

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

PRINTED: 05/13/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505306	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/07/2013
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF PORT TOWNSEND			STREET ADDRESS, CITY, STATE, ZIP CODE 751 KEARNEY STREET PORT TOWNSEND, WA 98368	
(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	Continued From page 1	F 000		
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>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).</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:</p>	F 157	<p>F157</p> <p>1. Residents #1 was assessed by primary physician and changes made to plan of care as indicated.</p> <p>2. Residents with abnormal vital signs/ abnormal labs have a potential to be affected by this practice. Residents were audited for abnormal vital signs /labs and physician / family updated of residents' status as indicated.</p> <p>3. Licensed staff were educated about physician notification. Audits will be conducted weekly x4 weeks then monthly x3 months for reporting changes of conditions. System changes include standardizing shift to shift handoff process.</p>	

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F 157

Continued From page 2

Based on interview and record review, the facility failed to immediately inform the physician about a fall and abnormal blood pressure for 1 of 3 sampled residents (Resident #1) reviewed for notification. This failure to immediately consult with the residents' physician had delayed the resident's treatment and denied the physician the opportunity to be timely informed of the resident's status.

Findings include:

The Washington State Nurse Practice Act, WAC 246-840-700 (a) states, "The registered nurse shall communicate significant changes in the client's status to appropriate members of the health care team. This communication shall take place in a time period consistent with the client's need for care."

<RESIDENT FALL>

Resident #1 was admitted to the facility on [REDACTED]/2012 with diagnoses that included [REDACTED] and [REDACTED]. The resident also had a history of abnormal blood pressure and a history of 5 falls.

According to facility documentation the resident fell on 1/29/13, the resident was found sitting on the floor and complained of left foot pain. The facility documentation stated the resident sustained a bruise from the fall, and the physician would be notified via fax "in the daytime." There was no further facility documentation to support the physician was notified.

F 157

4. Audit data will be reviewed by the Director of Nursing and brought to Monthly Performance Improvement meeting to identify the need for system revision or further educational needs for 3 months.

5. The Director of Nursing will ensure ongoing compliance.

6. Date of compliance is 6.3.13

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F 157	<p>Continued From page 3</p> <p>A second fall occurred on 3/3/13. The resident was found lying on the floor next to her bed. The evening shift Licensed Nurse (LN) documented neurological checks were initiated and requested the nursing assistant (NA) to obtain a urine sample from Resident #1 to check for a possible [REDACTED]</p> <p>According to facility documentation, the resident's urine dip was checked for infection, and that the physician was notified, but did not document how the physician was notified.</p> <p>There was no facility documentation that physician follow up contact/communication was done, to provide further direction for Resident #1's identified abnormal urine dip (abnormal protein level identified), neurological findings (sluggish pupillary response) and elevated blood pressures (B/Ps, greater than 140/90, defined below).</p> <p>A third fall occurred on 03/13/2013 at 11:55 P.M. in a hallway. The resident sustained a head injury. The injury was described as a lump measuring 1.5 cm (approximately 1/2 inch). The resident also sustained a bruise to her right shin.</p> <p>An entry in the computerized Progress Notes for 03/14/2013 timed at 9:43 A.M. indicated the resident's physician was notified at this time (almost 10 hours after the fall).</p> <p>A fourth fall (defined as going from one level to a lower level) occurred on 4/7/13, the LN documented the NA found the resident had</p>	F 157		

