

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

1371

PRINTED: 10/01/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505216	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/23/2013
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NAME OF PROVIDER OR SUPPLIER FIDALGO CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1105 27TH STREET ANACORTES, WA 98221
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Fidalgo Care Center on 09/23/13. A sample of 4 residents was selected from a census of 36. The sample included 3 current residents and the records of 1 former and/or discharged resident.</p> <p>The following complainants were investigated as part of this survey:</p> <p>2853932 2872181</p> <p>The survey was conducted by: [REDACTED], R.N., M.S.</p> <p>The survey team was from: Department of Social and Health Services Aging and Long-Term Support Administration Residential Care Services, Region 2, Unit B 3906 172nd Street NE, Suite 100 Arlington, WA 98223 Telephone: (360) 651-6850 FAX: (360) 651-6940</p> <p><i>[Signature]</i> 10/2/13 Residential Care Services Date</p>	F 000	<p>RECEIVED OCT 21 2013 ADSA/RCS Smokey Point</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE EXECUTIVE DIRECTOR	(X6) DATE 10/12/13
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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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F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p>	F 225	<ol style="list-style-type: none"> 1. Resident # 4 is no longer in the facility. Visitors & ancillary staff were not interviewed as investigator concluded they were unaware of and/or unfamiliar with narcotic accountability protocols. 2. The facility will conduct thorough interviews of staff, review medications of all residents in the facility and report allegations to all appropriate authorities, and implement a plan of prevention for all staff placing residents at risk of possible future misappropriation of medications. The Director of Nursing Services (DNS) performed an audit of medication inventory on 9-3-13. Shelly Keown, Pharmacist of Hoagland Pharmacy performed an audit of all CII & CIII medications on site on 9-28-13. The inventory matched the Controlled Inventory Log Book. 3. Nursing staff have been in-serviced on & signed acknowledgement agreeing to follow our narcotic storage, handling, record keeping & safety. The Hoagland Pharmacist will in-service nursing staff on 10-24-13 as well. 4. The DNS will randomly check medication carts for security concerns. Random observations of narcotic counts will be observed by DNS or designee. Results of audits will be reviewed during monthly QA meetings. 5. The DNS will monitor and Executive Director will oversee compliance. 	11-1-13

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F 225	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to conduct a complete investigation in one of four incidents reviewed for allegations of abuse/neglect/misappropriation. Failure to conduct thorough interviews of staff, review all medications of all residents in the facility, report possible allegations to all appropriate authorities, and implement a plan of prevention for all staff placed residents at risk of possible future misappropriation of medications.</p> <p>Findings include:</p> <p>The facility had a written policy for monitoring the presence and number of narcotic medications of each resident within each medication cart of the building at every shift change. The licensed nurse (LN) who was finishing their shift would review each page of the narcotics ledger and call out the number of tablets/vials/patches that should be present of each ordered narcotic medication of each resident. The oncoming LN counts the actual number of tablets/vials/patches present in the cassette for a named resident. The numbers in the ledger and the actual count should always match. The narcotic medications are stored under double lock at all times. Additionally, the current on duty LN must retain possession of the keys that lock and unlock their assigned medication cart at all times during the shift. This includes the double lock that provides access to the narcotic medications.</p> <p>Resident 4 was admitted in [REDACTED] 2013 for rehabilitation following [REDACTED]. Other diagnoses for Resident 4 included [REDACTED] and [REDACTED]. Her physician</p>	F 225		

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F 225	<p>Continued From page 3</p> <p>ordered [REDACTED] pain relief medication, to be given as needed (prn) for pain relief. On 09/01/13 about 8 p.m., Staff A reported 12 tablets of [REDACTED] for Resident 4 were missing from the medication cart.</p> <p>On 09/23/13 at 12:28 p.m., Staff B stated she worked during the weekend of discovery of the missing Percocet medication for Resident 4. She reported she knew the facility policy regarding double locking the medication cart at all times and keeping the keys with her at all times. Staff B accurately described the facility policy of how to conduct narcotic count between shifts. Staff B reported she did not consistently follow the policy for narcotic count at change of shift. She stated if a resident had orders for a prn pain relief medication and that resident did not complain of pain and/or request the ordered narcotic pain relief medication, there was no reason to notice whether the cassette for that medication was present in the medication cart during a shift. Staff B recalled Resident 4 did not complain of any pain issues during that shift; Staff B had no reason during the shift to check whether the cassette for Resident 4 was present on 09/01/13.</p> <p>At 1:50 p.m., Staff C reported she worked the weekend the [REDACTED] tablets were discovered to be missing. She had no reason to check for the presence of the cassette that contained the [REDACTED] as Resident 4 did not want thing for pain relief. She knew the policy for narcotic count at change of shift and the policy to keep the medication cart double locked at all times. Staff C stated not all the nurses kept the medication carts locked at all times per facility policy. Additionally, on some occasions in the past, two same shift LNs conducted the narcotic count</p>	F 225		

