

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

PRINTED: 02/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

1232

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505332	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  02/13/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF SAN JUAN ISLANDS	STREET ADDRESS, CITY, STATE, ZIP CODE 660 SPRING STREET FRIDAY HARBOR, WA 98250
--	---

(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	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced, standard Quality Indicator Survey conducted at Life Care Center of San Juan Islands on 2/7/13, 2/8/13, 2/11/13, 2/12/13 and 2/13/13. A sample of 34 residents was selected from a census of 49. The sample included 32 current residents, and the records of 2 discharged residents.</p> <p>The survey was conducted by:</p> <p>Mary Vassey, R.N., B.S.N., M.B.A. Ric Woodrum, R.N., B.S.N. Leslie Martin, B.S.H.S.</p> <p>The survey team is from:</p> <p>Department of Social &amp; Health Services Aging &amp; Disability Services Administration Residential Care Services, Region 3, Unit A 3906 172nd St N.E., Suite 100 Arlington, WA 98223-4740</p> <p>Telephone: (360) 651-6850 Fax: (360) 651-6940</p> <p><i>[Signature]</i> Sign _____ Date 2/21/13</p>	F 000	<p>F000</p> <p>This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers. 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 the plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute deficiency or that the scope or severity regarding any of the deficiencies cited are accurately applied.</p> <p style="text-align: right;">RECEIVED MAR - 4 2013 ADSARCS Smokey Point</p>	
-------	---	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE Executive Director	(X6) DATE 3/1/13
---	-----------------------------	---------------------

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505332</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/13/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF SAN JUAN ISLANDS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>660 SPRING STREET FRIDAY HARBOR, WA 98250</b>
---	---

(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 253  
SS=D

483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES

The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, and record review, the facility failed to maintain a sanitary, clean, appealing environment. By not maintaining resident care equipment, sanitary bathrooms, or repairing broken flooring, residents had the potential to experience a diminished quality of life.

Findings include but are not limited to:

**CARE EQUIPMENT**  
During all days of the survey, Resident 2 was observed in a wheelchair with a back cushion. The right side of the cushion had a rip along the seams approximately 3 inches long. The contents inside the cushion were exposed and the surface area was unable to be cleaned. When asked on 2/13/13 at 8:20 a.m. if the ripped cushion was of concern, the resident replied she would like to have it repaired.

Resident 10 was observed on 2/7/13 at 8:55 a.m., to be eating breakfast while sitting in a wheelchair. The wheelchair had dried debris along the seat, the wheels, and framework. A review of the facility procedure for cleaning wheelchairs revealed this particular wheelchair was to have been cleaned by the night shift staff the evening before.

F 253

F 253

**Correction as it relates to the resident:**  
Resident 2's wheelchair cushion has been replaced. Resident 10's wheelchair has been cleaned; the flooring in resident 10's room has been patched and is cleanable. Facility has applied through construction review to introduce a new flooring surface in room 117. The toilet tank cover in bathroom between rooms 115-117 has been replaced. In room 123 the telecommunications cable and wall molding have been replaced and the wall has been cleaned. The ceiling vent has been cleaned and cover replaced.

**Action taken to protect residents in similar situations:**  
Facility rounds were completed by Maintenance director and Executive Director to include cleanliness of wheelchairs and walls, non-cleanable surfaces to flooring and wheelchairs, missing toilet tank covers, severed telecommunication cables, placement of ceiling vent covers and molding. Identified issues were corrected.

**Measures taken or systems altered to ensure the problem does not recur**  
Nursing assistants have been re-trained by the Staff Development Coordinator on following the wheelchair cleaning schedule

Staff has been re-educated by the Staff Development Coordinator on identifying

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

PRINTED: 02/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505332</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/13/2013</b>	
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF SAN JUAN ISLANDS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>660 SPRING STREET FRIDAY HARBOR, WA 98250</b>		
(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 253	<p>Continued From page 2</p> <p>All subsequent days of the survey revealed the resident sitting in the soiled wheelchair. When asked on 2/13/13 at 9:25 a.m., the Director of Nursing Services confirmed the wheelchair cleaning schedule was current and the resident's wheelchair should have been cleaned on 2/6/13.</p> <p><b>FLOORS, EXPOSED WIRES, AND TOILET TANKS</b></p> <p>All days of the survey revealed broken floor tiles in room 117 between the resident's bed and window. Tiles were broken and some were missing. The subflooring was visible. The floor of the entire room was cracked with areas unable to be cleaned. When asked on 2/13/13 at 7:33 a.m., Resident 10 stated the floor should be in better shape.</p> <p>During observations on 2/7/13, 2/8/13, and 2/13/13, the toilet tank cover in the bathroom between rooms 117-115 was propped against the wall and floor. Personal resident hygiene supplies were precariously balanced over the water in the tank. When the Administrator was informed on 2/13/13 during a mid-day meeting, he stated staff should have reported the absent tank lid when they first discovered it.</p> <p>During all days of the survey, a severed telecommunication cable was observed in room 123 by a night stand of one resident. In the bathroom, the wall molding was missing by the toilet and brown, organic material was staining the wall near the missing wall molding. A ceiling vent fan cover was missing, leaving an exposed, dusty, vertical shaft into the ventilation system.</p> <p>When interviewed on 2/13/13 at 9:25 a.m., the</p>	F 253	<p>and reporting maintenance and/or housekeeping concerns via use of the request form.</p> <p>The Resident Care Manager or designee will inspect wheel chair cleanliness according to wheel chair cleaning schedule daily for 4 weeks then weekly for two months to monitor compliance with cleaning schedule. Issues with noncompliance will be addressed immediately and reported to Director of Nursing.</p> <p>Managers will audit the facility weekly for three months to verify that maintenance and/or housekeeping issues are being identified and that requests forms are being generated. The maintenance request form has been updated to better track completion of facility repairs. Findings of noncompliance will be forwarded to the Executive Director for immediate follow up.</p> <p><b>Plans to monitor performance to ensure solution is sustained</b></p> <p>Results of the audits and maintenance request forms will be forwarded to the facility Performance Improvement Committee for three months</p> <p><b>Date Certain</b> March 13, 2013</p> <p><b>Title of Person Responsible for Compliance</b> Executive Director</p>	