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F 157	<p>Continued From page 4</p> <p>"partially fall out of bed." The Neurological assessment flow sheet identified the resident had abnormal elevated B/Ps.</p> <p>According to the facility documentation, on 4/24/13, the resident was lethargic and with "increasing weakness over the last few days." A physician ordered lab work to be done, and the facility would report the results to the primary care physician (PCP), and the PCP recommendations to be reported to the family to discuss how they wished to pursue treatment options.</p> <p>There was no documentation to support evidence the facility had notified Resident #1's family to discuss wishes on how to pursue treatment options, or that the physician was contacted after the abnormal elevated blood pressures for the physician to direct further care/treatment if needed.</p> <p>The Director of Nursing Services was asked for information about the facility process when a fall occurs. Information titled "FALL REDUCTION PROGRAM" and the facility policy for "Changes in Resident's Condition or Status" was presented. Although this information directed the facility staff to call the physician when a resident is involved in any accident or incident that results in injury, and document this in the nurses' notes and 24-hour report, no information was provided to support the physician was called immediately after the fall.</p> <p><RESIDENT BLOOD PRESSURE></p> <p>The facility policy for "Changes in Resident's</p>	F 157		
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F 157	<p>Continued From page 5</p> <p>Condition or Status" indicated Nursing services were responsible for notifying the resident's attending physician as soon as practical but in no case to exceed twenty-four hours when there was a significant change in the resident's status.</p> <p>The facility did not notify Resident #1's physician after the 3/3/2013 fall, where Resident #1 had identified abnormally high blood pressures for more than twenty four hours. Although the facility staff followed the facility policy, and took the blood pressures after the fall, documented the findings, but failed to communicate the information to the physician immediately as required.</p> <p>Initial blood pressures after the resident's fall was documented as 163/81 (140/90 is considered high blood pressure). The following are the resident's subsequent blood pressure readings on 3/3/2013-3/5/2013.</p> <p><3/3/13></p> <p>3:45 P.M. 148/83 4:00 P.M. 158/78 4:15 P.M. 120/76 4:45P.M. 184/92 5:15 P.M. 169/70 6:15 P.M. 165/80 7:15 P.M. not obtained 8:15 P.M. not obtained</p> <p><3/4/13></p> <p>12:15 A.M. 166/75 4:15 A.M. 140/88 8:15 A.M. illegible 12:15 P.M. not obtained</p>	F 157		
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F 157	<p>Continued From page 6</p> <p>" Eve " 171/73 " Noc " 153/67</p> <p>The facility did not notify Resident #1's physician after the third fall occurring on 3/13/2013, where Resident #1 hit her head and had identified abnormally high blood pressures for more than nine hours. Although the facility staff followed the facility policy, and took the blood pressures after the fall, documented the findings, but failed to communicate the information to the physician immediately as required.</p> <p>The initial blood pressure after the resident's third fall was documented as 208/108 (140/90 is considered high blood pressure). The following are the resident's subsequent blood pressure readings on 3/14/2013.</p> <p>12:15 A.M. 190/90 12:30 A.M. 190/81 12:45 A.M. 179/77 01:00 A.M. 183/79 01:30 A.M. 185/79 02:00 A.M. 181/75 02:30 A.M. 168/72 03:00 A.M. 157/74 04:00 A.M. 172/85 08:00 A.M. 190/92 10:00 A.M. 158/83 11:00 A.M. 129/76</p> <p>The facility did not notify Resident #1's physician after the fourth fall from her bed occurring on 4/7/2013, where Resident #1 had identified abnormally high blood pressures for more than twenty four hours. Although the facility staff followed the facility policy, and took the blood</p>	F 157			

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F 157	<p>Continued From page 7</p> <p>pressures after the fall, documented the findings, but failed to communicate the information to the physician immediately as required.</p> <p>The initial blood pressure after the resident's fourth fall was documented as 190/85. The following are the resident's subsequent blood pressure readings on 4/7/2013-4/9/2013.</p> <p><4/7/13></p> <p>10:30 P.M. 191/85 10:45 P.M. 177/90 11:00 P.M. 173/70 11:30 P.M. 185/79</p> <p><4/8/13></p> <p>12:00 A.M. 204/89 1:00 A.M. 190/92 2:00 A.M. 190/80 4:00 A.M. 180/90 6:00 A.M. not obtained 10:00 A.M. 169/82 2:00 P.M. 180/78 6:00 P.M. 148/76 10:00 P.M. 164/80</p> <p><4/9/13></p> <p>2:00 A.M. 180/80</p> <p>The facility did not notify Resident #1's physician after the fifth fall on 4/26/2013, where Resident #1 had identified abnormally high blood pressures for more than twenty four hours. Although the facility staff followed the facility policy, took the blood pressures after the fall, documented the</p>	F 157		

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F 157	<p>Continued From page 8 findings, but failed to communicate the information to the physician immediately as required.</p> <p>Initial blood pressures after the resident's fall was documented as 181/81 (140/90 is considered high blood pressure). The following are the resident's subsequent blood pressure readings on 4/26/2013-4/27/2013.</p> <p><4/26/13></p> <p>8:15 P.M. 174/87 8:30 P.M. 176/89 8:45 P.M. 177/89 9:00 P.M. 175/82</p> <p>Next documented as "assessed by 911 med team "</p> <p>9:30 P.M. 165/79 10:00 P.M. not obtained 11:00 P.M. not obtained</p> <p><4/27/13></p> <p>12:00 A.M 190/84 2:00 A.M. 150/72 6:00 A.M. not obtained 12:00 P.M. 154/75 2:00 P.M. 142/76 6:00 P.M. 167/61 10:00 P.M. not obtained</p> <p>An undated fax provided from the facility, with no verification of transmission, to the PCP, documented the resident had fallen out of her wheelchair, sustained an abrasion, did not complain of pain except for the bump on forehead, and that Resident #1's neurological checks and vital signs were within normal limits,</p>	F 157		