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F 225	<p>Continued From page 4</p> <p>rather than the current shift LN and the oncoming shift LN. She wrote a statement of this practice deviation and provided it to the Director of Nursing Services (DNS) during the investigation.</p> <p>At 1:40 p.m., the DNS reported she conducted the investigation of the missing Percocet of Resident 4. She stated all the LNs of the building were trained in Spring 2013 to double lock the medication carts and perform the shift change narcotic count page by page in the narcotic ledger. They were not to skip any pages. She discovered during the investigation that not all LNs consistently implemented this policy. She learned that some staff knew this occurred. The DNS did not address the mandatory requirement of all staff to report allegations/suspensions of misappropriation to the State Hotline as part of the plan to prevent any possible future reoccurrence of misappropriation from residents. She did not report all the nurses who violated the policy for narcotic count and double locking the medication carts, thus contributing to the opportunity for an unknown person(s) to misappropriate the Percocet of Resident 4 to the State licensing board. The DNS did not investigate whether any other LNs, clinical staff or ancillary staff suspected or knew of the history of non-compliance of some LNs during shift change narcotic count or locking and management of narcotic medications in the carts.</p> <p>Review of the facility investigation revealed Staff A told the DNS she did not always keep the medication cart locked at all times, including the weekend in which the [REDACTED] of Resident 4 was discovered missing. There was no evidence of documentation of staff interviews for any observations of any LNs leaving medication carts</p>	F 225		

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F 225	Continued From page 5 unlocked as alleged by Staff B. There was no documentation of any interviews with any visitors who were present during the time of the incident. The investigation concluded the Percocet was misappropriated from Resident 4 by unidentified person(s). The plan to prevent future reoccurrence did not address mandatory reporting of possible factors contributing to misappropriation of resident medications or other resident possessions.	F 225	
F 281 SS=D	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, the facility nursing staff failed to meet professional standards for narcotic scheduled medication storage and management. Failure to consistently implement facility policy to double lock narcotic medications, lock medication carts, and perform change of shift narcotic count as trained contributed to misappropriation of narcotic medications from Resident 4 and placed all other residents at risk of possible misappropriation of medications. Findings include: On 09/23/13 at 12:30 p.m., the Director of Nursing Services (DNS) reported the facility policy for narcotic medications included the following: The staff licensed nurse (LN) must store the	F 281	<ol style="list-style-type: none"> 1. Resident # 4 no longer resides in facility. 2. The DNS & Pharmacist performed independent inventories of schedule II & III narcotics. There were no further discrepancies noted. Nurse A was counseled on narcotic counting, storage, record keeping & safety on 9-3-13. Staff A,B & D received disciplinary action including report to the Washington State Board of Nursing on 9-23-13. There have been no other concerns of narcotic shift to shift count, double locking of narcotics or safeguarding cart locks. 3. Nursing staff have been in-serviced on & signed acknowledgement agreeing to follow our narcotic storage, handling, record keeping & safety. The Hoagland's Pharmacist will in-service nursing staff on 10-24-13 as well. 4. The DNS or designee will randomly check medication carts for security concerns. Random observations off narcotic counts will be observed by DNS or designee. Results of audits will be discussed during monthly QA meetings. 5. The DNS will monitor and Executive Director will oversee compliance.

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F 281	<p>Continued From page 6</p> <p>narcotic medications under double lock - first lock is the medication general lock and the second was a separate location for the narcotic medications within the locked medication cart.</p> <p>Each LN working on a shift must retain the keys to the medication cart at all times. If the LN needs to relinquish the medication cart keys - that LN and the LN who will now manage the medication cart must perform a narcotic count prior to the release of the keys to the oncoming LN.</p> <p>Narcotic count must be performed at each change of shift by the current LN and the oncoming LN. The current LN read the count for each medication for each resident - page-by-page - in the narcotic ledger. The oncoming LN checks for the presence of the medication cassette for each resident and counts the actual number of tablets/vials/patches of the medication. The number listed in the ledger and the actual count number should be the same. IF there is a discrepancy, it must be resolved immediately.</p> <p>Resident 4 was admitted in [REDACTED] 2013 for strength building and recovery after [REDACTED] surgery. Her physician ordered [REDACTED] pain relief medication, as needed for pain management.</p> <p>On 09/01/13 about 8 p.m., Staff A observed 12 [REDACTED] a narcotic pain relief medication, were missing for Resident 4. She reported the missing narcotic medication to the DNS.</p> <p>On 09/23/13 at 11:30 a.m., the DNS reported during the investigation, Staff A admitted she signed for the accuracy of the narcotic medications during change of shift without actually counting the medications. Additionally,</p>	F 281		

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F 281	<p>Continued From page 7</p> <p>Staff A failed to consistently lock the medication cart when she worked. Staff A did not know when the medications were taken.</p> <p>At 12:28 p.m., Staff B reported she worked the weekend the Percocet was taken. Although Staff B knew the policy for narcotic medication storage and management, she did not consistently implement the policy. She did not know whether the narcotic cassette was present during the time she worked. She the Staff A did not review the narcotic ledger page-by-page; they skipped pages. Staff B stated they could have missed a cassette when they skipped pages.</p> <p>At 1:50 p.m., Staff C reported she knew Staff D did not consistently lock the medication cart whenever she worked her shift in the building. She stayed late sometimes to perform the narcotics count with Staff D when Staff D arrived late for her shift. Sometimes Staff C performed the narcotic count with another LN from the same shift she worked rather than with the LN for the oncoming shift. Staff C stated other people in the building knew that Staff D often worked with the medication cart unlocked. She was uncertain who might have taken the missing Percocet.</p> <p>Review of the facility investigation revealed evidence of documentation Staff A acknowledged she did not consistently lock the medication cart. Staff A and Staff D failed to consistently review the narcotic ledge page-by-page as required by facility policy. Staff D acknowledged she did not consistently lock the medication cart.</p> <p>See F225 for additional details.</p>	F 281		