

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

PRINTED: 10/24/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505381</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>10/18/2012</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SAN JUAN REHAB AND CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>911 21ST STREET ANACORTES, WA 98221</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Abbreviated Survey conducted at San Juan Rehabilitation and Care Center on 10/18/12. A sample of 4 resident's were selected from a census of 44. The sample residents were current resident's.</p> <p>The following compliant was investigated as part of the survey:</p> <p># 2684610</p> <p>The survey was conducted by:</p> <p>Louvenia Ringuette, RN, BSN</p> <p>The survey team is from:</p> <p>Department of Social &amp; Health Services Aging &amp; Disability Services Administration Residential Care Services, District 2, Unit B 3906 172nd St NE, Ste 100 Arlington, WA 98223</p> <p>Telephone: (360) 651-6850 Fax: (360) 651-6940</p> <p><i>[Signature]</i> Residential Care Services      Date</p>	F 000	<p>RECEIVED NOV. 02 2012 ADSA/RCS Smokey Point</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cheryl Lee</i>	TITLE <i>Operations Manager</i>	(X6) DATE <i>10-31-12</i>
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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 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>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.</p> <p>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.</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:</p>	F 431	<p>San Juan Rehab will store all drugs &amp; biologicals in locked compartments and permit only authorized personell access to keys.</p> <p>All nurses will be re-educated to keep all drugs &amp; biologicals locked up if not under their direct supervision</p> <p>The Director of Nursing Services (or designee) and the Operations Manager will monitor medication carts on rounds @ least bi-weekly to assure compliance.</p> <p>The DNS will assure compliance</p>	11/7/12

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F 431	<p>Continued From page 2</p> <p>Based on observation, interview and record review the facility failed to store medications in a secure manner on two of the facility medication carts. This failure had potential for unauthorized staff and/or residents to access medications.</p> <p>Findings include:</p> <p>On 10/18/12 at 8:28 a.m., two medication carts were observed in the 200 hallway. At 8:30 a.m., Staff A, a Licensed Nurse, was observed having just finishing preparing medications for Resident 2. Staff A left the medication cart with the medications he had just prepared, entered Resident 2's room and shut the door. Staff A had left the resident's insulin vial, being stored in a plastic bag, unattended on top of the medication cart. No other staff or residents were observed in the hallway.</p> <p>Upon returning to the medication cart Staff A picked up the plastic bag with the resident's insulin, looked at it, charted the medication he had given, then locked the plastic bag with the insulin into the medication cart. When Staff A was asked about leaving the medication on top of the cart unattended he stated, "I usually put it on the cart so I know which insulin I have given. It should have been locked up for resident safety."</p> <p>The second medication cart located about two feet away from the first cart was observed also at 8:28 a.m. to have a plastic bag with a small IV bag containing the injectable antibiotic meropenem, a syringe containing normal saline to flush the IV site and other supplies left unattended. When Staff A, was asked about this cart he stated that Staff B was assigned to that</p>	F 431		

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F 431	<p>Continued From page 3 medication cart and he went on went passing his assigned medications.</p> <p>At 8:35 a.m., Staff B, a Licensed Nurse, returned to the medication cart she was assigned to. She prepared medications for a resident in room 206. After preparing the medications she left the cart, and entered room 206, leaving the IV medication unattended on the top of her medication cart. Staff B then left room 206 and entered room 202, she then assisted other residents in their rooms. There was no staff or residents in the hallway at this time.</p> <p>At 8:40 a.m. Staff C, a nursing assistant, approached the medication cart assigned to Staff B. Staff C placed a piece of paper on the top of the medication cart and began using the cart as a writing surface. Staff A &amp; B were observed walking past the cart with the medications on top several times while Staff C used the cart as a writing surface.</p> <p>At 8:45 a.m. Staff B returned to the cart and prepared medications for room 210, again Staff B left the IV medication on the cart as she provided the resident in room 210 with their medications.</p> <p>At 8:55 a.m. Staff B returned to her cart and prepared Resident 1's medications including the IV antibiotic bag. When asked what the facility policy was regarding the storage of medications. Staff B stated that all medications were to be locked in the medication cart or in the medication room. When asked about the IV bag that had been laying unattended on the top of the medication cart, Staff B stated, "It should be kept locked up. I usually pull it (the IV)out of the</p>	F 431		
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F 431	Continued From page 4 refrigerator and put it on the cart because the resident gets it early in the shift and this is more convenient. The medications carts we have do not have a space on the cart to store things like this. "  On 10/18/12 at 10:20 a.m., in an interview with the Director of Nursing Services (DNS), she stated it was not the facility policy to store medications on the top of the medication carts. She said the facility did not have a written policy regarding storage of medications. The DNS continued "It is common sense, and both of the nurses know very well that medications are to be stored in the medication room or in the medication cart."	F 431			