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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	505403		C 07/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY AT SILVER LAKE	2235 LAKE HEIGHTS DRIVE EVERETT, WA 98208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Survey conducted at Bethany at Silver Lake on 07/01/2013-07/08/2013. A sample of 4 residents (one closed record) was selected from a census of 107. The following complaint was investigated as part of this survey: #2831735 The survey was conducted by: Cathy Prentice, MN, R.N. The survey team is from: Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, District 2, Unit C Creekside Two 20425 72nd Avenue South, Suite 400 Kent, WA 98032-2388 Telephone: (253) 234 6003 Fax: (253) 395 5071 Debra Vaca 7-22-2013 Residential Care Services Date	F 000	This Plan of Correction is submitted as required under Federal and State statutes and regulations. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the state surveyors' findings or conclusions are accurate, that the findings constitute deficiencies, or that the scope and severity determinations regarding the alleged deficiencies were correctly applied. RECEIVED JUL 31 2013 DSHS/ACES/RCS	

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

Mel Kunath — Administrator — 07/30/13

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 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 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). 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. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to immediately inform and/or consult with	F 157	Resident #1 has discharged to a facility with lower level of care following successful completion of antibiotic treatment and rehabilitation therapy. Medication administration policy and procedure has been reviewed and revised regarding steps to follow when medications are not delivered timely by the pharmacy. Licensed nursing staff and nurse managers will be in-serviced on procedures to follow in situations of medication not being available. The in-service will include the policy/procedure and expectations for informing and consulting physicians when medications are held, documenting specific reasons for withholding medication and documenting notifications to the physicians. Two of the licensed nurses involved with these issues no longer are employed at this facility. Nurse Managers and the Director of Nursing will monitor. The Administrator will ensure compliance.	8/22/13

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F 157	Continued From page 2 the resident's physician, for 1 of 4 residents sampled (Resident #1), when the facility did not administer an ordered medication for Diabetes on 6 occasions, did not administer an ordered oral nutritional vitamin supplement for 16 of 24 days, and did not administer an ordered injectable vitamin for the resident's vitamin deficiency on 2 out of 4 occasions. This failure to notify and consult with the resident's physician when ordered medications were not given to Resident #1, placed the resident at risk for decreased health maintenance and nutritional status during the resident's recovery from surgery while residing at the facility. Findings include: According to record review of the facility medical records on 07/02/13, Resident #1 was admitted to the facility on [redacted]12 for rehabilitation after surgery for a hip fracture. The medical record also revealed Resident #1 had Diabetes. According to the facility "Dietary Notes" dated 10/17/12, the day after admission to the facility, the dietician noted Resident #1 "per available information, is at nutritional risk". VITAMIN SUPPLEMENTS FOR DEFICIENCY AND NUTRITION Record review revealed facility "Admitting Physician Orders" dated [redacted]12 for Resident #1, included a medication order for: Prenatal Vitamins every day for nutritional supplement. According to the facility Medication Administration Record dated [redacted]12 through 11/09/12,	F 157		

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F 157	Continued From page 3 Resident #1 did not receive the ordered daily Prenatal Vitamins from 10/17/12 through 11/1/12, a total of 16 days without the ordered vitamin for nutritional supplementation. Record review only revealed 7 entries during that time period in the facility "Interdisciplinary Progress Notes" dated 10/17/12, 10/18/12, 10/23/12, 10/24/12, 10/28/12, 10/29/12, 11/1/12 that noted the medication was not given due to "waiting for delivery". The facility medical record for Resident #1 had no documentation of any notification to the resident's physician regarding the omission of the ordered medication for 16 days. Record review revealed facility "Admitting Physician Orders" dated [redacted]12 for Resident #1, included an ordered medication: Vitamin B12 1000mcg injection 1 times per week for 4 weeks for a B12 deficiency. According to the facility Medication Administration Record dated [redacted]12 through 11/09/12, Resident #1 did not receive the ordered injectable Vitamin B12 medication for vitamin deficiency on 11/2/12 and, 11/9/12 schedules for 9:00 a.m.. According to the facility "Interdisciplinary Progress Notes" dated 11/02/12 and 11/09/12 at 10:34 a.m., the Vitamin B12 injections were held both days due to "waiting for delivery". Resident #1 was then discharged at 1:05 p.m. on 11/09/12 without receiving 2 of the 4 ordered Vitamin B12 doses. There was no documentation of any notification to the physician that Resident #1 did not receive the ordered medication on 2 of 4 occasions.	F 157		

