

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  <b>C</b> <b>01/28/2013</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 INITIAL COMMENTS

F 000

This report is the result of an unannounced Abbreviated Survey conducted at San Juan Rehabilitation and Care Center on 01/16/2013, 01/23/2013 and 01/28/2013. A sample of 4 residents was selected from a census of 50. The sample included 2 current residents and the records of 2 former/discharged residents.

The following complaint was investigated as part of this survey:

2734082

The survey was conducted by:

 R.N., M.S.

The survey team was from:  
Department of Social and Health Services  
Aging and Disability Services Administration  
Residential Care Services, Region 2, Unit B  
3906 172nd Street NE, Suite 100  
Arlington, WA 98223  
Telephone: (360) 651-6850  
FAX: (360) 651-6940

RECEIVED  
MAR 18 2013  
ADS/RCS  
Smokey Point

*Pinda Lanco* 3-13-13 for IDR Program Manager  
Residential Care Services Date

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Cheryl Lee*  
TITLE  
*Operations Manager*  
(X6) DATE  
*3-15-13*

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 notify appropriate parties for change in

F 157

LN's will promptly notify resident's physician, legal representative or interested family member of: accident with injury that will potentially require physician intervention; significant change in physical, mental, psychological status; need to significantly alter treatment; or decision to change room/roommate; decision to transfer or discharge resident from the facility; or change in resident rights.

Resident 2 no longer resides at this facility.

2/15/13

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condition of Resident 2. Failure to notify Resident 2's physician and family of repeated firing of the automated implanted cardiac defibrillator ( ) prevented timely informed decision making and resulted in harm of unnecessary delay of needed medical treatment.

Findings include:

Resident 2 was admitted in the afternoon of 12 for rehabilitation after surgical repair of a . She had a long history of extensive , including , such as . In 2011 she had an placed. The role of the defibrillator was to initiate an electrical shock whenever it sensed arrhythmia such as rapid atrial fibrillation, and attempt to convert the heart to a more appropriate rhythm and rate.

On 01/18/13 at 10:21 a.m., Resident 2 reported sometime on the afternoon of 12/24/12 she told a nursing assistant her ( ) "went off". No one contacted her physician or family at that time. She felt the "fire" multiple more times during the next day. No one contacted her physician or family on 12/25/12. Resident 2 stated she asked facility staff to call "911". Staff replied they would speak with the Licensed Nurse (LN).

On 01/23/13 at 5:33 p.m., Resident 2's physician reported LN 2 phoned her at 12:18 a.m. on 12/25/12. LN 2 told the physician Resident 2 reported her fired. The physician stated she did not learn the had fired multiple more times after that incident until 12/26/12 when the emergency department (ED) physician

F 157 All licensed nurses have been re-educated regarding mandatory requirement to notify appropriate party (s) per F157 and to document said notifications. 2/28/13

The Director of Nursing Services (DNS) will review the 24 hour Documentation Record, and a minimum of twice ~~monthly~~ weekly will monitor nursing documentation to verify resident, resident legal representative, interested family member, and physician were promptly notified per mandatory requirements. 2/11/13

The DNS will assure compliance.

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contacted her and explained Resident 2 was currently in the hospital ED. Her [REDACTED] had fired multiple times in the past couple of days at the facility. She required hospital admission for additional evaluation and treatment. Resident 2's physician added if the facility had notified her of the additional [REDACTED] firings, she would have instructed them to send Resident 2 to the ED for evaluation.

On 01/28/2013 at 09:01 a.m., LN 2 reported she received verbal report at night change of shift on 12/24/12. LN 1 told her Resident 2 reported the [REDACTED] fired during the evening shift. LN 1 did not notify Resident 2's physician. When Resident 2 reported another possible firing of the [REDACTED] to LN 2 just before midnight, LN 2 telephoned the physician. The physician instructed LN 2 to attempt to calm Resident 2. If Resident 2 did not calm down, or if she reported repeat firing of the [REDACTED], she should go to the hospital for evaluation. Resident 2 reported additional firings of the [REDACTED] on 12/25/12 and 12/26/12 to LN 2. LN 2 did not notify the physician or family of these incidents.

Review of the clinical record of Resident 2 revealed on 12/24/12 at 7 p.m., LN 1 documented Resident 2 "thought her [REDACTED] went off." LN 1 noted she passed this event on at shift change to LN 2. LN 1 did not notify Resident 2's physician or family.

On 12/25 12 at 12:20 a.m., LN 2 recorded a telephone order from Resident 2's physician. The order read "attempt to calm resident first. OK to send to ED if resident continues to report [REDACTED] going off."

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On 12/26/12 at 2 a.m., LN 2 documented Resident 2 had [REDACTED] and reported her [REDACTED] "just went off". LN 2 wrote she checked Resident 2's vital signs (blood pressure, pulse, respirations) "each time resident states the [REDACTED] has gone off." LN 2 did not send Resident 2 to the ED for the repeated firings of the [REDACTED]. There was no evidence of documentation Resident 2's family was notified of the repeated firings of the [REDACTED].

F 157

F 309 SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

On 12/25/12 at 12:58 p.m., LN 3 documented Resident 2 complained of [REDACTED] and [REDACTED]. There was no evidence of documentation Resident 2's physician or family was notified of these events.

F 309 Each resident will receive, <sup>2/15/13</sup> and the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental, & psychosocial well-being in accordance with the comprehensive assessment and plan of care.

