

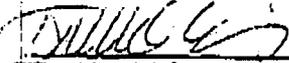
DEPARTMENT OF HEALTH AND MAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

1424

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505239	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 06/25/2013
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NAME OF PROVIDER OR SUPPLIER  PARK ROSE CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3919 SOUTH 18TH STREET TACOMA, WA 98405
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(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
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Park Rose Care Center on June 25, 2013. A sample of 5 residents was selected from a census of 106.</p> <p>The following complaints were investigated. 2806225 2810347 2810352 2825759</p> <p>The survey was conducted by:  [REDACTED] R.N., B.S.N., Complaint Investigator The Complaint Investigator was from:  Department of Social &amp; Health Services  Aging and Long-Term Support Administration/AL TSA  Division of Residential Care Services  P.O. Box 45819  Olympia, WA 98504-5819  Telephone: 360-664-8432  Fax: 360-664-8451   Date: <u>6/28/13</u> Residential Care Services</p>	F 000	<p>This Plan of Correction is being submitted in compliance with specific regulatory requirements. Neither its completion nor contents should be construed as an admission by this provider of the validity of any findings or citations contained herein.</p>	<p style="text-align: right;">RECEIVED JUL 09 2013 DSHS - WA HOS - REGION 5</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  	TITLE  Administrator	(X6) DATE  7/8/13
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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 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the standards of professional practice were maintained for medication administration monitoring, assessment and following physician orders for 2 of 6 (#'s 3 &amp; 4) residents reviewed. The failure to monitor and assess a resident and report the results of a medication hold to the physician placed the resident at risk of receiving un-necessary medication. The failure to obtain laboratory test and current medication orders placed the resident at risk for the incorrect dose of the medication and increased risk of bleeding or blood clots.</p> <p>Findings include: Interviews took place 6/25/13</p> <p>According to Fundamentals of Nursing, Lippincott, Williams, &amp; Wilkins, 7th Edition 2011, page 723: The nursing process can be applied to medication administration. Assessment includes a comprehensive medication history, awareness of the patient's allergies, and patient assessment, as well as ongoing assessments of the patient's response during and after medication administration. Nursing diagnoses are developed from the assessment data. Patient centered outcomes are evaluated after implementation of the plan of care and are tailored to the patient's</p>	F 281	<p>Ftag 281</p> <p>Resident #3 was losing weight. Resident's weight continues to be monitored weekly. Remeron was discontinued on 6/25/13. Resident # 4 INR was rechecked 6/25/13.</p> <p>Residents who have held medication and on Coumadin have been reviewed and staff in serviced.</p> <p>All held medications will be put in the flipbook tool by Resident Care Manager and the medication will be followed up on the last day of being held if applicable.</p> <p>All INR orders will be put in the flipbook tool by Resident Care Manager and verified by the Director of Nursing for completion.</p> <p>Resident Care Manager to report trends to Director of Nursing and Director of Nursing to report to QA committee monthly</p>	7-17-13

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F 281	<p>Continued From page 2</p> <p>needs. Page 326: Documentation is the record of pertinent interactions with the patient- assessing, diagnosing, planning, implementing and evaluating.</p> <p>The Fundamentals of Nursing, 7th Edition, (Taylor, Lillis &amp; LeMone), 2011 page 732 documented no medication may be given to a patient without a medication order from a licensed practitioner.</p> <p>According to 2006 Lippincott's Nursing Drug guideline, page 1228. When administering Coumadin (anti-coagulant) there must be regular monitoring of the INR (time it takes blood to clot) to adjust the dosage and evaluate the drugs' effect.</p> <p>Resident #3 had diagnoses to include [REDACTED]. She had physician orders to include [REDACTED] for [REDACTED] and [REDACTED] for [REDACTED].</p> <p>It had been reported to the physician Resident #3 had been gaining weight. On 5/30/13, the physician ordered the [REDACTED] be held for 7 days, monitor the resident's weight and report to the physician at the end of the 7 days. At the end of the 7 days, the [REDACTED] was re-started and there was no documented evidence the physician had been notified of the resident's weight or the fact the [REDACTED] was re-started.</p> <p>Review of the medical record indicated the resident did not have any weight change during the 7 days the [REDACTED] was held. There was no documentation of assessment of appetite or change in amount the resident ate.</p>	F 281		