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F 157	Continued From page 4 DIABETES MEDICATION Record review revealed facility "Admitting Physician Orders" dated [redacted]12 for Resident #1, included an ordered medication: Metformin 1000mg twice per day for Diabetes. According to the facility Medication Administration Record dated [redacted]12 through 11/09/12, Resident #1 did not receive the ordered Metformin medication for Diabetes on the evenings of 11/1/12, 11/2/12, 11/4/12, 11/5/12, 11/7/12, and 11/8/12. According to the facility "Interdisciplinary Notes": 11/01/12 evening "held Metformin had minimum amount of food taken" (no notification of MD noted); 11/02/12 evening "held Metformin decreased amount of food intake" (no notification of MD noted); 11/04/12 evening "held Metformin" (no reason or MD notification noted); 11/05/12 evening "held Metformin refused" (no MD notification noted); 11/07/12 "Metformin held resident just had 2 bites of toast which she vomited after" (no MD notification noted); 11/08/12 evening, "held Metformin had 25 percent of food taken at dinner and post prandial blood sugar is 143" (no notification of MD noted). Record review revealed no notification or consultation with the MD regarding the medications being held, and no physician order to hold the medication for any reason. In an interview on 07/02/12 at 3:55 p.m., Staff A, an administrative employee, confirmed she would expect the licensed nurses to notify the physician when ordered medications were held.	F 157		

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F 157	Continued From page 5 The facility's failure to notify and consult with the physician when 3 ordered medications were not administered on multiple occasions, placed Resident #1 at risk for decreased health maintenance.	F 157		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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 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. 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 329	Resident #1 has discharged to a facility with lower level of care following successful completion of antibiotic treatment and rehabilitation therapy. This facility will continue to strive to assure residents' medication regimes are free from unnecessary medications. The house bowel policy has been reviewed and appropriate revision made to include medications and treatments that might be ordered along with the house bowel regime. Physician orders will be followed with house constipation regime being used as written if further intervention is needed. In-services will be held for nurse managers and floor licensed nurses on facility constipation policy and	8/22/13

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F 329	Continued From page 6 failed to ensure 1 of 4 residents sampled (Resident #1), had a drug regimen free from unnecessary drugs, when the facility administered a bowel medication without adequate indications for its use, without adequate or documented clinical rationale for the benefit of the use of multiple medications/duplicate therapy on an older person at risk for adverse reactions. This failure may have contributed to Resident #1's loss of body fluids due to diarrhea, nausea and vomiting. Findings include: Record review on 07/02/12, revealed Resident #1 had Alzheimer's Dementia. Further review revealed two family members were the legal representatives for Resident #1, and they signed all consents and made all healthcare decisions for Resident #1. According to a document in the medical record from a Neurological Center dated 4/10/2008, Resident #1 was "not capable of making complex decisions such as medical decisions" and chose family members to do so. The "Admission Assessment" also noted Resident #1 had poor judgement, impulsiveness, and was forgetful and confused. In addition, the "Admission Assessment" noted Resident #1 did not manage her medications at her prior residence. According to the facility "Admission Assessment" dated [redacted]12, Resident #1 last had a bowel movement on 10/12/12 at the hospital. The facility "Admission Assessment" noted Resident #1 had a "bowel history: frequency of bowel movement every two days", the section for "how did the	F 329	procedure. In-services will include instruction to complete comprehensive assessment when looking into adding or changing bowel medications or treatments for the resident. In-service will also include need for proper documentation even if conversations with physician happens 1 to 1 on the nursing unit. Resident and family/surrogate will be included in decision making and order changes. In-service on processing orders and notification of resident and family/surrogate will be presented to nurse managers and licensed nursing staff. This training will include emphasis on the need to contact family/surrogate for all new or changed physician orders. Physicians also readily communicate directly with residents and family/surrogate when the physicians are in the facility. The licensed nurse who did not communicate the Miralax order to the family/surrogate is no longer employed at this facility. Nurse Managers and Director of Nursing will monitor. The Administrator will ensure compliance. RECEIVED JUL 31 2013 DSHS/ALTSA	

