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

1356

PRINTED: 05/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505016		C 05/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAYS HARBOR HEALTH & REHABILITATION CENTER	920 ANDERSON DRIVE ABERDEEN, WA 98520

(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 Grays Harbor Health and Rehabilitation Center on May 15, 2013. A sample of 1 of 4 residents, 1 former resident was selected from a census of 87. The following complaints were investigated: 2787409 2799543 2802749 2807269 The survey was conducted by: [redacted] R.N., B.S.N., Complaint Investigator [redacted] R.N., M.S.N., Field Manager The Complaint Investigator was from: Department of Social & Health Services Aging & Long-Term Support Administration Residential Care Services, District 3, Unit C P.O. Box 45819 Olympia, WA 98501 Telephone: 360-664-8432 Fax: 360-664-8451 Joan Pierce Date: 5-22-13 Residential Care Services	F 000	RECEIVED JUN 04 2013 DSHS/ADSA/RCS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure 1 of 4 former resident's (#1) clinical record contained complete, accurate information reflecting the resident's observed health status including changes in baseline health conditions. Failure to document the health status change that prompted an x-ray to be ordered and to follow the facility ' s Change in Condition Policy and Procedure and Content of the Health Record policy prevented the physician from being alerted to potential changes in the baseline condition of Resident #1. In addition, the facility's policy for Alert Charting and Change in Condition Charting failed to clearly articulate how and when that charting should be implemented. Failure to have clear policies around medical record charting potentially places residents at risk of not having changes of conditions identified and responded to timely.	F 514	Plan Of Correction for 23 May 2013 Citation • How the nursing home will correct the deficiency as it relate to this resident: Resident #1 died on April 4, 2012. • How the nursing home will act to protect resident in similar situations The facility will revise the Alert Charting policy to more clearly articulate how and when to implement alert charting. All licensed nurses will receive training on the new policy. They will also be trained on the policy for Content of the Health Record Nurses Notes.	

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F 514	Continued From page 2 <Resident #1> Resident #1 was admitted to the facility [redacted]/11. Her diagnoses included a history of [redacted], [redacted], [redacted], [redacted], [redacted] and [redacted]. The resident relied on staff for assistance with all activities of daily living. Interview with the complainant on 4/9/13 revealed that she had multiple concerns regarding the care that Resident # 1 received at the facility. In reviewing the facility's clinical record for Resident #1, a chest x-ray result for 2/22/12 was noted. The x-ray report results indicated findings of " [redacted] and [redacted], 2nd [redacted]s in the [redacted]. Follow up is recommended." There was no documentation in the nursing notes or physician orders to indicate that a chest x-ray had been ordered for the resident on 2/22/12 or acknowledging the results of the x-ray on 2/23/12. Interview on 4/23/13 at 3:55 pm with the x-ray service company that performed the chest x-ray revealed that they received a request from a facility nurse for a chest x-ray on Resident #1 on 2/22/12. The x-ray company confirmed that the x-ray was completed and the results faxed to the third floor of the nursing home on 2/23/12. In addition, review of the resident's record failed to reveal any documentation indicating what symptoms Resident #1 was experiencing that were a change from her baseline functioning that prompted a facility nurse to obtain a chest x-ray. Interview on 4/30/13 at 9:45 am with the former facility nurse who had ordered the x-ray indicated	F 514	• Measure the nursing home will take or the systems it will alter to ensure that the problem does not recur Unit managers will audit charts of residents on alert charting on at least three times a week for: *1. 24 hour report checked for completion and reviewed for changes in condition.* *2. Nursing notes reflect documentation of Change in Condition and notification of M.D. and family.* *3. Change in condition/alert charting completed by nursing.* *4. Lab results obtained and called to Physician.*	

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F 514	Continued From page 3 that although she did not remember exact details of the event which prompted her to order the x-ray, she did recall that the resident was experiencing signs and symptoms of a change in respiratory status. The standard practice was to order a chest x-ray when residents were experiencing [redacted] symptoms. Review of Resident #1's clinical record revealed that there was infrequent Departmental Notes regarding the resident's health status written by nursing. Review of the Departmental Nursing Notes revealed that the last Nursing Note entered for this resident before the date the chest x- ray was 2/16/12. The subject of the note involved the resident being removed from Alert Charting as the antibiotic treatment for a [redacted] was completed. The next nursing note dated 2/23/12 was documented as a Late Entry note and referenced a change in medication that occurred on 2/8/12. There was no documentation of any respiratory symptoms or a chest x-ray being ordered. The following note on 3/3/12 referenced that the MD had seen the resident. Although the resident's physician visited the resident on 3/3/12 and found no acute changes, documentation does not indicate the physician was aware of a chest x-ray taken on 2/23/12. Interview with the physician on 4/22/13 at 1:20pm confirmed that the physician was not aware that an x-ray had been ordered or the results communicated. Interview with a facility staff member, Staff A, on 4/24/13 at 8:00 am revealed that the facility had a Resident Change in Condition Policy. That policy included a statement under the 4th bullet that stated "Status changes, which are not significant	F 514	*5. Lab report reflects notification to physician and physician response* • How the nursing home plans to monitor its performance to make sure that the solutions are sustained All residents on alert charting will have their conditions and charting reviewed each week at the Interdisciplinary Team Meeting • Dates when the corrective actions will be completed July 5, 2013	

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F 514	Continued From page 4 enough to be reported, must be documented in the medical record." A facility policy entitled Content of the Health Record Nurses' Notes item #5 stated "Unusual occurrences will be charted every shift for 72 hours." Staff A stated that changes in a resident's condition should be charted. Bullet # 3 of that same policy indicated "Intermediate care residents will be charted on at least weekly/monthly in accordance with state regulations." Although the results of the x-ray indicated that a follow-up was recommended, the absence of charting related to the resident's respiratory status, prevented the physician from being alerted to the potential changes in the resident's baseline condition. In addition, there were no nursing notes charted on her health condition between 3/8/12 and 4/2/12 at which time the resident was found to need emergent medical intervention. There is no documentation in the clinical record to evidence the condition change in Resident #1's baseline condition that supported the reason why the chest x-ray was ordered on 2/22/12. There was no follow up to the chest x-ray as recommended. On 4/24/13 Staff A outlined the facility's procedures for ensuring that lab results and x-ray results were communicated to the physicians. There is no evidence the facility ensured the results of the chest x-ray were received and reviewed by the resident's physician per their procedure. Although, the facility had policy and procedures regarding the need to report changes in residents' health status in the medical record, they did not ensure that these procedures were followed. As a result, it was not possible to ensure that residents'	F 514	• The title of the person responsible to ensure correction Administrator	

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F 514	Continued From page 5 medical records contained complete, accurate information reflecting the changing health status' of residents.	F 514		