

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

PRINTED: 06/21/2013  
FORM APPROVED  
OMB NO. 0938-0391

1362

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505126	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/12/2013
NAME OF PROVIDER OR SUPPLIER  AVALON HEALTH & REHABILITATION CENTER - PASCO			STREET ADDRESS, CITY, STATE, ZIP CODE 2004 N 22ND AVENUE PASCO, WA 99301	
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Avalon Health &amp; Rehabilitation Center on June 6, 2013 and June 12, 2013. A sample of 4 residents was selected from a census of 61 residents. The sample included 4 current residents.</p> <p>The following were complaints investigated as part of this survey: #2809870 #2810037</p> <p>The survey was conducted by: [REDACTED] R.N.</p> <p>The survey team is from: Department of Social &amp; Health Services Aging &amp; Long Term Support Administration Residential Care Services, District 1, Unit C 3611 River Road, Suite 200 Yakima, Washington 98902</p> <p>Telephone (509) 225-2800 Fax: (509) 574-5597</p> <p><i>[Signature]</i> 6/21/13 Residential Care Services Date</p>	F 000	<p>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 Facility, of the Executive Director or any employees, agents, or other individuals who draft or may be discussed in this response. 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 correctness of any conclusions set forth in the allegation by the survey agency.</p> <p>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 the Plan of Correction with ten (10) days of the survey as a condition to participate in Title 18 and 19 programs.</p>	<del>6/21/13</del> 7/3/13
F 329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose</p>	F 329	<p>The submission of the Plan of Correction within this time frame should in no way be considered or construed as an 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.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE Administrator (X6) DATE 7/3/13

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 329	<p>Continued From page 1 should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review the facility failed to recognize and consistently monitor for adverse reactions; and provide adequate indication for the use of psychoactive medications for 1 of 3 sampled residents (#1) reviewed for unnecessary medications. In addition, the facility administered an excessive dose of a [REDACTED] medication without evidence of additional therapeutic benefit for the resident. This failed practice resulted in Resident #1 experiencing a decline in function with activities of daily living. Findings include:</p> <p>Resident #1: Admitted to the facility on [REDACTED]/13 with diagnoses which included [REDACTED] with [REDACTED] and [REDACTED]. Medications prescribed by the physician on admission</p>	F 329	<p>F - 329</p> <p>The facility continued to notify Resident #1's physician and reduced the Ativan and Seroquel orders, and revised the plan of care. Resident #1 has returned to his baseline level of functioning.</p> <p>The facility conducted a Psychotropic medication review of other residents receiving psychotropic medications for potentially unnecessary or excessive dosages. No other discrepancies were noted.</p> <p>The facility provided education to the ARNP regarding F-329 and the daily, maximum thresholds of psychotropic medications in the Nursing Home environment. Licensed Staff were educated on June 28<sup>th</sup>, 2013 on psychotropic medications regarding proper identification of behaviors, non-pharmacological interventions, obtaining appropriate diagnosis for use, informed consent, ruling out underlying medical issues, and the daily dose thresholds for psychotropic medications. Additionally, Licensed Staff were educated on how to monitor for potential side effects. Medication Administration Records have the potential adverse reactions listed on the sheet. The Social Service Director has</p>	<p><i>[Signature]</i> 7/3/13</p>

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F 329

Continued From page 2 included [redacted] 25 milligrams (mgs) daily and [redacted] 1 mg every 12 hours as needed for anxiety. [redacted] is an [redacted] medication with adverse reactions which included drowsiness, agitation, fatigue, weakness, and dizziness and [redacted] is an [redacted] medication with adverse reactions of sedation, drowsiness, dizziness, blurred vision, muscle weakness- lack of balance and coordination, agitation, disorientation, and hyperactivity.

Review of the behavior monitoring forms between May 1 - June 5/2013 for the use of [redacted] noted the targeted behaviors were "repeated health complaints" and "anxious regarding his placement." There was inconsistent monitoring of the resident's behaviors by staff as evident by omissions in documentation for 44 of the possible 108 shifts. Documentation that was evident noted the resident had not exhibited the targeted behaviors during that time.