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F 281	<p>Continued From page 3</p> <p>Resident #3 was observed around 1030a.m. in her room. She was in no obvious distress and voiced no concerns to this Investigator during an interview regarding her care and treatment.</p> <p>When interviewed, S#D stated whenever there was any kind of medication change, the resident was to be assessed every shift for at least 72hours.</p> <p>When interviewed, S#A could not determine if physician had been notified and went to S#B and S#C. Their determination was the physician had not been notified and the staff had completed a medication error for re-starting the [REDACTED] without physician notification. They stated the physician would be notified immediately and staff education provided.</p> <p>Resident # 4 had history of a [REDACTED] and had [REDACTED]. He had physician orders for [REDACTED] ([REDACTED]).</p> <p>There was a physician order to recheck the INR (lab test to determine amount of [REDACTED] to receive) on 6/15/2013.</p> <p>Review of medical record indicated the resident did not have his INR checked on 6/15/2013 as ordered. Named Resident continued to receive [REDACTED] without a current order.</p> <p>When interviewed S#B stated she did not know what happened. She said they had recently switched to computer and some stuff got missed. She had not realized the INR had not been obtained and could not state how she would or if</p>	F 281		
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F 281	Continued From page 4 she would have determined it had not been done if not brought to her attention. S#B stated she would start the process of notifying the physician and correcting the medication error.	F 281			
F 333 SS=D	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 observation, document review and interview, the facility failed to ensure residents were free of medication errors for 2 of 6 (#'s 3 & 4) residents reviewed when they failed to monitor and assess the residents for changes related to medication hold and/or carry out laboratory orders and notify the physician of the results. This failure to ensure assessments were completed, laboratory orders were carried out and the results communicated to the physician put the residents at risk for receiving un-necessary medication or the wrong dose of medication and placed them at risk for complications.  Findings include:  All interviews took place 6/25/2013  Resident #3 had diagnoses to include [REDACTED] She had physician orders to include [REDACTED] for [REDACTED] and [REDACTED] for appetite.  It had been reported to the physician Resident #3 had been gaining weight. On 5/30/13 the physician ordered the [REDACTED] be held for 7	F 333			

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F 333	<p>Continued From page 5</p> <p>days, monitor the resident's weight and report to the physician at the end of the 7 days. The [redacted] was re-started after 7 days.</p> <p>Resident #3 was observed in her room around 1030a.m. She was in no obvious distress and voiced no concerns to this investigator during an interview regarding her care and treatment.</p> <p>Review of the medical record indicated the resident did not have any weight change during the 7 days the [redacted] was held. There was no documentation of assessment of appetite or change in amount the resident ate. There was no indication the physician was notified. According to the Medication Administration Record, the staff re-started the [redacted] after the 7 days.</p> <p>When interviewed, S #D stated whenever there was any kind of medication change, the resident was to be assessed every shift for at least 72 hours.</p> <p>When interviewed, S #A could not determine if physician had been notified and went to S #B and S #C. Their determination was the physician had not been notified and the staff had completed a medication error for re-starting the [redacted] without physician notification. They stated the physician would be notified immediately and staff education provided.</p> <p>Resident # 4 had history of a [redacted] and had [redacted]. He had physician orders for [redacted] ([redacted]).</p> <p>There was a physician order to recheck the INR (lab test to determine amount of [redacted] to</p>	F 333	<p>Ftag 333</p> <p>Resident #3 was losing weight. Resident's weight continues to be monitored weekly. Remeron was discontinued on 6/25/13. Resident # 4 INR was rechecked 6/25/13.</p> <p>Residents who have held medication and on Coumadin have been reviewed and staff in serviced.</p> <p>All held medications will be put in the in the flipbook tool by Resident Care Manager and the medication will be followed up on the last day of being held if applicable.</p> <p>All INR orders will be put in the flipbook tool by Resident Care Manager and verified by the Director of Nursing.</p> <p>Resident Care Manager trends to report to Director of Nursing and Director of Nursing to report to QA committee monthly</p>	7-17-13

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F 333	<p>Continued From page 6 receive) on 6/15/2013.</p> <p>Review of medical record indicated the resident did not have his INR checked on 6/15/2013 as ordered. Named Resident continued to receive [REDACTED] without a current order.</p> <p>When interviewed S #B stated she did not know what happened. She said they had recently switched to computer and some stuff got missed. She had not realized the INR had not been obtained and could not state how she would or if she would have determined it had not been done if not brought to her attention. S #B stated she would start the process of notifying the physician and correcting the medication error.</p>	F 333		