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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 C 02/11/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF THE SAN JUAN ISLANDS		STREET ADDRESS, CITY, STATE, ZIP CODE 660 SPRING STREET FRIDAY HARBOR, WA 98250	

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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Life Care Center of San Juan on 01/24/2014, 02/10/2014 and 02/11/2014. A sample of 8 residents was selected from a census of 43. The sample included 6 current residents and the records of 2 former/discharged residents.</p> <p>The following complaints were investigated as part of this survey:</p> <p>2947235 2947803</p> <p>The survey was conducted by: [REDACTED], MS, RN-BC</p> <p>The survey team is from: Department of Social & Health Services Aging and Long-Term Support Administration Residential Care Services, Region 2, Unit B 3906 H1. Street NE, Suite 100 Arlington, WA 98223-4740</p> <p>Telephone: (360) 651-6850 Fax: (360) 651-6940</p> <p>[REDACTED SIGNATURE] 2/19/14 Residential Care Services Date</p>	F 000	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.</p> <p>F 225</p> <p>Correction as it relates to the resident: LN involved in medication error for resident 4 had a medication pass observation completed. LN compliant with the five rights of medication administration.</p> <p>Resident 4 was interviewed and denies the urinal was intentionally placed out of reach and reports it was a one time occurrence and has been resolved.</p> <p>Action taken to protect residents in similar situations: Incidents involving medication errors and falls will be investigated to rule out abuse/neglect and include interventions to prevent reoccurrence.</p> <p>Measures taken or systems altered to ensure the problem does not recur: Licensed nurses (LNs) were re-educated by the Staff Development Coordinator (SDC) or designee on medication administration including a review of the five rights.</p> <p>The Executive Director (ED) and Director of Nursing (DON) were re-educated on the</p>	
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LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [REDACTED SIGNATURE]	TITLE Executive Director	(X6) DATE 2/27/14
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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 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>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.</p> <p>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 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>	F 225	<p>completion of a thorough investigation including plans to prevent reoccurrence by the Divisional Director of Clinical Services.</p> <p>Plans to monitor performance to ensure solution is sustained: Investigations involving medication errors and falls will be reviewed by Regional Director of Clinical Services to ensure abuse/neglect ruled out and interventions implemented to prevent reoccurrence. Any concerns identified will have the required follow up completed. The Results of the audits will be presented to the Performance Improvement Committee (PI) monthly for 3 months to identify any further educational needs or system revision.</p> <p>Date Certain: 3/13/14</p> <p>Title of Person Responsible for Compliance: Director of Nursing</p>	

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F 225	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to complete two of six investigations for allegations of abuse/neglect. Affected were two of five sampled residents (4 and 6). Failure to thoroughly investigate allegations of possible neglect for Residents 4 and 6 placed them and other residents at risk of possible abuse/neglect.</p> <p>Findings include:</p> <p>1. Resident 4 admitted in [REDACTED] 2010 with multiple diagnoses including chronic [REDACTED] disease, chronic [REDACTED] disease, and chronic [REDACTED] syndrome. Her most recent Minimum Data Set (MDS) assessment, dated 12/19/13, identified her recall and memory abilities as severely impaired (3/15 points on the memory assessment tool). Throughout her stay in the building, her MDS assessments identify a history of chronic pain managed by scheduled pain relief medication.</p> <p>On 01/20/14, her physician ordered the scheduled pain relief medication lowered to 5 milligram (mg) [REDACTED]/325mg [REDACTED] from 5mg/500mg dose. On 01/21/14, Staff B administered twice the ordered dose, 10mg [REDACTED]/650 mg [REDACTED]. The error was discovered 8 hours later when Staff C administered the next scheduled dose of pain relief medication.</p> <p>On 02/11/14 at 1:05 p.m., Staff D had no information regarding any education in-services for staff regarding medication administration and medication errors.</p>	F 225		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 225	<p>Continued From page 3</p> <p>Review of the facility investigation revealed this was the second narcotic pain relief medication error by Staff B within 6 weeks. There was no evidence of documentation of observation of Staff B administering medications, no indication of monitoring of Staff B's technique(s) over time when passing medications, and no indication of a plan to prevent future reoccurrence of medication error(s) by any staff for any resident. Additionally, there was no evidence of a conclusion to rule out neglect by Staff B.</p> <p>2. Resident 6 admitted in [REDACTED] 2014 for [REDACTED] and [REDACTED] after he suffered a [REDACTED] with [REDACTED] at home. His admission MDS assessment, dated 01/13/14, identified his memory and recall abilities as intact (15/15 points on the memory assessment tool). He used a walker for mobility assistance.</p> <p>On 02/11/13 at 10:35 a.m., Resident 6 reported he fall a couple of nights ago. He reported it would not have happened if the urinal was within reach. Because it was not within reach, he got up out of bed and fell reaching for the urinal. He hit his [REDACTED] elbow when he fell.</p> <p>Review of the facility investigation revealed Resident 6 sustained a skin tear to his [REDACTED] elbow that was cleansed and dressed when he fell on 02/08/14. A written statement from Resident 6 noted he got out of bed to use the urinal. He noted "the whole thing would not have happened if the urinal was within reach." There was no indication whether staff members complied with facility policy when the urinal was not within reach of Resident 6. There was no evidence of documentation who placed the urinal beyond reach of Resident 6 during the night and how this</p>	F 225		