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F 329	Continued From page 7 patient manage constipation at home, did the patient take bowel meds, prune juice, hot beverages" was left blank. Thus, the bowel history assessment for Resident #1 was incomplete in the facility medical record. In interviews on 07/05/13 and 07/08/13, the legal representatives/family members for Resident #1 stated the facility did not discuss bowel history with them for Resident #1, and did not ask what was usual therapy at home for Resident #1's bowel health maintenance. Record review revealed facility "Admitting Physician Orders" dated [redacted]12 for Resident #1 included routine bowel medications: Doss 100mg twice per day for constipation; Senna 8.6 mg twice per day for constipation; Milk of Magnesia 300 milliliters everyday as needed for constipation; Dulcolax suppository 10mg everyday as needed for constipation; House Bowel Program. In an interview on 07/02/13, Staff B, a supervisory licensed nurse, stated the facility's "Procedure for Constipation" revised 04/26/12, was the "House Bowel Program" on the Physician's Orders and the Bowel Program used for the residents in the facility. On 07/02/12 at 3:55 p.m., Staff A, an administrative employee confirmed the same. Review of the facility House Bowel Program revealed the following parameters used by the facility for residents: "Constipation is defined as insufficient frequency of defecation (i.e. more than 3 days) ....." and "the nurse manager is responsible for assessment and implementation	F 329		

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F 329	Continued From page 8 of the [house bowel] procedure.."; "assess the resident for history of bowel habits, use of laxatives ..."; "no more than 2 bowel meds should be ordered at one time unless assessment of resident reflects otherwise: licensed nurse to check and insure that resident has been offered/given non-medication measures before instituting medication"; "no bowel movement (BM) for 6 shifts, give prune juice 120cc-180cc; small BM is considered a 0.; Milk of Magnesia 30 milliliters for no bowel movement 9 shifts. Consult with MD/ARNP if constipation is not adequately managed ..." According to the facility Admission Assessment dated [redacted]12, and the facility Medication and Treatment Administration Record dated for October and November 2012, Resident #1 had not had a Bowel Movement (BM) since 10/12/12 in the hospital and was given a suppository on 10/17/12 which was day 4 since last BM. Review of the medical record for Resident #1 revealed no other non-medicine interventions were administered to Resident #1 such as prune juice or hot water, as described in the House Bowel Program that was ordered by the physician on [redacted]12. Further review of the facility Medication and Treament Administration Record for Resident #1 revealed, Resident #1 then had a medium bowel movement on 10/17/12, and on 10/18/12 a medium and a large BM . On 10/19/12, a small bowel movement. On 10/20/12, no bowel movement, and then medium bowel movements on 10/20, 10/21, and 10/22/12.	F 329		

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F 329	Continued From page 9 Record review revealed there was no evidence that assessment or non-medicine interventions such as prune juice or other non-medicine interventions were attempted (per ordered Hose Bowel Program) for Resident #1 at the facility for the missed BM on 10/20/12. There was no indication that Resident #1 was constipated after 10/17/12 per the record and per the constipation definition in the ordered House Bowel Program. Also, as per the facility Admission Assessment, Resident #1 ' s history was to have a bowel movement every 2 days. Record review revealed a Physician Order dated 10/22/12, for a laxative, Miralax 17 grams packet daily for constipation. ARNP note dated 10/22/12 stated "bowel regimen per facility protocol, constipation, on Doss and Senna, add Miralax daily" . According to the facility House Bowel Program: residents were to be on "no more than 2 bowel medications at one time unless assessment of resident reflects otherwise". The facility medical record had no documentation of any assessment or clinical rationale as to why constipation was being treated with an additional oral medication when the resident was having bowel movements, and the record had no documentation of any collaboration by the facility with the ARNP in regards to assessment and plan for Resident #1's bowel regimen. According to the medical record of Physicians Orders and Medication Record, Resident #1 was now on 3 oral bowel medications, and was not constipated per both the House Program definition and/or the resident's history of having	F 329		

