

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

1418

PRINTED: 01/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505210	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF PORT ORCHARD			STREET ADDRESS, CITY, STATE, ZIP CODE 2031 POTTERY AVENUE PORT ORCHARD, WA 98366		
(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 Abbreviated Survey conducted at Life Care Center of Port Orchard on January 9, 2014. A sample of 4 current residents and 1 former resident was selected from a census of 107.</p> <p>The following complaints were investigated. 2921178 2921758 2928048 2934974</p> <p>The survey was conducted by: [REDACTED], R.N., B.S.N., Complaint Investigator The Complaint Investigator was from: Department of Social & Health Services Aging and Long-Term Support Administration/ALTSA Division of Residential Care Services P.O. Box 45819 Olympia, WA 98504-5819 Telephone: 360-664-8432 Fax: 360-664-8451 <i>Thom de D</i> Date: 1/14/14 Residential Care Services</p>	F 000			

RECEIVED
JAN 29 REC'D
DSHS - ADSA
RCS - REGION 5

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Thom de D

Executive Director

1/24/14

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 000	Continued From page 1	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law.	
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</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:</p>	F 157	<p>1. Physician notified of incident related to Resident #2.</p> <p>2. Physician will be notified of incidents similar in nature.</p> <p>3. Staff education will be provided related to timely physician notification of incident and accidents.</p> <p>4. Facility will audit incident reports to ensure timely notification of physician has occurred. This will be reviewed by the IDT team and any non-compliance will be followed up with staff education.</p> <p>Executive Director and Director of Nursing to ensure compliance.</p> <p>Date of Compliance: 1/31/14</p>	

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F 157	<p>Continued From page 2</p> <p>Based on interview and document review the facility failed to ensure timely notification of the physician for 1 of 5 (#2) residents reviewed for accidents. The failure to notify the physician timely after Resident #2 sustained a deep laceration to her lower leg placed the resident at risk for delay of treatment and worsening of medical condition.</p> <p>Findings include:</p> <p>Resident #2 was assessed by facility as being alert and oriented and able to make her needs known. She had diagnosis to include [REDACTED] and used a power wheelchair independently for mobility.</p> <p>In the nursing note written [REDACTED]/13 at 1:07P.M., it stated, "...0945 (9:45A.M.) resident came out of her room in wheelchair with pant leg rolled up, blood noted to be dripping from [REDACTED] leg, laceration noted to [REDACTED] lower extremity 7cm x 14 cm x 1 cm, floor in room covered with puddles of blood. Steri-strips applied as best as possible to site, ABD pads and kerlex applied tight to area. At 11:15A.M. dressing noted to be saturated with blood. Manager on duty in to see wound, puddle of blood noted under resident wheelchair, old dressing removed covered in blood and clots. INR (Resident was on [REDACTED] which is an anti-coagulant. INR is a test to check for clotting time) obtained = [REDACTED] (elevated), blood pressure [REDACTED], dressing reapplied immediately saturated, on call physician made aware, orders to send to emergency room, transferred at 11:45A.M."</p> <p>On 1/9/14 when asked why he did not immediately contact the physician, S-A stated, "I did not realize how deep it was until I had</p>	F 157		

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F 157	Continued From page 3 re-dressed it 3 times." He said he initially did not feel it was emergent which was why he did not inform the physician.	F 157		
F 281 SS=D	Refer to F 309 483.20(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: 1) Based on interview, observation and record review the facility failed to ensure services provided met professional standards of quality for 1 of 5 (#2) residents reviewed. The failure of S-A to recognize an emergent situation, complete a thorough assessment and notify the physician in a timely manner after suffering an injury placed Resident #2 at risk for delay of treatment and decline in medical condition. 2) Based on observation and interview, the facility failed to ensure professional standards of medication management and safety were maintained. When S-A left his medication cart unattended with open medications in reach and in view of residents he placed all residents at risk of harm related to ingestion of incorrect medication. Findings include:	F 281	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law. F 281 1. Resident #2 was assessed, protected from further injury and physician was notified. Medication was secured by a licensed nurse at the cart. 2. All residents with similar incidents and accidents will be assessed immediately and physician will be notified for timely treatment. All medications will be secured in a locked nurse's cart when unattended. 3. In-service will be provided to all licensed nursing staff regarding assessments and physician notification of incidents similar in nature. Education regarding proper securing of medications will also be provided.	

