

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

PRINTED: 08/18/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 08/14/2014
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NAME OF PROVIDER OR SUPPLIER  VICTORY HEALTH & REHAB OF BATTLE GROUND LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 510 NORTH PARKWAY BATTLE GROUND, WA 98604
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Victory Health and Rehab of Battleground on 08/13/2014 and 08/14/2014. A sample of 7 residents was selected from a census of 74. The sample included 4 current residents and the records of 3 former and/or discharged residents.</p> <p>The following complaint was investigated: #3030679</p> <p>The survey was conducted by: Rebecca Christiansen, RN, MS</p> <p>The survey team is from: Department of Social &amp; Health Services Aging &amp; Disability Services Administration Residential Care Services, District 3, Unit D 5411 East Mill Plain Blvd., Suite 203 Vancouver, WA 98661</p> <p>Telephone: 360-397-9550 Fax: 360-992-7969</p> <p><i>[Signature]</i> Residential Care Services      Date</p>	F 000	<p>Preparation and submission of this plan of correction by, Victory Health &amp; Rehab of Battle Ground, does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.</p> <p style="text-align: center;"><b>RECEIVED</b> AUG 29 2014 DSHS/ADSA/RCS</p>	9/3/2014
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE Administrator	(X6) DATE 8/29/14
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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 157 SS=D	<p><b>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</b></p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to inform the resident's legal representative or interested family</p>	F 157	<p>F 157</p> <ol style="list-style-type: none"> <li>1. Resident #1 was discharged from the facility on [REDACTED] 2014.</li> <li>2. On 8/22/2014 the Assistant Director of Nursing (ADON) conducted an audit of residents' medical record for the last 30 days to ensure that the residents' physician and responsible party have been informed of residents change in status or conditions including events, medication and treatment changes; concerns were addressed as indicated.</li> <li>3. On 8/22/2014 the licensed nursing staff were re-educated by the Staff Development Coordinator on the requirement of notifying resident's physician and responsible party of resident's significant change in status or condition including events, medication changes, treatment changes, and transfer or discharge.</li> </ol>	9/3/2014	

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F 157	<p>Continued From page 2</p> <p>member when the resident pulled out the PICC line (a small tube inserted into the vein for the purpose of delivering intravenous (IV) medication) and failed to consult with the resident's physician when there was a substantial inability to provide IV antibiotics as ordered for 1 of 7 residents (#1). This failure placed the resident at risk of having the family not be aware of treatment concerns and of having the physician not be consulted regarding a possible need to alter treatment.</p> <p>Findings include:</p> <p>Resident #1 was admitted to the facility on [REDACTED] 14 with [REDACTED] and [REDACTED]. The resident was to receive high doses of two antibiotics (Ampicillin and Gentamicin) intravenously to combat the infected areas [REDACTED].</p> <p>According to the Minimum Data Set (MDS), an assessment instrument, the resident was cognitively impaired, had confusion and the inability to make decisions. The resident required extensive assistance for activities of daily living.</p> <p>At the time of admission, the resident had a PICC line that was inserted at the hospital through which she was to receive Ampicillin 2000 mg (milligrams) per IV every 4 hours and Gentamicin 55 mg per IV every 8 hours until stopped by the Infectious Disease Physician.</p> <p>On [REDACTED] 14, according to chart records, the resident arrived at the facility at 2:20 p.m. The Ampicillin doses were scheduled to be given at 02:00 p.m., 06:00 p.m., 10:00 p.m., 02:00 a.m., 06:00 a.m. and 10:00 a.m. The Medication Administration Record (MAR) indicated no doses</p>	F 157	<p>4. Beginning the week of 8/25/2014 the ADON or designee will review five resident's medical records for changes in condition for 4 weeks then monthly for 2 months and then quarterly thereafter to ensure that resident's physician and responsible party are notified of residents who have a change in condition including events, medication changes, treatment changes, and transfer or discharge. A report will be submitted to the Quality Assurance Performance Improvement Committee for three months. The Quality Assurance Performance Improvement Committee will review the results and determine if any further interventions are needed at that time. The ADON or designee will be responsible for continued monitoring.</p> <p>Date of compliance: 9/3/14</p>	9/3/2014
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F 157 Continued From page 3  
 were administered on ■■■14 (scheduled for 06:00 p.m. and 10:00 p.m.) and no doses were administered on ■■■14 (scheduled for 02:00 a.m. and 06:00 a.m.) until 10:00 a.m. A nursing note reflected a dose being given at 01:00 a.m., however according to the MAR, the medication was first administered at 10:00 a.m. on ■■■14, nearly 20 hours after admission, with 4 doses of the medication not being given.

According to chart records, the Gentamicin doses scheduled on ■■■ at 04:00 p.m. and on ■■■ at 12:00 a.m. were not administered.

No information was found in the record regarding the antibiotics not being administered as ordered. The family was not informed. The physician was not consulted for possible alteration to the plan of treatment.

