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

1358

PRINTED: 04/04/2013
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
	505496		C 03/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON CARE CENTER AT NORTHPOINTE	9827 NORTH NEVADA SPOKANE, WA 99218

(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 Avalon Care Center at Northpointe on 3/25/13 and 3/26/13. A sample of 11 residents was selected from a census of 109. The sample included 10 current residents and the records of 1 former and/or discharged resident. The following were complaints investigated as part of this survey: #2777037 The survey was conducted by: [redacted] R.N., B.S.N. The survey team is from: Department of Social & Health Services Aging & Long Term Care Support Administration Division of Residential Care Services Rock Pointe Tower 316 West Boone Avenue, Suite 170 Spokane, Washington 99201-2351 Telephone: (509) 323-7302 Fax: (509) 329-3993 4/4/13. Residential Care Services Date	F 000	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited and is also not to be construed as an admission of interest against the facility or the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and 19 programs. The submission of the Plan of Correction within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. **This Plan of Correction is submitted as the facility's credible allegation of compliance.**	5-3-13

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary Dew — TITLE: Administrator — (X6) DATE: 4-24-13

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 281 SS=G	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 interview and record review, it was determined the facility failed to ensure licensed nurses followed professional standards of quality related to safe medication administration when a licensed nurse prepared oral medications for a resident and handed them to a nursing student to administer. In addition, the licensed nurse did not ensure the student identified the right resident prior to administering the oral medication and 2 doses of [redacted] in error. As a result, Resident #1 received doses of short-acting and long-acting [redacted] and [redacted] medication in error, that were ordered for Resident #2. The facility's failure to implement professional standards of practice related to medication administration resulted in harm to Resident #1 who required hospitalization to treat symptoms of low [redacted] and [redacted]. Findings include: See F333 Residents Free From Significant Medication Error for additional details. The facility policy General Guidelines for Medication Administration included the following: -The person who prepares the dose for administration is the person who administers the dose.	F 281	Resident #1 has returned to the facility and had no lasting negative effects from the medication error. All nursing staff are educated on student and staff responsibilities during student clinical rotation. The policy addressing the interaction with nursing students will be utilized to ensure licensed staff and student responsibilities during the student clinical rotation. When the clinical rotations occur, audits of the nursing students assignments will be conducted to ensure staff nurses are aware of the assignments. The results will be tracked and trended for follow-up by the QA Committee until a lesser frequency is deemed necessary. The Director of Nursing will ensure compliance.	5-3-13

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F 281	Continued From page 2 -Residents are identified before medication is administered. Methods of identification include: A. Checking identification band. B. Checking photograph attached to the medical record or the medication administration record. C. Calling resident by name. D. If necessary, verifying resident identification with other facility personnel. During the investigative visit, the facility did not have a written policy/procedure that addressed licensed staff responsibilities for ensuring student nurses consistently followed facility procedures for safe medication administration. Resident #1 had diagnoses including [redacted] and [redacted]. The resident's medication orders included one [redacted] medication and a [redacted] every morning. Resident #2 was Resident #1's room-mate. Resident #2 had diagnoses including [redacted], [redacted], and [redacted]. The resident's medication orders included [redacted] injections twice daily, short-acting [redacted] injections before each meal, 3 [redacted] medications each morning, and one heart medication twice daily. Per record review, on 3/21/13 at 8:00 a.m., Staff #A (a licensed nurse) was passing medications to residents on the West unit long hall. A student nurse approached Staff #A and stated she was checked off to give medications and check blood sugars. Staff #A asked the student nurse to check Resident #2's blood sugar, draw up the resident's [redacted], and administer medications. Staff #A prepared Resident #2's oral	F 281		

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F 281	Continued From page 3 medications, including 3 [redacted] and one [redacted] medication. He watched the nursing student draw up short-acting [redacted] in one syringe and long-acting [redacted] in a separate syringe. He checked the syringes, gave the student nurse the syringes and the oral medications he had prepared, and instructed the student nurse to administer the medications to Resident #2. Staff #A did not accompany the student nurse to the resident's room to ensure the student nurse had identified the right resident prior to administering the medication. Per record review, the student nurse administered all the medications to Resident #1 rather than Resident #2. Staff #A discovered the error when he met the student nurse in the residents' room to respond to the student nurse's additional questions about the medications. Staff #A immediately notified the supervisor. Per record review, the resident experienced complications and was transferred to the hospital before noon, where he was treated for low blood sugars, low blood pressure, and low heart rate, all related to receiving incorrect medications. In an interview on 3/25/13 at 4:50 p.m., Staff #B stated Staff #A should have administered the medications he prepared to Resident #2 and not handed them to the student nurse to administer. Regarding student nurses in the facility, Staff #B stated student nurses were in the facility for clinical training on Thursdays. Each student had assigned residents they were prepared to care for. The facility licensed nurse responsibilities for supervising a student nurse included the student only administering medications to the residents to which they were assigned and only under the direct supervision of the facility licensed nurse. Staff #B stated during investigation of the	F 281		