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F 281	<p>Continued From page 4</p> <p>1) Resident #2 was assessed by facility as being alert and oriented and able to make her needs known. She had diagnosis to include paraplegia and used a power wheelchair independently for mobility.</p> <p>In the nursing note written [REDACTED]/13 at 1:07P.M., it stated, "...0945 (9:45A.M.) resident came out of her room in wheelchair with pant leg rolled up, blood noted to be dripping from [REDACTED] leg, laceration noted to [REDACTED] lower extremity 7cm x 14 cm x 1 cm, floor in room covered with puddles of blood. Steri-strips applied as best as possible to site, ABD pads and kerlex applied tight to area. At 11:15A.M. dressing noted to be saturated with blood. Manager on duty in to see wound, puddle of blood noted under resident wheelchair, old dressing removed covered in blood and clots. INR (Resident was on [REDACTED] which is an anti-coagulant. INR is a test to check for clotting time) obtained = [REDACTED] (elevated), blood pressure [REDACTED], dressing reapplied immediately saturated, on call physician made aware, orders to send to emergency room, transferred at 11:45A.M."</p> <p>On 1/9/14 when asked why he did not immediately contact the physician, S-A stated, "I did not realize how deep it was until I had re-dressed it 3 times." He said he initially did not feel it was emergent which was why he did not inform the physician.</p> <p>Despite the fact the resident was bleeding uncontrollably, and was on [REDACTED] which could cause increased bleeding S-A did not, according to his documentation check the resident again until after 90 minutes had passed. He did not complete a thorough assessment and did not notify the physician per his own</p>	F 281	<p>4. Facility will audit incident reports to ensure proper assessment was completed and timely notification of physician has occurred. This will be reviewed by the IDT team and any non-compliance will be followed up with staff education. Audits will be conducted by nurse management team of nursing cart to ensure medications are stored securely.</p> <p>Executive Director and Director of Nursing to ensure compliance.</p> <p>Date of Compliance: 1/31/14</p>	

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F 281	<p>Continued From page 5</p> <p>admission because he did not feel it was emergent until after he had re-dressed it 3 times, only then realizing how deep it was.</p> <p>Refer to F309</p> <p>2) According to Fundamentals of Nursing, 7th Edition 2011, p. 739 to maintain safety, "After beginning to prepare drugs for administration, do not leave them unattended. If it is imperative to leave for a short time, place the drugs that have been prepared in a locked area, such as in the medication cart."</p> <p>On 1/9/14 at approximately 0930 this investigator noted a medication cart left unattended in the hallway outside a resident room. The medication cart had on it an open medication book with resident information in view. Also on the cart was a medication cup with medication in it. The cup was not labeled and the medication was not in any packaging. This investigator waited approximately 5 minutes for the nurse to return. When asked what was wrong with the cart, S-A said, "Oops, sorry" and indicated the medication should not have been left on the cart. When asked why it had been left out he replied, "I was called away for an emergency." S-A did state he should not have left the medication on the cart but should have returned it to the drawer or taken it with him. He did not have any explanation as to why he did not do what he should have done.</p> <p>Refer to F323</p>	F 281	
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F 309 Continued From page 6
F 309 483.25 PROVIDE CARE/SERVICES FOR
SS=G 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.

F 309
F 309

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law.

F 309

This REQUIREMENT is not met as evidenced by:
Based on interview and document review the facility failed to provide the necessary timely assessment, care and services in response to trauma for 1 of 5 (#2) Residents when Resident #2 suffered uncontrolled bleeding after sustaining a laceration to her [redacted] leg. This failure to timely, thoroughly assess and notify the physician led to Resident #2 being hospitalized with low [redacted] [redacted], needing a [redacted] and surgical intervention for the [redacted] on her leg.

