

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

PRINTED: 05/20/2013
FORM APPROVED
OMB NO. 0938-0391

1398

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505296	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2013
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NAME OF PROVIDER OR SUPPLIER ST FRANCIS OF BELLINGHAM	STREET ADDRESS, CITY, STATE, ZIP CODE 3121 SQUALICUM PARKWAY BELLINGHAM, WA 98225
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F 000 INITIAL COMMENTS

This report is the result of an unannounced Quality Indicator Survey conducted at St Francis of Bellingham on 5/13/13, 5/14/13, 5/15/13, 5/16/13, and 5/17/13. A sample of 29 residents was selected from a census of 111. The sample included 24 current residents and the records of 5 former and /or discharged residents.

The survey was conducted by:

_____, RN, BSN
_____, RN, BSN
_____, RN, BSN

The survey team is from:

Department of Social and Health Services
Aging & Disability Services Administration
Residential Care Services, District 2, Unit A
3906 172nd Street NE, Suite 100
Arlington WA 98223

Telephone: (360) 651-6878
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Lynn Dabker 5/20/13
Sign Date

F 000 This plan of correction is being submitted pursuant to the applicable federal and state regulations. Nothing contained herein shall be construed as an admission that the Facility violated any federal or state regulation or failed to follow any applicable standard of care.

RECEIVED
JUN 03 2013
ADSA/RCS
Smokey Point

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Tajad Myers</i>	TITLE Administrator	(X6) DATE 5/30/13
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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 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to review/revise a care plan for 1 of 27 (#91) sample residents reviewed for care planning. This failure had the potential to place Resident 91 at risk for possible adverse effects from use of psychotropic medications.</p> <p>Findings include:</p> <p>The facility's "Psychoactive Medication Protocol" with a review date of 11/12 stated: "The target behavior's are documented in the medical record</p>	F 280	<p>The facility will continue to ensure that we develop initially and periodically review and revise as needed a comprehensive care plan for each resident.</p> <p>Resident #91 (or #195 as it says on the resident list) care plan was immediately revised to include interventions and a measurable goal specific to episodes of anxiety including guidance for staff on non-pharmaceutical interventions.</p> <p>All charts were reviewed for those residents receiving psychoactive medications to ensure that care plans include resident specific interventions and measurable goals.</p> <p>Reviewed with 100% of licensed staff the Psychoactive Medication Protocol which includes identification of resident specific interventions and measurable goals on care plan.</p> <p>As part of our ongoing QA process, we will review a sample of resident records to ensure that care plans for those residents receiving psychoactive medications include resident specific interventions and measurable goals. RCM to conduct audit & DNS to ensure compliance.</p>	6/7/13

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F 280	Continued From page 2 while on alert status....then summarizes the information and develops interventions, which are entered on the care plan." Resident #91 was admitted in [REDACTED] 2013 with diagnoses including falls, [REDACTED], [REDACTED] and [REDACTED]. The resident was started on [REDACTED] (an [REDACTED] medication) prn (as needed) on April 10, 2013 for [REDACTED]. A review of the resident's care plan dated 5/16/2013, revealed no interventions or a goal regarding the use of an [REDACTED] medication. The care plan did not guide staff on interventions to attempt when [REDACTED] episodes were exhibited prior to administrating a [REDACTED] medication, as per their policy. Staff B, Resident Care Manager (RCM), was interviewed on 5/15/13 at 10:00 a.m. She confirmed the resident's mood and behavior problems, goals and interventions were not addressed on the care plan.	F 280			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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	F 329	The facility will continue to ensure that residents are free of any unnecessary drugs.		