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F 157	Continued From page 9 and were "stable," the LN documentation was inconsistent with identified elevated blood pressures on the neurological assessment flow sheet. Facility provided documentation the day after the investigation, dated 5/8/13, from the PCP that documented he was aware that the resident has episodic high blood pressure, that is also managed by the resident's [REDACTED] specialist. The statement did not indicate the resident's [REDACTED] specialist or primary physician was notified of the elevated blood pressures identified in Resident #1's neurological assessment flow sheets after falls/accidents.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law	F 225	F225 1. Residents #1 was assessed with no negative findings. 2. Residents with substantial injuries have a potential to be affected by this practice and will have appropriate departments notified as indicated. 3. Staff was educated on reporting requirements of CFR 483.13 C(2)(4). Audits will be completed of incident/ accident investigations at daily stand-up meeting M-F to ensure reporting requirements met.	

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F 225	<p>Continued From page 10 through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, interviews and record reviews, the facility failed to report a substantial injury to the head in accordance with CFR 483.13 (c)(2)(4) for 1 of 3 sampled residents (Resident #1) reviewed.</p> <p>Findings include:</p> <p><RESIDENT #1></p> <p>Resident #1 was admitted to the facility on [REDACTED]/12 with multiple diagnoses including severe [REDACTED], [REDACTED], [REDACTED], [REDACTED] and [REDACTED]. The</p>	F 225	<p>4. Audit data will be brought to the monthly Performance Improvement meeting by the DON for review and to identify the need for system revision or further educational needs for 3 months.</p> <p>5. The Executive Director will ensure ongoing compliance.</p> <p>Date of Completion June 3, 2013</p>	
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F 225 Continued From page 11
resident required extensive assistance of one staff person for transfers, toileting and bed mobility. The resident had a history of frequent falls.

According to facility documentation the resident fell on 1/29/13 which resulted in left foot pain and a burise.

A second fall ocured on 3/3/13, the resident was found lying on the floor next to her bed.

A third fall occurred on 03/13/2013 at 11:55 P.M. in a hallway. The resident sustained a head injury. The resident was heard calling out and found lying on the floor in the doorway of a room. The resident stated she hit her head on the floor and was found with a lump to the back of her head and bruising to her right lower extremity. The injury was described as a lump measuring 1.5 cm (approximately 1/2 inch). The resident also sustained a bruise to her right shin.

The facility accident/injury log documented the resident had sustained a substantial injury to her head, but did not report to the state Hotline as required.

Interview with the administration team indicated they were attempting to identify the root cause of the resident's frequent falls. No explanation was given why the head injury was not reported to the hot line as required.

F 225

F 323 483.25(h) FREE OF ACCIDENT
SS=D HAZARDS/SUPERVISION/DEVICES

F 323

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F 323	<p>Continued From page 12</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review the facility failed to provide sufficient supervision to ensure interventions to prevent falls for 2 of 3 residents (#1 & 2) were implemented. These failures to provide care and services according to Resident #1 & #2's plan of care resulted in injury when the residents fell.</p> <p>Findings include:</p> <p>All interviews took place on 05/07/13 unless otherwise stated:</p> <p><RESIDENT #1></p> <p>Resident #1 was admitted to the facility on [REDACTED] 12 with multiple diagnoses including severe [REDACTED] [REDACTED] a fall history and altered mental status. The resident required extensive assistance of one staff person for transfers, toileting and bed mobility.</p>	F 323	<p>F323</p> <p>1. Residents #1 was Assessed, fall care plan updated with revised interventions and it is being followed. PAS monitoring will be done every shift by a licensed nurse.</p> <p>Resident #2 was assessed. Resident has a mat on the floor</p> <p>2. Residents have a potential to be affected by this practice. All residents were reviewed for fall risk and had care plans updated as needed.</p> <p>3. Licensed staff were educated on accident prevention and supervision. System change includes reviewing new admitted residents for fall risk in stand up and implementing interventions for prevention. Audits will be conducted weekly x 4 weeks then monthly x 2 months to ensure care plans are followed.</p>	