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F 225	Continued From page 4 might have/have not contributed to the incident. There was no indication whether any other residents were assessed for availability of frequently used items to readily meet their needs.	F 225		
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to manage comfort for Resident 2. Failure to respond in a timely manner to repeated requests for removal of sutures resulted in extended delay of their removal and placed the resident at risk of additional discomfort when they were removed.</p> <p>Findings include:</p> <p>Resident 2 admitted in [REDACTED] 2013 after extensive [REDACTED] surgery for chronic [REDACTED]. She experienced severe pain post operatively requiring additional time in the hospital for pain management prior to her transfer to the facility. Per her nursing admission assessment note, dated 12/06/13, Resident 2's pain was "chronic and debilitating." Resident 2 was alert and able to make her needs known to staff.</p>	F 309	<p>F 309</p> <p>Correction as it relates to the resident: Resident 2 no longer resides in the facility.</p> <p>Action taken to protect residents in similar situations: An audit was completed for residents with sutures to ensure orders were in place for suture removal.</p> <p>Measures taken or systems altered to ensure the problem does not recur: The LNs were reeducated by the SDC on obtaining physician orders for suture removal when sutures are identified and the implementation of those orders. Education was also completed on customer service including timely response to resident and family concerns and the facility communication process.</p> <p>Plans to monitor performance to ensure solution is sustained: The DON (or designee) will audit orders for implementation daily for 2 weeks, then three times/week for 2 weeks then weekly for 2 months. Issues of non-compliance will be reported the physician and include the appropriate follow up as indicated. The Results of the audits will be presented to the Performance Improvement Committee (PI)</p>	

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F 309	<p>Continued From page 5</p> <p>On 02/07/14 at 12:03 p.m., Resident 2 reported she asked about having the sutures removed the day she arrived. The next day, the physician replied the sutures could be removed "anytime." She thought the sutures would be removed after he left that day. No one removed them. Resident 2 asked about suture removal a couple more times as did a family member. None of the staff replied or explained why the sutures could not be removed. Finally, a couple of days before discharge, a nurse attempted to remove the sutures. She could not remove all of them. On 02/13/14, the day of discharge, the nurse practitioner (ARNP) visited and removed the remaining sutures. Resident 2 stated the ARNP had to "dig out" the sutures. The experience was "very uncomfortable". Resident 2 reported she "hugged her pillow" during the removal of the sutures as it was "painful." She rated the suture removal as 6-7/10 with 10 being the worst pain ever experienced. Resident 2 reported she was "not happy" about the delay and pain of the suture removal. She did not think it was right to ask so many times and have to wait.</p> <p>On 02/11/14 at 11:50 a.m., the ARNP reported the remaining sutures were "deeper set" and there was some areas where the skin "scabbed ...was grown over". She described Resident 2 as "hypersensitive" to pain and she seemed to have some "discomfort" during the removal of the sutures.</p> <p>Review of the clinical record of Resident 2 revealed an order from the physician, dated 12/07/13, to contact the hospital regarding removal of the sutures in Resident 2's back. The order was acknowledged by Staff A on 12/09/13. Review of the Medication Administration Record,</p>	F 309	<p>monthly for 3 months to identify any further educational needs or system revision.</p> <p>Date Certain:</p> <p>3/13/14</p> <p>Title of Person Responsible for Compliance: Director of Nursing</p>	
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F 309	<p>Continued From page 6</p> <p>dated 12/13/13, revealed a task to remove the sutures. There was no evidence of documentation the task was performed. Additional review of the nursing notes, dated 12/13/13, revealed documentation "sutures removed, but not all have released as skin had grown over". Review of the care plan for Resident 2 revealed no identification of suture monitoring or removal as an issue for the resident.</p> <p>On 02/11/14 at 12:40 p.m., Staff A reported she read and viewed the order from the physician, dated 12/07/13, on 12/09/13. She phoned the hospital that day. Hospital staff told her the sutures could be removed. The sutures should have been removed that day. Staff A had no additional information regarding the delay of implementation of the order to remove the sutures.</p>	F 309		
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