DEPARTMENT OF HEALTH AND HUM/ SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505488	A. BUILDING _____ B. WING _____	C 07/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHMOND BEACH REHAB	19235 - 15TH AVENUE NORTHWEST SEATTLE, WA 98177

(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	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Survey conducted at Richmond Beach Rehabilitation on 07/24/2014-07/25/2014. A sample of 4 residents was selected from a census of 130. The following complaint was investigated as part of this survey. #3027802 The survey was conducted by: Cathy Prentice, MN, R.N. The survey team is from: Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, District 2, Unit C Creekside Two 20425 72nd Avenue South, Suite 400 Kent, WA 98032-2388 Telephone: (253) 234 6003 Fax: (253) 395 5071 Delano Vaca 7-29-2014 Residential Care Services Date	F 000	This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long term care providers for the abbreviated survey conducted 7/24/2014 and 7/25/2014. This Plan of Correction does not constitute an admission of liability on the part of the facility, and such is hereby specifically denied. The submission of this plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies cited are correctly applied. Please accept this Plan of Correction as our credible allegation of compliance. Our compliance will be achieved by 8/13/2014.	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	8/11/14

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to meet professional standards for intraveneous line flushing for 2 of 2 residents sampled with central venous lines (Resident #1, #2). This failure placed residents at risk for complications of central line access for needed intravenous medication. The facility also failed to transcribe and follow a Physician's Order for 1 of 4 residents (Resident #1) sampled, for the administration of an intravenous antibiotic for a blood infection. This failure caused the resident to miss 7 doses of needed IV medication to treat an infection, and placed the resident at risk for less than optimal healing and recovery. --also see F333-- Findings include: FAILURE TO FOLLOW PHYSICIAN ORDER According to record review of facility medical records on 07/24/2014, Resident #1 was admitted to the facility in [redacted]14 for treatment of a systemic infection with intravenous antibiotics and rehabilitation to go home. Review of the Phisicain	F 281	F 281 How the nursing home will correct the deficiency as it relates to the resident: Resident # 1 has discharged. Resident #2 Midline IV is flushed with 5cc NS and 3cc Heparin per pharmavcy/facility protocol. How the nursing home will act to protect similar residents in similar situations: Residents with IV lines are receiving appropriate flushes per pharmacy/facility protocol. Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur Modified Point Click Care (PCC) program to match IV protocol. LNs will be inserviced onpharmacy/facility IV protocol, flushing specific lines and PCC process.	

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F 281	Continued From page 2 Orders dated 07/02/2014 revealed, Resident #1 had a blood infection and was ordered to have intravenous (IV) antibiotics through a specific intavenous (IV) device called a porta cath. Additional review of facility Progress Notes dated 07/16/2014 revealed, Staff A received an Infectious Disease (ID) Physician's order dated 07/16/2014, to continue the IV antibiotics for Resident #1 until further notice, notified the facility practitioner of the order to continue the antibiotics, and received a verbal order to implement the IV antibiotic as ordered by the ID Physician from 07/16/2014 until further notice. In an interview on 07/24/2014 at 2:45 p.m., Staff A confirmed the order to continue the IV antibiotics for Resident #1 was not implemented by the facility after 07/18/2014, until 07/22/2014, and IV doses of the antibiotic were omitted during that timeframe until the error was found. Staff A further confirmed the error was due to the verbal order dated 07/16/2014 to continue the IV antibiotics for Resident #1, was never written/transcribed or implemented by the facility, until 07/21/2014. Failure to follow professional standards to transcribe and follow a Physician Order to continue needed IV medication treatment, led to Resident #1's treatment omission of 7 doses of medication treatment for an infection. INCORRECT IV LINE FLUSHING	F 281	How the nursing home plans to monitor its performance to make sure that solutions are sustained: RCMs Will review IV orders in am clinical standup meeting Routine audits will be completed to ensure appropriate IV flushes are followed. Date corrective action will be completed: 08/13/2014 Title of the person responsible to ensure correction: DNS/RCMs	

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F 281	Continued From page 3 RESIDENT #1 According to record review of the facility medical record on 07/24/2014, Resident #1 had a central IV line with an access device called a Porta-Cath. Review of the facility Treatment Record Administration dated July 2014 revealed, the facility flushed the IV line with "3cc's of normal saline, and 3cc's of Heparin 10 Units/ml every shift" for maintenance of the line, from 07/04/2014 to 07/22/2014. Review of the standards for Infusion Maintenance per the facility pharmacy protocol (Omnicare, 2010), the flush for a Porta-Cath IV line is: 5 cc's normal saline and 5 cc's Heparin 100 Units/ml. The facility failed to administer the IV line maintenance flush for Resident #1's IV for 19 days from 07/04/2014 to 07/22/2014. This failure placed the resident at risk for complications of the IV line. RESIDENT #2 Record review of the facility medical records on 07/25/2014 revealed, Resident #2 had a Midline IV for intravenous antibiotics in [redacted]4 in the facility, to treat a deep wound infection. Review of the facility Treatment Administration Record dated July 2014 revealed, the facility flushed the Midline IV with "3cc's of normal saline, 3cc's Heparin 10 Units/ml every shift" from 07/01/2014 to 07/11/2014.	F 281		

