

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

PRINTED: 06/06/2013  
FORM APPROVED  
OMB NO. 0938-0391

1324

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505507	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/05/2013
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NAME OF PROVIDER OR SUPPLIER  SHELTON HEALTH & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 153 JOHNS COURT SHELTON, WA 98584
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Complaint Survey conducted onsite at Shelton Health and Rehabilitation on 6/5/13. The sample included 4 current and 1 former residents out of a census of 65 Residents.</p> <p>The following complaint was investigated on this survey:</p> <p>#2813432</p> <p style="text-align: center;"><b>RECEIVED</b> JUN 21 2013</p> <p>The survey was conducted by: DSHS/ADSA/RCS [REDACTED] R.N., BSN</p> <p>The Complaint Investigators were from:</p> <p>Department of Social &amp; Health Services Aging &amp; Long-Term Support Administration Division of Residential Care Services, District 3, Unit C P.O. Box 45819 Olympia, Washington 98504-5819 Telephone: 360.664.8420 Fax: 360.664.8451</p> <p><i>[Signature]</i> Residential Care Services</p> <p style="text-align: right;">6-6-13 Date</p>	F 000	<p>Plan of correction for complaint survey dated 06/05/2013. B level citation F 333.</p> <p>Resident #1 referenced in the citation no longer resides in the facility.</p> <p>An audit of all residents who who receive sub-lingual morphine has been completed to validate that the residents are receiving the proper dosage as ordered by the MD.</p> <p>LN's have been re-educated on the 6 rights of medication administration and professional standards of practice.</p> <p>The Staff Development Coordinator is conducting ongoing medication pass competencies on all LN's to identify further educational needs of licensed staff and validate LN competency. Additional training</p>	6/10/13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE EXECUTIVE DIRECTOR	(X6) DATE 6/19/2013
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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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NAME OF PROVIDER OR SUPPLIER  <b>SHELTON HEALTH &amp; REHAB CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>153 JOHNS COURT SHELTON, WA 98584</b>		
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F 000	Continued From page 1	F 000	will be provided as the need is identified.		
F 333 SS=B	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure one of five sampled residents (Former Resident #1) received medication as prescribed by their physician. This failure placed all residents at risk for experiencing an adverse effect from medication errors.</p> <p>Findings include:</p> <p>"Using Safety Measures While Preparing Drugs" in Lippincott's, Williams &amp; Wilkins FUNDAMENTALS OF Nursing The Art and Science of Nursing Care (7th Edition, 2011) states, "Checking the Medication Order: The nurse is responsible for double-checking the dosage and appropriateness of the medication. The rights of medication administration can help to ensure accuracy when administering medications. Ensure that the (1) right medication is given to the (2) right patient in the (right dosage through the (4) right route at the and (5) right time."</p> <p>All observations, interviews and record reviews occurred on 06/05/13 unless otherwise stated.</p>	F 333	<p>Random weekly audits will be completed by Nurse Managers to validate that medications are administered according to the 6 rights of medication administration. Results will be brought to CQI to identify further/on-going educational needs</p> <p>The Director of Nursing Services is responsible for the plan of correction.</p>		

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F 333	<p>Continued From page 2</p> <p>Resident #1 (██████ resident) ████████ on ██████/13. The resident was on hospice services which started on ██████/13. The resident diagnoses included ████████ with ████████.</p> <p>The resident had a physician order dated 5/7/13 to receive 1-2 mg (milligrams) of ████████ (a ████████ reliever) every hour as needed for pain relief.</p> <p>The medication error was discovered on 5/21/13 when the nurse realized the resident had been receiving 4 mg of ████████ instead of the 2 mg as ordered by the physician.</p> <p>The medication label for the resident's ████████ read, "Give 1-2 drops (1-2mg) by mouth/sublingually every hour as needed for pain.</p> <p>The medication administration record (MAR) for the resident read ████████ 1-2 mg sublingually every hour for pain as needed.</p> <p>The MAR revealed the resident received the incorrect dose of ████████ from 5/17/13 thru 5/21/13 from four different licensed nurses on four different occasions.</p> <p>Review of the resident's progress notes revealed the resident's respirations remained at 26 despite the increased does of ████████ with her heart</p>	F 333		

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F 333	<p>Continued From page 3 rate remaining in the low 100's.</p> <p>The Director of Nurses (DNS) was interviewed 11:15 a.m. She stated the four nurses involved in the incident were given retraining on the medication process. The facility investigation revealed the nurses read the order for the [REDACTED] as 1-2ml, instead of 1- 2 mg (2 mg in each ml) so the resident received 4 mg of [REDACTED] instead of 2 mg.</p> <p>The DNS went on to say as result of the incident, the facility had met with the pharmacy who supplied medications to thier facility to have more clear labeling on the medications being sent to the facility.</p> <p>Record review of the resident's record showed the facility medical director was notified of the incident. The medical director indicated the resident "took multiple doses of the increased dose of [REDACTED] without acute change in condition. [REDACTED] was appropriate and gradual as expected." The physician also recommended discussions with the pharmacy to have more clear labeling on future prescriptions.</p>	F 333		