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

PRINTED: 01/17/2013
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
	505296		C 01/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST FRANCIS OF BELLINGHAM	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	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Survey conducted at St. Francis Extended Healthcare on 1/4/13. A sample of 4 residents were selected from a census of 104. The same included 2 current residents and the records of 2 former and/or discharged residents. The following complaint was investigated as part of this survey: #2729437 The survey was conducted by: Louvenia Ringuette, RN BSN The survey team is from: Department of Social & Health Services Aging and Disability Services Administration Residential Care Services, District 2, Unit B 3906 172nd St NE, Ste 100 Arlington, WA 98223 Telephone: (360) 651- 6850 FAX: (360) 651-6940 Roberta Crawford 1/17/13 Residential Care Services 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 JAN 28 2013 ADSA/RCS Smokey Point	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tonya Myers
TITLE: Administrator
(X6) DATE: 1/25/13

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.

The facility will continue to ensure that we conduct initially and periodically a

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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 interview and record review the facility failed to ensure 1 of 4 sample residents was free from significant medication errors. The failure to ensure Resident 1 received medication prescribed to prevent recurrence of blood clots compromised the resident's health and resulted in harm. The resident developed decreased blood flow to lower extremities causing pain, swelling and frequent medical testing. Findings included: All interviews took place on 01/04/2013 unless otherwise indicated. Resident 1 was admitted to the facility on [redacted] Her diagnoses included [redacted] The resident was alert, confused and dependent on staff for her activities of daily living including medication management. Review of Resident 1's July 2012 physician orders revealed the resident was to receive [redacted] a blood thinner medication, seven days a week. The medication order directed staff to give the resident [redacted] 2.5 milligrams	F 333	The facility will continue to ensure that residents are free of any significant medication errors. Resident #1 [redacted] 2.5mg dose restarted on 8/28/12. INR checks completed as ordered. INR reached therapeutic level at 2.2 on 9/4/12. Left lower extremity monitored for redness, swelling, increased warmth and pain. Pedal pulse checked daily utilizing doppler and verified pulse remained present. Resident monitored for shortness of breath and/or respiratory distress and showed no indications of either. Completed 100% audit of orders and labs for all patients receiving [redacted] therapy to verify that [redacted] therapy was being managed according to physicians' orders. The facility process to reconcile medication orders was followed per facility standard. The facility has reviewed and revised the process to reconcile physician orders to ensure that discontinued orders are verified.	

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F 333	Continued From page 2 (mg) each evening for six days a week and [redacted] 5 mg was ordered for one day a week. On 7/29/12 a licensed nurse inadvertently discontinued the resident's 2.5 mg dose of [redacted] (ordered and administered 6 days a week). Staff continued the 5 mg of [redacted] as ordered one day a week. The resident missed 24 doses of her [redacted] 2.5 mg tablets from July 29, 2012 to the date the error was caught and the medication restarted on August 28, 2012. On August 30, 2012, a doppler ultrasound study confirmed the resident had developed a "very extensive deep vein thrombus" (a blood clot) to her left leg. On 8/19/12 the resident was noted to have "2+ swelling on her left leg from her foot to her knee". Edema is the build-up of fluid between the tissue and cells under the skin which causes swelling. The Director of Nursing Services (DNS) stated during interview on 01/16/2013 that the facility used the "standard pitting edema measurements." She went on to state that "2+" edema meant after 5 seconds the indentation returned to the prior level. The edema increased to "3+" on 8/21/12 and the resident was unable to wear her shoe. On 8/27/12 the resident had redness and weeping to the top of her left foot and the next day the resident was medicated for left leg pain and her left foot had an open area that was hot to touch. On the evening of 8/28/12 staff documented that the resident, " denies pain in calf but was very painful to touch at top of foot." The resident was started on antibiotics for left leg cellulitis. Staff	F 333	Reviewed with 100% of licensed nurses [redacted] Therapy Guideline which includes two nurses verifying all [redacted] orders. Clarified and instructed 100% of licensed nurses that when they receive a [redacted] order stating "no change" they must verify that patient is receiving [redacted] dose as stated on the order. Education provided by Medical Director for 100% of licensed nurses regarding [redacted] Therapy Management and Associated Risks. As part of our ongoing QA process, DNS investigates all medication errors and reports on findings through Quality Assurance committee monthly. Quality assurance review of 100% of [redacted] orders monthly to verify that therapy was being managed according to physicians' orders until 100% compliance is reached for three months and then will be reviewed quarterly for one year and reported through our QA committee. RCM to conduct audit & DNS to ensure compliance.	2/1/13

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F 333	Continued From page 3 notified the MD by fax of the medication error. On 8/29/12 the resident was seen by her medical provider. The resident had, "leg edema from foot to thigh." The medical provider ordered labs to be drawn at that time and doppler studies to check the blood flow to the resident's leg. The resident was found to have a deep vein thrombus on doppler. Her treatment included daily blood test to monitor the effectiveness of the medication to dissolve the clot and return the blood flow to her leg. The DNS stated the facility switched to EMAR, an electronic medication administration record system in July 2012. Failure to have a system in place to reconcile medication orders including the discontinuance of medications resulted in harm for one resident who developed a deep vein thrombus with pain and swelling	F 333		