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F 281	Continued From page 4 medication error, Staff #A stated he did not know he was not supposed to ask students to administer medication he prepared, and was supposed to watch the nursing students administer medications to the residents. When asked by the surveyor, Staff #B stated the facility had no written procedures and/or instructions about licensed nurse responsibilities for supervising student nurses. In an interview on 3/25/13 at 12:13 p.m., Staff #C stated she learned about supervising student nurses while in facility orientation from the licensed nurse who oriented her to medication pass. In an interview on 3/25/13 at 12:40 p.m., Staff #D stated nursing students only passed medications to residents to whom they were assigned. He stated he relied on the student nurses to inform him if they were observing or if they were approved by the nursing instructor to pass medications with his supervision. In an interview on 3/25/13 at 2:10 p.m., Staff #E stated the nursing instructor told her when the students were approved to pass medications. She stated usually the nursing students were not approved to administer [redacted] right away. She stated sometimes nursing students asked to do more than pass medications to their assigned residents but she told them no. In an interview on 3/26/13 at 7:50 a.m., Staff #A stated he worked evening shift until a few weeks ago and 3/21/13 was the first time he had supervised a student nurse. He stated the nursing student told him she was signed off on medication pass. He stated he did not check with the nursing instructor about what the nursing student could safely do before asking the nursing student to administer medications.	F 281		

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F 281	Continued From page 5 The facility's failure to ensure all licensed staff consistently followed professional standards of quality related to safe medication administration, including ensuring nursing students consistently followed the same professional standards of quality for medication administration, resulted in harm to Resident #1.	F 281	Resident #1 has returned to the facility and had no lasting negative effects from the medication error. Staff A has been educated and provided a return demonstration regarding proper medication administration procedures. The Nursing Instructor will make the students aware of the expectations regarding identification, care and medication administration processes whenever students perform clinical rotations at Avalon. Staff A presented an education addressing the professional standards of quality related to safe medication administration. Medication administration audits will be conducted a minimum of two times weekly. Results will be tracked and trended by the QA Committee, follow-up will occur until a lesser frequency is deemed appropriate. The Director of Nursing will ensure ongoing compliance.	5-3-13
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure that 1 of 11 sample residents reviewed for medications (#1) was free from significant medication errors. Resident #1 received doses of short-acting and long-acting [redacted] and [redacted] medication in error that were ordered for Resident #2. This significant medication error resulted in harm to Resident #1 who required hospitalization to treat symptoms of low blood pressure and low blood sugar. Findings include: See F281 Services Provided Meet Professional Standards of Quality for additional details. Resident #1 had diagnoses including [redacted] and [redacted] Per record review, the resident had [redacted] problems. The resident's medication orders included one [redacted] medication and a [redacted] every morning.	F 333		

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F 333	Continued From page 6	F 333		

Resident #2 was Resident #1's room-mate. Resident #2 had diagnoses including [redacted], [redacted] problems, and [redacted] Per record review, the resident had no memory problems. The resident's medication orders included long-acting [redacted] injections twice daily, short-acting [redacted] injections before each meal, 3 [redacted] each morning, and one heart medication twice daily.

Per record review, on 3/21/13 at 8:00 a.m., Staff #A was passing medications to residents on the West unit long hall. A student nurse approached Staff #A and stated she was checked off to give medications and check blood sugars. Staff #A asked the student nurse to check Resident #2's blood sugar, draw up the resident's insulin, and administer medications.

Staff #A (a licensed nurse) prepared Resident #2's oral medications; including 3 [redacted] and one [redacted] medication. He watched the nursing student draw up 30 units of short-acting [redacted] in one syringe and 30 units of long-acting [redacted] in a separate syringe. He checked the syringes, gave the student nurse the syringes and the oral medications he had prepared, and instructed the student nurse to administer the medications to Resident #2. Staff #A did not accompany the student nurse to the resident's room to ensure the student nurse had identified the right resident prior to administering the medication.

Per record review, the student nurse returned to Staff #A a few minutes later with questions about how the resident took the [redacted] Staff #A responded to the questions. The nursing student went back to the resident's room and returned a few minutes later with additional questions. Staff #A met the nursing student in the residents' room

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F 333	Continued From page 7 and found Resident #2 asleep. The nursing student called Staff #A to Resident #1's bedside and identified Resident #1 as the resident she administered [redacted] to, Staff #A immediately notified the supervisor. Per record review, by 9:00 a.m., the resident experienced low blood sugars and low blood pressure. The physician ordered intravenous fluids. By 11:00 a.m., the resident was difficult to arouse and was transferred to the hospital for treatment. Review of hospital records dated 3/21/13 revealed the resident was treated for low blood sugars, low blood pressure. and slow heart rate, all related to receiving incorrect medications. In an interview on 3/25/13 at 1:30 p.m., Resident #1 was in a wheelchair and responded positively to his name. In an interview on 3/25/13 at 4:00 p.m., Resident #2 was alert & oriented; he reported no problems with his medications. In an interview on 3/25/13 at 4:50 p.m., Staff #B stated Staff #A should have administered the medications he prepared to Resident #2 and not handed them to the student nurse to administer. The facility's failure to ensure all licensed staff safely administered medications and supervised nursing students administering medications resulted in a signifcant medication error and harm to Resident #1.	F 333		