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F 281	Continued From page 4	F 281		
	Review of the standards for Infusion Maintenance per the facility pharmacy protocol (Omnicare, 2010), the flush for a non-valved Midline IV line is: 5 cc's normal saline, 3 cc's Heparin 10 Units/ml.			
	Failure to flush the IV line for Resident #2 according to standards for 11 days, placed the resident at risk for complications of the IV line.			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333	F 333	
	The facility must ensure that residents are free of any significant medication errors.		How the nursing home will correct the deficiency as it relates to the resident: Resident # 1 has discharged.	
	This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 of 2 residents (Resident #1) receiving intravenous (IV) antibiotics for infection, remained free of significant medication errors, when the facility did not administer 7 doses of intravenous antibiotic needed for a severe infection. This failure placed the resident at significant risk for less than optimal healing and rehabilitation.		How the nursing home will act to protect similar residents in similar situations: Residents with IV orders will be reviewed in am clinical standup to ensure orders are transcribed appropriately.	
	---see also F281---		Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur Staff were in-serviced regarding the proper protocol on IV antibiotic administration.	
	Findings include:			
	According to record review of facility medical			

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F 333	Continued From page 5 records on 07/24/2014, Resident #1 was admitted to the facility in [redacted]14 for treatment of a systemic infection with intravenous antibiotics, and rehabilitation to go home. Review of the Physician Orders dated 07/02/2014 revealed, Resident #1 had a blood infection and was ordered to have intravenous (IV) antibiotics everyday at the facility until 07/18/2014, and followup with the Infectious Disease Physician during the stay at the facility. Review of the facility Minimum Data Set (MDS) assessment dated 07/11/2014 revealed, Resident #1 was alert and oriented, BIMS 15/15, and was dependent on facility staff for bed mobility, transfer, and all mobility and hygiene. Additional review of the Physician Orders dated 07/02/2014 revealed, antibiotic blood levels were being monitored at the facility so Resident #1 would maintain specific blood level of the ordered IV antibiotic medicine to treat the severe infection. Further review of the medical record revealed, Resident #1 saw the Infectious Disease Physician as planned on 07/16/2014, while residing at the facility. Review of the Physician Order Sheet dated 07/16/2014 revealed, the Infectious Disease Physician ordered the IV antibiotic to continue for Resident #1 "until further notice" for the infection. Review of the Medication Administration record for July 2014 revealed, Resident #1 had the ordered IV antibiotics until 07/18/2014. After	F 333	The LN who failed to transcribe order was inserviced/counseled LNs will be inserviced on medication transcription and e-kit policy. Modified e-kit protocol to assure medications removed are ordered timely. Notification of MD/DNS if medication not received. How the nursing home plans to monitor its performance to make sure that solutions are sustained: RCMs will routinely monitor availability of e-kit medication and transcription of orders Date corrective action will be completed: 08/13/2014 Title of the person responsible to ensure correction: DNS/RCMs	

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F 333	Continued From page 6 07/18/2014, Resident #1 missed 7 doses of the ordered IV antibiotic from 07/19/2014, to 07/22/2014, although the Infectious Disease Physician ordered the medicine to continue until further notice on 07/16/2014. Further review of the facility Progress Notes dated 07/21/2014 revealed, Staff A, a licensed nurse, noted the order dated 07/16/2014, to continue the IV antibiotic was not carried out and the medication was discontinued after 07/18/2014. Additional review of facility Progress Notes dated 07/16/2014 revealed, Staff A received the Infectious Disease Physician's order to continue the IV antibiotics on 07/16/2014, and notified the facility practitioner for Resident #1 of the order to continue the antibiotics, and received a verbal order to implement the IV antibiotic as ordered by the ID Physician, until further notice. In an interview on 07/24/2014 at 2:45 p.m., Staff A confirmed the order to continue the IV antibiotics for Resident #1 was not implemented by the facility after 07/18/2014 until 07/22/2014, and IV doses of the antibiotic were omitted during that timeframe until the error was found after the family inquired about the IV medication. Failure to administer 7 doses of IV antibiotics as ordered by the physician, placed Resident #1 at significant risk for untreated and continued infection, and less than optimal health condition.	F 333		

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