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F 329	Continued From page 10 bowel movements every 2 days. In an interview on 07/02/13 at 3:00 p.m., Staff B, a supervisory nurse for care of Resident #1, stated no knowledge of why an order for Miralax laxative was obtained for Resident #1 on 10/22/12 and had no information about an assessment or non-medicine interventions for resident #1 in regards to the alleged constipation by the ARNP. Further record review revealed no documentation of notification or consent obtained from the resident's representatives when adding a new medication (Miralax laxative). Review of the facility Physician Order for 10/22/12, revealed a checkmark on the physician order for the laxative indicating that the resident had been notified of the new treatment change (Resident #1 not able to make decisions regarding medications), and the family had not been notified. Since Resident #1 was unable to make medication decisions, the legal representative/family member, who managed all of Resident #1's medications prior to being admitted to the facility, should have been notified and collaborated with regarding adding a third laxative to Resident #1's regimen. In interviews on 07/05/13 and 07/08/13, the legal representatives/family members for Resident #1 stated they had no knowledge of the additional medication on 10/22/12, and if they had been consulted and notified, they would have refused the new medication/laxative because Resident #1 had a history of difficulty tolerating laxatives and normally did not use them. According to the Lippincott Nursing Drug	F 329		

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F 329	Continued From page 11 Handbook 2012, Miralax is a laxative indicated for short term treatment of occasional constipation. Adverse reactions include abdominal cramping, diarrhea, excessive stools and nausea. It may be more likely to cause diarrhea in older patients. These patients should be urged to report diarrhea. There was no evidence the facility considered side effects of this medication in elders, no assessment or clinical rationale for adding a third bowel medication for Resident #1, and no collaboration between nursing, family and physician for the bowel regimen decisions made on 10/22/12. According to the facility Medication Record, Resident #1 received Miralax from 10/23 through 10/28 and 11/5, 11/6. The facility Medication Record also revealed, Resident #1 began having diarrhea on 10/28/12 through 11/2/12. Although the resident was on an antibiotic from 10/19/12 through 10/28/12, then a new antibiotic on 10/29/12 through morning of 11/1/12, as well as narcotics for pain, there was no indication of assessment by the facility that the laxative Miralax could have contributed to the adverse reactions of diarrhea and nausea that Resident #1 was experiencing. Further review of the facility Medication Record dated November 2012 for Resident #1 revealed, Resident #1 had diarrhea from 10/28/12 through 11/02/12. Further review revealed Resident #1 had vomiting 7 times from 11/2/12 through 11/6/12, and 9 shifts without a bowel movement during that time.	F 329		

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F 329	Continued From page 12 There was no documentation of any non-medicine interventions implemented, nor any assessment documented for the 9 shifts without a BM, yet the laxative Miralax was administered again on 11/05/12 and 11/06/12, although Resident #1 was experiencing nausea and vomiting during that time. According to the Medication Record, Milk of Magnesia was never given to Resident #1 as ordered, at the facility, and a suppository was only given once on the day after admission to the facility. Three oral bowel medications were the only interventions administered to Resident #1 for bowel health maintenance. The facility failed to follow the ordered House Bowel Program for Resident #1 in regards to non-medical interventions, as well as the number of medications used for bowel care. The facility administered an unnecessary medication (laxative) without clinical rationale or indication when the resident was not constipated, and failed to review the medication regimen for Resident #1 to thoroughly assess the need for 3 laxatives after the resident experienced adverse reactions with diarrhea and nausea and vomiting.	F 329		

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