

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

PRINTED: 05/01/2014
FORM APPROVED
OMB NO. 0938-0391

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 04/29/2014
NAME OF PROVIDER OR SUPPLIER ST FRANCIS OF BELLINGHAM			STREET ADDRESS, CITY, STATE, ZIP CODE 3121 SQUALICUM PARKWAY BELLINGHAM, WA 98225	
(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	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Off-Hours Quality Indicator Survey conducted at St. Francis of Bellingham on 04/23/14, 04/24/14, 04/25/14, 04/28/14 and 04/29/14, The survey included data collection on 04/25/14 from 4:30 a.m. to 7:30 a.m. A sample of 29 residents was selected from a census of 110. The sample included 26 current residents and the records of 3 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>Nedra Vranish, R.N., B.S.N., M.S.Ed Susan Harris, R.N., B.S.N. Michelle Scollard, R.N., B.S.N. Rick Woodrum, R.N., B.S.N.</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Disability Services Aging and Long-Term Support Administration 3906 172nd St NE, Suite 100 Arlington, WA 98223</p> <p>Telephone: (360) 651-6850 FAX: (360) 651-6940</p> <p><i>[Signature]</i> 5/1/14 Residential Care Services /Date</p>	F 000	<p>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.</p> <p>RECEIVED MAY 14 2014 ADSA/RCS Smokey Point</p>	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
<i>[Signature]</i>		Administrator		5/12/14

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 167 SS=B	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to inform the residents, the public, and staff, the location of the results of previous surveys (inspections). This failure had the potential to affect resident rights and hinder the rights of the public wanting to review the previous citations.</p> <p>Findings include:</p> <p>During multiple observations on 4/23/14, 4/24/14, and 4/25/14, the results of previous surveys could not be located. On 4/25/14 at 1:10 p.m., a book (which contained results of previous surveys) was found in an alcove behind the receptionist area, on a coffee table with magazines and brochures on it.</p> <p>During an interview with Resident 4 on 4/25/14 at 6:30 a.m., he stated he was aware of a survey book, but did not know of its location. He understood he could go to the receptionist and ask for it.</p>	F 167	<p>This facility will continue to ensure that the Survey Results are readily accessible.</p> <p>The Survey has been kept in a clearly labeled three-ring binder in the lobby area so it could be easily accessed without assistance. There is a large sign posted outside the Social Services office, at the front of the building, stating that "A complete copy of our Medicare/Medicaid Survey is available at: Social Service Office and Reception Area".</p> <p>The "Survey Book" was moved to a wall pocket immediately beneath the large sign at the front of the building. The Administrator followed up with each of the three identified residents to ensure they are aware of where the survey book is kept.</p> <p>The Administrator requested to address the next Resident Council meeting to ensure all involved residents are informed of where the survey book is kept.</p> <p>As part of our ongoing Quality Assessment and Process Improvement (QAPI) system, at least five residents will be asked each month if they know where the survey report ("survey book") is located. We will continue this audit until 100% compliance is reached for at least three months. Results will be reported through and addressed by our QAPI Team. Guest Services will conduct audit. Administrator will ensure compliance.</p>	5/12/14

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F 167	Continued From page 2 During interviews on 4/29/14 at 8:55 a.m. and at 9:10 a.m., Residents 121 and 60 stated they had not seen the survey book, and did not know where it was located. [REDACTED] had recently finished serving in the role of Resident Council President. During an interview on 4/29/14 the administrator indicated the book containing the survey results was located where it has always been. She was not aware of residents' difficulty in locating the survey book.	F 167			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to consistently and comprehensively assess a non-pressure related skin condition for 1 of 3 sample (82) residents reviewed for skin breakdown. The failure to assess Resident 82's skin condition on an ongoing basis placed her at	F 309	This facility will continue to ensure that each resident receives and the facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Resident #82 immediately had a comprehensive assessment completed of the non-pressure related skin condition which was documented in the chart. All residents with identified skin conditions were reviewed to ensure that comprehensive assessment was completed and documented.		

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F 309	<p>Continued From page 3 risk for a deteriorating skin condition and related complications.</p> <p>Findings include:</p> <p>Resident 82 was admitted █ 10 with diagnoses including dementia, insulin dependent diabetes, and aphasia. The resident had a history of moisture associated skin damage. She had been assessed and identified as at risk for skin breakdown. The most recent Minimum Data Set, dated 3/14/14, indicated the resident needed two people to assist her with bed mobility and used a wheelchair when out of bed. She was incontinent of both bowel and bladder.</p> <p>Review of the progress notes, dated 4/22/14, in the medical record revealed the resident was being treated for a coccyx wound. Further review of the record revealed dressing changes to the coccyx wound but without a comprehensive assessment of the wound. A comprehensive wound assessment should include the following: documentation of the wound edges, wound bed, location, shape, and condition of surrounding tissues, presence of drainage, pain, and signs and symptoms of infection. Documentation of the wound did not include any of this information. The only reference to the wound condition was in the March 2014 progress notes, which stated the wound was healing.</p> <p>An interview with Staff D, a registered nurse, on 4/25/14 at 10:30 a.m., revealed the resident had a skin wound which occurred from moisture. She stated the wound in the skin opened periodically and healed when treated. She reviewed the records and found no documentation of wound description, sizing or dimensions. She said there</p>	F 309	<p>Review with licensed staff all elements to be included in completing a comprehensive skin condition assessment.</p> <p>As part of our ongoing Quality Assessment and Process Improvement (QAPI) system, we will review a sample of resident records to ensure that a comprehensive assessment was completed and documented for identified skin issues. We will continue this audit until 100% compliance is reached for at least three months. Results will be reported through and addressed by our QAPI Team. ADON to conduct audit. DNS to ensure compliance.</p>	5/14/14