Findings include:

Resident #2 was assessed by facility as being alert and oriented and able to make her needs known. She had diagnosis to include [redacted] and used a power wheelchair independently for mobility. She was on medications to include [redacted] (anti-coagulant).

In the nursing note written [redacted] 13 at 1:07P.M., it stated, "...0945 (9:45A.M.) resident came out of her room in wheelchair with pant leg rolled up, blood noted to be dripping from [redacted] leg, laceration noted to [redacted] lower extremity 7cm x 14 cm x 1 cm,

1. Resident #2 was assessed, protected from further injury and physician was notified. Incident was investigated and care plan revised.
2. All residents with similar incidents and accidents will be assessed immediately and physician will be notified for timely treatment.
3. In-service will be provided to all licensed nursing staff regarding assessments and physician notification of incidents similar in nature.
4. Facility will audit incident reports to ensure proper assessment was completed and timely notification of physician has occurred. This will be reviewed by the IDT team and any non-compliance will be followed up with staff education.

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F 309	<p>Continued From page 7</p> <p>floor in room covered with puddles of blood. Steri-strips applied as best as possible to site, ABD pads and kerlex applied tight to area. At 11:15A.M. dressing noted to be saturated with blood. Manager on duty in to see wound, puddle of blood noted under resident wheelchair, old dressing removed covered in blood and clots. INR (test to check for clotting time) obtained = [REDACTED] (elevated), blood pressure [REDACTED], dressing reapplied immediately saturated, on call physician made aware, orders to send to emergency room, transferred at 11:45A.M."</p> <p>There was no evidence to support there was any assessment done of the resident between 9:45A.M. and 11:15A.M. even though the resident was on [REDACTED], which could make bleeding worse, and documentation indicated blood had been "dripping" down her leg and there were "puddles of blood" in her room. There was no indication a blood pressure had been obtained at the time of injury or the physician had been notified.</p> <p>In an interview with S-A on 1/9/13, he stated staff had come to tell him the dressings were saturated. When asked why he did not immediately contact the physician, S-A stated, "I did not realize how deep it was until I had re-dressed it 3 times." He said he initially did not feel it was emergent which was why he did not inform the physician.</p> <p>According to the physician notes written [REDACTED]/13 after the resident returned to the facility, the resident had been sent to the emergency room where she was noted to have significant amount of bleeding from the leg. The wound was an [REDACTED] type of wound ([REDACTED] away) with</p>	F 309	<p>Executive Director and Director of Nursing to ensure compliance.</p> <p>Date of Compliance: 1/31/14</p>	
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F 309	Continued From page 8 active arterial bleeding. It was also noted she was hypotensive (blood pressure low) and was started on a [REDACTED] drip (to prevent blood pressure from dropping further and patient going into shock). She received 4 units of plasma. She had to have surgical debridement of the wound and a subsequent skin graft.	F 309	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of federal and state law.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure medications were safely secured. This failure to safely secure medications caused an unsafe environment and placed residents at risk for potential harm from ingestion of inappropriate medications. Findings include: On 1/9/14 at approximately 0930 this investigator noted a medication cart left unattended in the hallway outside a resident room. The medication cart had on it an open medication book with resident information in view. Also on the cart was a medication cup with medication in it. The cup was not labeled and the medication was not in any packaging. This investigator waited	F 323	F 323 1. Medication was secured by a licensed nurse at the cart to ensure safety of all residents. 2. All medications will be secured in a locked nurse's cart/medication room when unattended. 3. Education regarding proper securing of medications will be provided. 4. Audits will be conducted by nurse management team of nursing cart to ensure medications are stored securely. Executive Director and Director of Nursing to ensure compliance. Date of Compliance: 1/31/14	

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F 323	Continued From page 9 approximately 5 minutes for the nurse to return. When asked what was wrong with the cart, S-A said, "Oops, sorry" and indicated the medication should not have been left on the cart. When asked why it had been left out he replied, "I was called away for an emergency." S-A did state he should not have left the medication on the cart but should have returned it to the drawer or taken it with him. He did not have any explanation as to why he did not do what he should have done.	F 323		