Review of the behavior monitoring forms between May 1 - June 5/2013 for the use of [redacted] noted the targeted behaviors were "resistive to care" and "physically abusive." There was inconsistent monitoring of the resident's behaviors by staff as evident by omissions in documentation for 42 of the possible 108 shifts. Documentation noted the resident exhibited resistant to care behaviors on ten shifts and only on two shifts prior to 5/23/13; and was physically abusive during five shifts.

Review of Progress Notes between 5/1-22/13 noted the resident was alert and oriented to self only, two assist required for transfers, toileting, and bed mobility. The only documented entries

F 329

F - 329  
Continues

been re-educated on identifying specific individualized target behaviors and non-pharmacological interventions.

Resident's with a change of psychotropic medication will be monitored daily by the Director of Nursing Services and / or designee daily during the MACC meeting to ensure adverse reactions are noted and acted upon immediately. Social Service will monitor for effectiveness of psychotropic medications monthly through the IDT psychotropic meeting. GDR's and AIMS will be noted during this meeting and conducted in accordance with regulations.

The Director of Nursing Services will ensure compliance daily through the MACC process and monthly through the IDT psychotropic and Quality Assurance meetings until a lesser frequency is deemed appropriate.

  
7/3/13

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F 329	<p>Continued From page 3</p> <p>relative to behavioral issues during that time were on 5/8 which stated the resident seemed restless that day thus restorative walked him with his walker and he seemed to calm down, and an assessment on 5/13 by the Activities Director stating when the resident was agitated he would push a tray table away, however diversional activity was effective for the resident.</p> <p>Despite the lack of exhibited behaviors by the resident as noted above his [REDACTED] dosage on 5/23/13 was doubled to 50 mgs daily and [REDACTED] was increased from an as needed every 12 hours order (had received only five doses between 5/1-22/13) to 1 mg three times daily by the Nurse Practitioner (NP). The total daily dose threshold of [REDACTED] is 2 mgs per day, thus the new order was an excessive dose.</p> <p>Review of the above NP's assessment dated 5/23/13 noted the nursing staff had reported the resident had an increase in confusion and anxiety as noted by him calling out for his family, and making accusations about his wife and son. Review of the physical exam performed by the NP that day revealed the resident was "very sleepy today, but does answer some of my questions...appears lethargic...sleepy, but not restless or angry or delusional at the moment."</p> <p>Review of Progress Notes by Licensed Nurses (LNs) on 5/28/13 at 3:45 a.m. revealed the "resident very lethargic this evening (referring to the evening of 5/27/13). The next entry on 5/28/13 at 12:45 p.m. noted "no adverse effects from addition of meds and dosing changes except the res (resident) is sleepier." Review of the resident's Medication Administration Record</p>	F 329		
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F 329	<p>Continued From page 4</p> <p>revealed the 2:00 p.m. dose of [REDACTED] was not given as the resident had refused the medication. All other doses were given as prescribed despite noted lethargy and sleepiness. All scheduled doses were given on 5/29/13. On 5/30/13 at 3:35 a.m. documentation by Staff A (LN) stated the LN was worried about medicating the resident higher than needed. The resident had been sleeping through the shift (6:00 p.m. on 5/29/13 through 3:35 a.m. on 5/30/13). The LN also documented the LN who had worked the previous shift (6:00 a.m to 6:00 p.m. on 5/29/13) had stated the resident had slept most of that shift also. The LN documented it did not "look normal" for the resident and thought the resident was "being over medicated." Despite the documentation by Staff A, [REDACTED] was administered at 8:00 p.m. on 5/29/13. In addition there was no attempt to contact the physician relative to the medications and adverse effects on the resident.</p> <p>On 5/30/13 at 12:18 p.m. documentation revealed the resident was assisted with his meal, "very tired barely answers questions...not his normal self". A fax was sent to the physician on 5/30/13 requesting a change in the [REDACTED] dosage back to an as needed order due to "heavy sedation." The LN was instructed by an administrative LN to hold the next dose of [REDACTED] while waiting for a physician response. Documentation on 5/31/13 at 12:18 a.m. noted the resident was in bed sleeping when the LN arrived on shift (approximately 6:00 p.m. on 5/30/13). He got up for 45 minutes around 8:00 p.m. and had a snack but then returned to bed and had been sleeping soundly since then. He was difficult to arouse at 11:00 p.m for routine pain medication and had been sleeping since that time. On the morning of</p>	F 329		