On ■■■14 in the evening, the resident pulled the PICC line out and was sent to the hospital to have the IV replaced, following consultation with the physician. The family was notified. The resident returned to the facility on ■■■14 at 09:40 p.m.

On ■■■14 at 07:30 a.m., the PICC line was partially pulled out by the resident's movements. The physician and family were notified and the resident was sent to the hospital for replacement.

On ■■■14 at 10:30 p.m., the PICC line was again pulled partially out by the resident. The physician was notified and decided to wait until the morning to plan the next course of action. There was no indication the family was notified until they arrived for a visit at 10:00 a.m. the next day.

F 157

9/3/2014

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F 157	Continued From page 4 On 8/14/14 at 12:30 p.m., the Director of Nursing stated "I would expect the doctor to be called any time there is a deviation from the norm or what is expected. The family should be notified as well."	F 157			
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS  The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure residents received proper treatment and care for parenteral fluids and foot care for 4 of 7 residents (#1, 3, 5 & 6). This failure caused the residents to not receive treatment and care for special services.  Findings include:  According to facility policies for Intravenous Therapy (IV), dated 04/08, facility staff must document a baseline assessment for all PICC lines (a small catheter inserted into the arm vein	F 328	F 328  1. Resident # 1 was discharged from the facility on [REDACTED] 14. Resident # 3 was discharged from the facility on [REDACTED] 14. On 8/22/14 Residents # 5 was re-assessed to ensure nail care was completed by the Licensed Nurse and for needed podiatry services by the ADON ;no other concerns were noted. On 8/22/14 Resident # 5 care plan and care guide were updated by the ADON to reflect residents current status. On 8/22/14 Residents # 6 was re-assessed for nail care by the ADON to ensure nail care was completed by the Licensed Nurse and for needed podiatry services; no other concerns were noted. On 8/22/14 Resident # 6 care plan and care guide were updated by the ADON to reflect residents current status.	9/3/2014	

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F 328	<p>Continued From page 5</p> <p>which delivers medication near the center of the body), including total catheter length, external catheter length and mid-upper arm circumference. The site was to be monitored for signs/symptoms of infection or dislodgement every shift. All IV orders were to be detailed and complete.</p> <p>According to the facility policy for Parenteral Nutrition (TPN or PN), dated 04/08, the order for parenteral nutrition must include an order for 10% dextrose (sugar) solution in case the parenteral nutrition was interrupted for any reason. Additionally, if necessary to stop the TPN infusion, any rate of infusion in excess of 50 ml per hour should be tapered down over a period of time to prevent possible dextrose-related complications.</p> <p>&lt;Parenteral Fluids&gt;</p> <p>1) Resident #1 was admitted to the facility on [REDACTED] 14 with [REDACTED] and [REDACTED]. The resident was to receive high doses of two antibiotics (Ampicillin and Gentamicin) intravenously to combat the infected areas [REDACTED]. The resident pulled out the PICC line 3 times and had to be sent to the hospital for replacement. On [REDACTED] 14, when the resident was sent for replacement, the family decided to place her at another facility.</p> <p>According to the Minimum Data Set (MDS), an assessment instrument, the resident was cognitively impaired, had confusion and the inability to make decisions. The resident required extensive assistance for activities of daily living.</p> <p>According to the resident's medication administration record (MAR), the PICC line was</p>	F 328	<p>2. On 8/22/2014 the ADON conducted an audit of residents to ensure diabetic residents nail care was completed by the Licensed Nurse and for needed podiatry services were documented; concerns were addressed as needed. There are currently no residents in house with IV, PICC line or TPN at this time.</p> <p>3. On 8/22/2014 the Nursing staff were re-educated by the SDC on diabetic residents need for nail care by a Licensed Nurse, documentation and Podiatry services as needed and on the procedure for IV/PICC line and TPN therapy to ensure baseline assessment for measuring total external catheter length and mid upper arm circumference with intravenous site to be monitored for signs and symptoms of infection or dislodgement, and to ensure IV orders are complete to include the rate of the IV infusion, and to ensure TPN orders include 10% Dextrose in the event the TPN is interrupted.</p>	9/3/2014