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F 329	<p>Continued From page 3 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 record review and interview, it was determined the facility failed to ensure monitoring of the usage and response to non-pharmalogical interventions for 2 of 10 (#12 and 91) sample residents reviewed for unnecessary medications. This failure placed residents at risk for receiving psychoactive medications that may not have been needed.</p> <p>Findings include: A review of the facility's "Psychoactive Medication Protocol" with a review date of 11/12 stated: - All behaviors must be clearly documented with target behaviors and failed attempts to use non-pharmaceutical interventions before obtaining pharmaceutical interventions.</p>	F 329	<p>Resident #12 Physician order was updated to include identified specific target behaviors. LN to document non-pharmaceutical interventions attempted prior to administering medication while utilizing the lowest effective dose. LN to document response to medication.</p> <p>Resident #91 (or #195) care plan was immediately revised to include interventions and a measurable goal specific to episodes of anxiety including guidance for staff on non-pharmaceutical interventions. Physician order was updated to include identified specific target behaviors. LN to document non-pharmaceutical interventions attempted prior to administering medication. LN to document response to medication.</p> <p>All charts were reviewed for those patients receiving PRN psychoactive medications to ensure the care plan includes resident specific interventions and measurable goals; the physician order includes identified target behaviors; the eMAR includes documentation of non-pharmaceutical interventions attempted prior to administering medication at the lowest effective dose and response to medication.</p>	

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F 329	<p>Continued From page 4</p> <p>- If non-prescriptive approaches are unsuccessful then the licensed staff can proceed with a prescriptive route. The order to include the target behaviors identified.</p> <p>RESIDENT #12 Resident #12 had diagnoses of [REDACTED], [REDACTED] and frequent falls. The resident's annual Minimum Data Set (MDS), an assessment tool, dated 2/18/13 indicated mood concerns.</p> <p>A review of the resident's care plan dated 3/08/13 identified a behavioral management plan alerting staff of behaviors and signs of [REDACTED]. The interventions directed staff on redirecting the resident and dealing with any mood or behavior concerns when present.</p> <p>The resident had two different physician orders for [REDACTED], an [REDACTED] medication, as follows:</p> <ol style="list-style-type: none"> [REDACTED] 0.5 mg as needed 1 to 2 tablets every six hours for [REDACTED] with an order date of 11/1/12. [REDACTED] 1 mg every six hours as needed for [REDACTED] with an order date of 11/13/12, and to start with lower dose first. <p>Upon review of the Medication Administration Record (MAR) for the months of March through May 2, 2013, the resident used as needed [REDACTED] 26 times. There was no documentation prior to the administration of the medication of the non-pharmalogical interventions attempted. In addition, the higher dose of the medication was used 11 of the 26 times without attempting the use of the lower dose first.</p> <p>Additionally, the physician order did not indicate the specific target behaviors as per the facility</p>	F 329	<p>Review with 100% of licensed staff the Psychoactive Medication Protocol including appropriate documentation when utilizing PRN psychoactive medications.</p> <p>As part of our ongoing QA process we will review a sample of resident records to ensure that those receiving PRN psychoactive medications have a care plan that includes resident specific interventions and measurable goals; the physician order includes identified target behaviors; the eMAR includes documentation of non-pharmaceutical interventions attempted prior to administering medication at the lowest effective dose and response to medication. Reviews will continue until 100% compliance is reached for three months and then it will be reviewed quarterly for one year and reported through our QA committee. RCM to complete audit. DNS to ensure compliance.</p>	6/7/13

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F 329	<p>Continued From page 5 policy.</p> <p>RESIDENT #91 The resident was admitted in [REDACTED] 2013 with diagnoses including [REDACTED], [REDACTED] and frequent falls. The resident had mood indicators identified on his MDS assessment dated 4/08/13.</p> <p>A review of the resident's care plan dated 5/16/2013, revealed no interventions or a goal regarding the use of an [REDACTED] medication.. The care plan did not direct staff on interventions when [REDACTED] episodes were exhibited prior to administrating an unnecessary medication.</p> <p>The physician order dated 4/10/13 was as follows: [REDACTED] 0.25 mg (milligrams) as needed four times a day for [REDACTED]. There were no target behaviors identifying the signs and symptoms of the resident's [REDACTED].</p> <p>[REDACTED] was administered 15 times from April 10 - May 15, 2013. There was only one documented intervention prior to administering the [REDACTED].</p> <p>The Director of Nursing Services (DNS) was interviewed on 5/16/13 at 1:33 p.m. She stated the expectation of the license nurse was to attempt and document non-pharmalogical interventions prior to the administration of a as needed anti-anxiety medication. This information was documented in the resident medical record. The DNS was acknowledged this was not consistently done for either resident.</p> <p>This is a repeat citation from 2/24/12.</p>	F 329			