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F 329	<p>Continued From page 5</p> <p>5/31/13 documentation revealed the resident had breakfast and his scheduled medications then went to sleep, was "difficult" to arouse. Despite the resident's above change in condition as noted earlier on 5/30/13 and duration of hours he was sleeping, LN staff administered [REDACTED] and [REDACTED] to the resident at bedtime on 5/30/13 and the morning of 5/31/13.</p> <p>On 5/31/13 documentation at 1:20 p.m. stated the physician decreased the resident's [REDACTED] from 3 mgs to 2 mgs daily - "hold for increased lethargy" with no change in the [REDACTED].</p> <p>Telephone interviews on 6/3 and 6/17/13 with the resident's family member noted she and the resident's spouse had visited the resident on 6/2/13 and the week prior to that. He was "overly sedated - just like a vegetable ...not himself...could not even form words...now he is not there - it scares me...can't even get up." She stated the resident's spouse left the facility crying as the resident was not able to say her name and tell her he loved her as he had in the past.</p> <p>Observation of the resident at 10:30 a.m. on 6/6/13 noted he was tilted back in a wheelchair - with his eyes closed. His verbal responses were very slow with slurred speech. At 12:15 p.m. he was being fed in the dining room by Staff B (Administrative LN). Staff B stated the resident was very lethargic secondary to an increase in [REDACTED] and [REDACTED] which had been decreased since 5/31/13. She stated the resident had been able to feed himself with cueing and now was not able to do so. She stated he no longer could propel his wheelchair.</p>	F 329		
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F 329	<p>Continued From page 6</p> <p>On 6/6/13 at 1:05 p.m. the resident was tilted back in his wheelchair sleeping. He made no response when his name was called. At 1:15 p.m. the resident was unable to grasp with his hands when requested to do so by the Director of Nursing. His voice was very soft and difficult to understand. At 3:00 p.m. the resident was observed being transferred to bed from his wheelchair by three Nursing Assistants. His eyes remained closed and he made no attempt to assist staff with the transfer.</p> <p>Despite the above observations on 6/6/13 and physician orders on 5/31/13 to hold the [REDACTED] for increased lethargy the [REDACTED] had been administered that morning (6/6/13) to the resident.</p> <p>An interview with Staff C (Restorative Aide) on 6/6/13 at 2:15 p.m. noted the resident was scheduled to be in an ambulation program, however he had not ambulated since 5/25/13 (12 days prior) due to "being sleepy". On 5/25/13 the resident had walked 300 feet utilizing a walker and gait belt. He stated the resident used to feed himself but now had to be assisted due to being sleepy.</p> <p>On 6/12/13 an interview with Staff D (Physical Therapist) revealed the resident was more sedated the end of May to the beginning of June 2013. He "couldn't follow instructions, passive, very little communication verbally - not as much as he had been...sleepier than usual."</p> <p>Review of a visit form for the NP dated 6/4/13 relative to the resident noted increased sedation with a staff recommendation by Staff B to continue the [REDACTED] as previously ordered but</p>	F 329		
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F 329	Continued From page 7 change the [REDACTED] to an as needed dose. Staff B stated it was the intent for the NP to see the resident on 6/4/13, however she did not see the resident that day as planned and had not seen the resident since 5/23/13. Despite the resident's above noted increased sedation on 6/4/13 and above observations of the resident on 6/6/13 there was no documented attempts to contact the resident's physician for medication changes.	F 329		