the Interact Tool for BP and pulse parameters, proper notification to physician when needed, and to ensure that if medication is held that LN will initial and circle in MAR and add note for clarification to back of MAR or other appropriate documentation.</p> <p>III. Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur:</p>	3/7/13
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F 514	<p>Continued From page 26</p> <p>Medication records for November 2012, December 2012 and between 1/1/13 and 1/25/13 contained circled licensed staff initials to indicate they did not administer [REDACTED] on 37 separate days. Four times, on 11/3/12, 11/12/12, 11/20/12 and 11/27/12 staff left the medication record blank. Between 1/22/13 through 1/24/13 staff marked the resident out of the facility. A nursing note dated 1/24/13 indicated the resident left the facility that day for an outside appointment and later returned.</p> <p>No evidence was found in the record why staff did not administer the medication during all days circled, what happened on days the medication record was left blank or why the resident did not receive the medication on days staff noted the resident out of facility or before leaving for an appointment on 1/24/13.</p> <p>On 1/30/13 at approximately 10:00 a.m., Staff K reported licensed staff should document the reason on the reverse side of the medication record when medications were held and not given.</p> <p>The facility provided no further evidence to indicate staff completed Resident #38's medication record documentation.</p> <p>The record did not contain evidence staff completed documentation to indicate why [REDACTED] had been held 37 times during November 2012, December 2012 and January 2013.</p>	F 514	<p>LN's will be reeducated on proper usage of the Interact Tool for BP and pulse parameters, proper notification to physician when needed, and to ensure that if medication is held that LN will initial and circle in MAR and add note for clarification.</p> <p>IV. How the nursing home plans to monitor its performance to make sure that solutions are sustained:</p> <p>Nurse management, or designee, will perform periodic audits for no less than one month following the LN reeducation to ensure ongoing compliance, and may be extended if deemed necessary. This plan of correction will be monitored for a minimum of the next three scheduled QA meetings to ensure that ongoing compliance is sustained.</p> <p>V. Dates when corrective action will be completed: Mar 7, 2013</p> <p>VI. The title of the person/s responsible to ensure correction:</p> <p>Director of Nursing, Resident Care Manager, LNs, Administrator or Designee</p>	3/7/13
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