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF PORT TOWNSEND	STREET ADDRESS, CITY, STATE, ZIP CODE 751 KEARNEY STREET PORT TOWNSEND, WA 98368
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F 323	<p>Continued From page 13</p> <p>According to the resident's plan of care Resident #1 was a fall risk, and the goal was for the resident's "risk of injury due to falls will be minimized." Approaches and interventions were documented to include a low bed, the call light within reach, reminding the resident the purpose of the call light including return demonstration of its use.</p> <p>On 5/7/13, Resident #1 was observed lying in her bed, with a bruise under her right eye. Resident #1 stated she had several falls recently. Resident #1 stated she will at times put her call light on, but not wait "maybe as long as I should" for the staff to assist her, or attempt to turn down the volume of her roommate's television.</p> <p>Review of the resident's fall history indicated on 1/29/13 the resident was found sitting on the floor and complained of left foot pain and sustained a bruise. The resident demonstrated for the staff how she unclipped her Pressure Alarm Sensor (PAS) clip to deactivate her alarm.</p> <p>On 3/3/13, the resident was found lying on the floor next to her bed. The evening shift Licensed Nurse (LN) documented in the Progress note, "found resident laying on floor next to her bed," and that the resident "denies hitting head, no bruises or lacerations."</p>	F 323	<p>4. Audit data will be brought to the monthly Performance Improvement meeting for review and to identify the need for system revisions or further educational needs for 3 months.</p> <p>5. The Director of Nursing will ensure compliance.</p> <p>6 Date of compliance is June 3, 2013.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 14 According to facility documentation, on 3/13/13 at 11:55 p.m., the resident was heard calling out and found lying on the floor in the doorway of a room. The resident stated she hit her head on the floor and was found with a lump to the back of her head and bruising to her right lower extremity. The facility investigation of the incident documented the resident was known to be impulsive, had a history of falls and "frequent auditory hallucinations." The resident had a PAS in place which did not sound, the resident had a prior history of dismantling the alarm, and did demonstrate she could turn off the alarm. To prevent future falls, the plan of care directed for staff to assess the resident to determine her ability to use the call light, have a PAS on her bed, and for NA supervision every 15 minutes because the resident may not remember to use the call light. The Plan of Care directed staff to place the PAS alarm under the bed to "decrease the likelihood of the resident playing with it." It further documented the resident "does not always remember to use call light." According to the resident's plan of care revisions dated 3/13/13, staff were directed to "check the alarm to ensure it's functioning" and to "remind resident to request assistance prior to	F 323			

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F 323	<p>Continued From page 15 ambulation, and remind the resident she has anemia and may cause her to be dizzy."</p> <p>On 4/7/13, the LN documented the alarm and call light were on and the NA found the resident had "partially fall [sic] out of bed."</p> <p>According to a facility report, dated 4/26/13, a Nuring Assistant was "passing by, saw the resident lying (on her left side) across the door jamb of her room into hall." The LN documented the resident had sustained an abrasion to her right forehead and was provided first aid and neurological checks were initiated. It documented the resident was evaluated by emergent staff at an urgent care clinic for care. The fall plan of care with a dated 4/26/13 entry, directed staff to "decrease risk (of) injury by moving items away from bed." According to facility documentation, on 4/27/13, the resident complained of a headache, and was observed with an abrasion to the left side of her forehead.</p> <p>The DNS stated, "We've literally done everything we could think of, there isn't anything else to do really," in regards to the resident's fall plan of care intervention of educating/reminding the resident with her known cognitive impairments and continuation of alarms that the resident demonstrated how to dismantle.</p>	F 323		

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F 323	<p>Continued From page 16</p> <p>There was no documentation found to indicate the facility monitored the implementation of safety devices. The DNS stated the staff make rounds during their shift to ensure the devices were in place. The administrative team revealed there was no formalized process or system in place to ensure care planned interventions for safety were consistently implemented.</p> <p><RESIDENT #2></p> <p>Resident #2 was admitted to the facility on [REDACTED] 2011 with [REDACTED] including [REDACTED] and [REDACTED]. The resident was dependent on staff for assistance with all activities of daily living including safety and mobility.</p> <p>On 05/07/2013 the resident was unable to provide additional information regarding her fall due to her impaired thought process. The resident was noted to have faded bruises below both eyes and at the upper cheek area. The right side more dominant than the left. The resident stated she was "Well" and did not have pain. When asked about her elbow, she stated she was doing "Well."</p> <p>On 04/22/2013 the resident rolled out of bed onto the floor and sustained injuries to her face and left elbow. The resident was transported to an emergency room for evaluation and treatment</p>	F 323		
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F 323	<p>Continued From page 17 and returned.</p> <p>According to the resident's plan of care, the resident was to have a soft mat placed on the floor next to the bed. This was to prevent severe injury in the event of a fall in the area of her bed.</p> <p>Facility documentation indicated the mat was not placed on the floor next to the bed at the time of the resident's fall on 04/22/2013.</p> <p>There was no documentation found to indicate the facility monitored the implementation of safety devices. The DNS stated the staff made rounds during their shift to ensure the devices were in place. No formalized process or system was followed to ensure care planned interventions for safety were consistently implemented.</p>	F 323		