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F 328	<p>Continued From page 6</p> <p>to be monitored for signs and symptoms of infection or dislodgement every shift. Between the time of admission and the time of discharge, there were 30 opportunities for staff to record whether the PICC line was intact. Monitoring was not documented during 9 of the possible opportunities. About 30% of the monitoring was not recorded as being completed. No measurements of the PICC line were found. No mid-arm circumference measurements were found. No information was available regarding how much fluid was administered with each dose of medication and how quickly it was to be infused.</p> <p>On 8/14/14 at 12:30 p.m., when asked how the nurses measure PICC lines, or how they would know if the PICC had become dislodged, the Director of Nursing stated "The nurses would notice if more of the PICC line than usual was exposed, then they would measure how much had come out. If it was 3 inches or more, the resident would be sent out for PICC line replacement. They would be able to tell if it was 3 inches or more by looking at the PICC line."</p> <p>2) Resident #3 was admitted on [REDACTED] 14 with diagnoses to include [REDACTED] and [REDACTED]. In July, the resident was sent to the hospital when she developed a perforated bowel and had to have abdominal surgery. When she re-admitted on [REDACTED] 14, she had orders for Parenteral Nutrition (TPN, a solution that is mixed in a bag, and given IV which contains high concentrations of sugar, amino acids, fats, electrolytes, vitamins and minerals that will meet the patient's total nutritional needs) to be given continuously over a 24 hour period at 100 ml (milliliters) per hour through a PICC line.</p>	F 328	<p>4. Beginning the week of 8/25/2014 the ADON or designee will complete 3 audits weekly of diabetic residents for nail care and of IV/PICC lines and TPN therapy, when the facility has residents with orders, for 4 weeks then monthly for 2 months and then quarterly thereafter to ensure that podiatry services are provided and documented as needed and nursing care plans are followed, implemented and documented as needed. To ensure baseline assessment for measuring total external catheter length and mid upper arm circumference with intravenous site are monitored for signs and symptoms of infection or dislodgement, and to ensure IV orders are complete to include the rate of the IV infusion, and to ensure TPN orders include 10% Dextrose. A report will be submitted to the Quality Assurance Performance Improvement Committee for three months. The Quality Assurance Performance Improvement Committee will review the results and determine if any further interventions are needed at that time. The ADON or designee will be responsible for continued monitoring.</p> <p>Date of compliance: 9/3/14</p>	9/3/2014	

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F 328	Continued From page 7  According to the MDS, the resident had cognitive impairment and required extensive assistance from staff for ADLs.  On 7/30/14, a nursing note written by Licensed Nurse (LN) C indicated "TPN (parenteral nutrition) pending pharmacy shipment. TPN arrived at 9 pm. It will be ran at midnight to wait for the bag to cool off." No order regarding the 10% dextrose solution was found, it was not clear if the TPN had been stopped abruptly or tapered down.  On 8/14/14 at 12:00 p.m., When asked about the facility policy regarding the 10% dextrose solution, LN A stated "In the last place I worked, it was standard of practice for nurses to administer 10% dextrose solution if the parenteral nutrition had to be stopped for any reason. But we don't do that here unless we have a doctor's order."  At 12:05 p.m., during telephone interview LN C stated "When I came on duty at about 03:00 p.m. on 7/30/14, the TPN bag that was hanging was almost out. I did not have a replacement bag of parenteral nutrition to hang until it was delivered by the pharmacy about 09:00 p.m. The bag was cool and I didn't want to give such cold fluid to the resident so I decided to wait until later to hang it. I think the night nurse hung the new bag of TPN at about midnight. I did not administer any 10% dextrose solution to the resident because we didn't have an order for that." When asked if she was concerned the resident was suddenly removed from the TPN for more than 9 hours, LN C stated "No, the resident was taking a little bit of food orally."	F 328			

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F 328 Continued From page 8  
<Foot Care>  
3) Resident #5 was admitted to the facility on [REDACTED] 10 with diagnoses to include diabetes and high blood pressure. The resident had sustained a fractured hip in 2012. Per the plan of care, the resident was to have nail care by the licensed nurses because of being diabetic.

According to the MDS, the resident was not alert to self, but was independent with activities of daily living.

A review of the record revealed no documentation regarding when or if nail care had been accomplished.

On 8/14/14 at 09:15 a.m., LNA stated the doctor for that resident comes in quarterly. We don't have podiatry care on the standing orders for that resident. Maybe we should."

At 10:10 a.m., the resident's feet and hands were observed to have the nails well trimmed with no concerns identified.

4) Resident #6 was admitted to the facility on [REDACTED] 13 with diagnoses to include [REDACTED] diabetes and high blood pressure. Per the plan of care, the resident was to have nail care by the licensed nurses because of being diabetic.

According to the MDS, the resident was alert and oriented but required physical assistance with ADLs.

A review of the record revealed no documentation regarding when or if nail care had been accomplished.

F 328

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F 328	Continued From page 9  On 8/14/14 at 09:25 a.m., LN G stated "The nurses aides fill out skin sheets whenever they give a shower. The licensed nurse completes a skin assessment once a week. We are not documenting nail care anywhere."  At 09:40, the Director of Nursing was asked how residents requiring podiatry care would be accommodated and he stated "The Business Office Manager keeps a list of residents that need podiatry care. The podiatrist does not leave any notes." When asked how someone would know if a resident had been seen by podiatry, the DNS replied "The podiatrist has a list."  At 12:05 the Business Office Manager stated "I only set up the podiatry appointment. The podiatrist comes about every 3 months. He leaves no notes, we have no information about what the Podiatrist does."	F 328			

9/3/2014