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F 309	Continued From page 4 should be some documentation of it healing or not healing but the nurses had not been doing this.	F 309			
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 should be reduced or discontinued; or any combinations of the reasons above. 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure adequate monitoring for 1 of 5 residents (72) reviewed for unnecessary medications. These failures placed the resident	F 329	This facility will continue to ensure the Drug Regimen is free from unnecessary drugs. It was immediately reviewed with nurses for Resident #72 the need to ensure adequate monitoring completed and clear documentation to indicate if medication was administered or held for all blood pressure medications with specific parameters. All charts reviewed for those patients that have medications with specific parameters to ensure that adequate monitoring is completed and documentation is clear to indicate if medications were administered or held. Review with licensed staff the need to ensure adequate monitoring completed and documentation is clear for medications with specific parameters to indicate if medications were administered or held.		

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F 329	<p>Continued From page 5</p> <p>at risk for undetermined efficacy and adverse consequences related to the medication.</p> <p>Findings include:</p> <p>Resident 72 was admitted to the facility March 2014 with a diagnosis to include high blood pressure.</p> <p>A review of the physician orders was done on 4/29/14. The resident received two different medications (hydralazine and amlodipine) for high blood pressure. The physician orders had directed the Licensed Nurse (LN) not to administer the hydralazine if the systolic blood pressure reading was below 125. Additionally, the LN was not to administer the amlodipine if the systolic blood pressure reading was below 120.</p> <p>A review of the March and April 2014 Medication Administration Records (MAR) was done. According to the documentation on the MAR, the resident received both medications when his blood pressure reading fell below the parameters set by the physician. The resident received 12 doses of the hydralazine when his systolic blood pressure was below 125, and 7 doses of the amlodipine when his systolic blood pressure was below 120.</p> <p>In an interview on 4/29/14 at 9:35 a.m., the Director of Nursing Services stated the LN should follow any parameters set by the physician. If the order stated not to give a medication if the systolic blood pressure was below 125, as indicated with Resident 72, then the LN should not have given the medication. When a medication was not administered, the LN was to document on the MAR by using the codes</p>	F 329	<p>As part of our ongoing Quality Assessment and Process Improvement (QAPI) system, we will review a sample of resident records to ensure that adequate monitoring is completed and documentation is clear to indicate if medications with specific parameters were administered or held. We will continue this audit until 100% compliance is reached for at least three months. Results will be reported through and addressed by our QAPI Team. ADON to complete audit. DNS to ensure compliance.</p>	5/14/14	

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F 329	Continued From page 6 specified on the bottom of the MAR. There should also be a corresponding progress note reflecting this action. In an interview on 4/29/14 at 9:00 a.m., Staff A, a LN, stated she did not give the medications, however the documentation on the MAR indicated the two blood pressure medications were administered. The progress notes were reviewed with Staff A, and there were no codes specified on the MAR or corresponding progress notes indicating the medications were not given.	F 329			
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.	F 356	This facility will continue to post staffing information on a daily basis. The Administrator followed up with the two residents identified to ensure they each know where the staffing numbers are posted. The policy was updated to include daily census and how many employees were scheduled and how many actually worked the particular shift. The posting was moved from the nurses' stations to a clear signboard at the front of the facility.		

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F 356	<p>Continued From page 7</p> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to post required staffing levels in an area that was easily seen by the residents or the public. This failure placed residents and visitors at risk for not knowing how many staff were working for any particular shift. Additionally, several components of the staffing information were missing.</p> <p>Findings include:</p> <p>During all days of the survey, daily staffing sheets were located on a clipboard at two nursing stations. The clipboards hung on the wall, behind the nurse's station. The information could only be read if the reader went behind the nurse's station and turned their head sideways. Various other clipboards were noted on the walls. There was no indication as to which clipboard held the required posting information.</p> <p>Residents 121 and 60 were interviewed on 4/29/14 from 8:55 a.m. until 9:10 a.m. Neither were aware of the location of the staffing information sheet.</p> <p><i>corrected w/L Dasher 5/19/14 - JMN</i></p>	F 356	<p>As part of our ongoing Quality Assessment and Process Improvement (QAPI) system, at least five residents will be asked each month if they know where the staffing levels are posted. We will continue this audit until 100% compliance is reached for at least three months. Results will be reported through and addressed by our QAPI Team. Guest Services will conduct audit. Administrator will ensure compliance.</p>	5/14/14

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F 356	Continued From page 8 On 4/29/14 at 8:30 a.m., the Director of Nursing Services (DNS) was interviewed. She provided a facility policy that indicated the requirements of the posting. However, it did not include the requirement of the daily census and how many employees were scheduled and how many actually worked the particular shift.	F 356			