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

PRINTED: 02/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505332</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/13/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF SAN JUAN ISLANDS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>660 SPRING STREET FRIDAY HARBOR, WA 98250</b>
---	---

(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 253 Continued From page 3  
Administrator stated there was a process of daily rounds conducted by all managers and the policy was to have concerns written on a form for the maintenance department to address.

F 253

F 309 SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  
  
Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

F 309  
F309  
**Correction as it relates to the resident:**  
Resident 72 pain assessment was updated. MD informed and new orders were received.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview and record review, the facility failed to provide consistent and effective pain management for 1 of 2 sampled Resident's 72 reviewed for pain. The failure to consistently monitor and document Resident 72's usage placed this resident at risk for diminished quality of life and unmet care needs.

**Action taken to protect residents in similar situations:**  
Orders for residents on transdermal pain patches have been reviewed to indicate clearly, time of application and removal, specific sites and frequency. Pain assessments were updated for the residents on transdermal pain patches.

Findings include:

**Measures taken or systems altered to ensure the problem does not recur**  
The Staff Development Coordinator will re-inservice the Nurses on pain management, inclusive of requirements and/or recommendations with transdermal patch orders. Telephone orders for transdermal patches will be reviewed during morning meeting in order to ensure order includes all necessary components.

Resident 72 re-admitted to the facility on 11/17/12 with multiple diagnoses to include spinal stenosis (narrowing of the spinal cord) and hypertension. The Minimum Data Set (MDS) assessment dated 12/19/12 indicated the resident was receiving scheduled pain medication.

**Plans to monitor performance to ensure solution is sustained**  
MARS will be reviewed by RCM or designee daily for seven days, then weekly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505332</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/13/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF SAN JUAN ISLANDS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>660 SPRING STREET FRIDAY HARBOR, WA 98250</b>	
(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 309	Continued From page 4  Review of the physician ordered medications found the resident to have 2 transdermal pain patches (A transdermal patch is applied to the skin for slow controlled release of medication through the skin). One patch was to be placed on the resident's left shoulder and the other patch placed on the right hip. The nursing Medication Record indicated both patches should be applied at 8am in the morning and removed in the evening 12 hours later.  On 2/13/13 at 9:17 a.m., Resident 72 was observed in her wheelchair slowly moving herself away from the main nurses station. She could be heard making moaning, groaning noises. When asked if she needed assistance, she stated her shoulder and hip were hurting "bad" and the pain she was feeling was "getting up there". While saying this, she was observed to be rocking back and forth. When asked if she could rate her pain on a scale of 1 to 10, with 1 as the least amount of pain and 10 the worst she responded with "I do not understand". She attempted to reveal the pain patch on her left shoulder by trying to pull her clothing away from her left shoulder. She stopped and stated, "The pain is getting worse and I want to go back to my room and lie down".  On 2/13/13 at 10:00 a.m., a review of the nursing Medication Record for 2/1/13-2/10/13 was completed. Multiple days indicated the resident's transdermal patch for the right hip was applied at different times rather than the ordered time of 8a.m. On 2/1/13 the patch was placed at 7a.m, next day at 10a.m. and then 2/3/13 at 9a.m. For 2 days nursing did not document what time the patch was applied. On 2/8/13 nursing	F 309	for four weeks, then monthly for two months for compliance with transdermal patch orders. Findings of noncompliance will be forwarded to the Director of Nursing for immediate follow up. The DON will report the results the audits to the facility Performance Improvement Committee for the next three months.  <b>Date Certain March 13, 2013</b>  <b>Title of Person Responsible for Compliance Director of Nursing</b>	

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

PRINTED: 02/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505332</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/13/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF SAN JUAN ISLANDS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>660 SPRING STREET FRIDAY HARBOR, WA 98250</b>
---	---

(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 309	<p>Continued From page 5</p> <p>documented a null sign possibly indicating the patch had not been placed at all. There was no documentation found to indicate what had happened on that date. On 2/5, 2/6, 2/7, and 2/8 nursing did not document what time the patch was removed. There was no way to determine how long the patch had been on as prescribed by the physician.</p> <p>Review of the documentation for the placement of the transdermal patch on the left shoulder also found the same issues. The patch was applied at various times with missing documentation of when nursing took the patch off. Nursing did not document removal of the patch for 8 of the 10 days reviewed.</p> <p>On 2/13/13 at approximately 11:00a.m., the Resident Care Manager stated she was aware that Resident 72 was in a lot of pain "so receiving the patch timely and removal of the previous one should also be timely". With consistent placement and timely removal of the patches, Resident 72 would receive the slow controlled release of the pain medication needed for both her hip and shoulder.</p>	F 309		
-------	--	-------	--	--