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.

This REQUIREMENT is not met as evidenced by:  
Based on interview and record review, the facility failed to assess and treat Resident 2 for change in physical and mental condition after possible discharge of the [REDACTED]. This failure resulted in harm of delay in treatment and mental distress for multiple firings of the [REDACTED] that

Resident #2 no longer resides at the facility.

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

PRINTED: 03/13/2013  
FORM APPROVED  
OMB NO. 0938-0391

**IDR AMENDED**

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Resident 2's vital signs (pulse, respirations, blood pressure). LN 1 did not notify Resident 2's physician or family of the event. There was no evidence of documentation of assessment for pain, dizziness or other changes Resident 2 may have experienced with the event. She told LN 2 of the event at change of shift (evening to night).

In an interview on 01/28/13 at 09:01 a.m., LN 2 reported early in the night shift, Resident 2 told her she thought the [redacted] fired again. LN 2 telephoned the physician of Resident 2 who instructed LN 2 to try and calm Resident 2. If Resident 2 did not calm or if she again reported the [redacted] fired, staff should send her to the hospital for evaluation. LN 2 wrote the physician order in Resident 2's clinical record. LN 2 recalled on 12/25/12 about 9 p.m., Resident 2 again told her she thought the [redacted] fired. Resident 2 described the feeling "as if someone threw a football and it hit you in the chest". LN 2 did not know what that meant.

LN 2 stated she had no training at the facility for care and assessment of [redacted]. She added her only experience with an [redacted] firing was a personal family member. That person would yell and complain of pain when the [redacted] fired. LN 2 was uncertain whether the [redacted] fired for Resident 2 as her description was different from the personal family member and her vital signs (blood pressure and heart rate) were stable. At 11 p.m. on 12/25/12, and again at 5:30 a.m. on 12/26/12, Resident 2 reported firing of the [redacted] to LN 2. LN 2 stated Resident 2's vital signs were stable after each report. Although LN 2 offered to send Resident 2 to the hospital after the firing at 05:30 a.m., Resident 2 declined. LN 2 did not

F 309 When a resident is admitted with an uncommon/unfamiliar diagnosis: LN's will be educated (prior to care) regarding the diagnosis, appropriate care, assessment & documentation. 2/18/13

All LN's have been educated regarding their responsibility to immediately notify the DNS or alternate if a resident who will potentially be under her/his care has a diagnosis/condition, or treatment that said LN is unfamiliar with. 2/15/13

The DNS or alternate will provide adequate training/education to assure the LN is qualified to provide 2/15/13

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telephone the physician of the multiple firings that occurred in less than 9 hours. LN 2 reported the multiple firings at change of shift (night to day) the morning of 12/26/12. She told the day LN it might be appropriate to send Resident 2 to the hospital if she reported the [redacted] firing again.

On 02/01/2013 at 12:05 p.m., the Director of Nursing Services (DNS) reported no training for assessment and management of an [redacted] had been conducted for staff prior to the admission of Resident 2. The DNS added Resident 2 was the first resident admitted to the facility with a known [redacted].

On 12/26/12 about 10 a.m., Resident 2 was sent to the hospital. Her initial heart rate was high; [redacted]. She was admitted to the hospital for multiple firings of the [redacted] and worsening condition of her [redacted]. The hospital cardiologist interrogated the [redacted] and confirmed it fired 12 times in the recent past.

Review of the clinical record of Resident 2 revealed LN 2 documented Resident 2 was "restless" and slept "intermittently" the night of 12/24/12. Resident 2 again complained her [redacted] fired during this shift. LN 2 wrote Resident 2 appeared "anxious related to possible" firing of the [redacted]. There was no evidence of documentation of assessment for pain, vertigo or other related symptoms with the firing of the [redacted].

On 12/25/12 at 12:58 p.m., LN 3 noted Resident 2 was evaluated for [redacted] and complaints of [redacted] without any specific details of those evaluations. There was no mention of

F 309 appropriate nursing care, assessment, & documentation to address said diagnosis.

The DNS, or alternate 2/15/13 will make rounds / speak with nurses a minimum of weekly to assure LN's feel competent/ educated to provide care for assigned residents.

All LN's involved in reviewing / accepting new admissions have been re-educated to thoroughly review records and assure nursing staff is currently knowledgeable, or is promptly educated, as needed to provide care / assessment / documentation on new residents. 2/15/13

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**IDR AMENDED**

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assessment for possible firing of the [REDACTED]. There was no evidence of documentation of notification of Resident 2's physician.

On 12/25/12 at 7 p.m., LN 2 wrote Resident 2 awoke with a "startle reaction". She "yelled out". Resident 2 was uncertain whether she was dreaming or whether the [REDACTED] had gone off. There was no evidence of assessment of pain, vertigo or other related symptoms for a possible [REDACTED] firing event. Additionally, documentation noted multiple firings of the [REDACTED] without detail of assessment or notification to the physician of these events. There was no written explanation of why facility staff did not implement the physician order to send Resident 2 to the emergency department for evaluation and treatment of multiple firings of the [REDACTED].

See F157 for additional details of lack of notification of change in condition and F241 for failure to maintain dignity of residents.

F 309

The DNS and or designated LN will spot-check nursing documentation records and care plans weekly to help assure appropriate care, documentation, and care planning is taking place.

2/15/13

The DNS will assure compliance

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