

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

PRINTED: 04/23/2013
FORM APPROVED
OMB NO. 0938-0391

1429

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505362	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/18/2013
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NAME OF PROVIDER OR SUPPLIER FOREST VIEW TRANSITIONAL HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5129 HILLTOP ROAD EVERETT, WA 98203
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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>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Forest View Transitional Health Center on 04/16/13 and 04/18/2013. A sample of 3 current residents and 1 former resident were selected from a census of 51 residents.</p> <p>The following complaints were investigated as part of this survey:</p> <p>complaint #2783851</p> <p>The survey was conducted by:</p> <p>[REDACTED], RD, MS</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging & Disability Services Administration Residential Care Services, Region 3, Unit B 3906 172nd Street NE, Suite 100 Arlington, WA 98223</p> <p>Telephone: (360) 651-6850 Fax: (360) 651-6940</p> <p><i>[Signature]</i> 4/23/13 Residential Care Services Date</p>	F 000	<p>RECEIVED MAY -6 2013 ADSA/RCS Smokey Point</p>	5-17-13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>William D. [Signature] RN</i>	TITLE ONS	(X6) DATE 5-2-13
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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 329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that one of three residents reviewed was free of unnecessary medications. Failure to implement changes in Resident # 1's medication regime placed the resident at risk for complications associated with unnecessary drugs.</p>	F 329		
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NAME OF PROVIDER OR SUPPLIER FOREST VIEW TRANSITIONAL HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5129 HILLTOP ROAD EVERETT, WA 98203		
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F 329	<p>Continued From page 2</p> <p>Findings include:</p> <p>Resident # 1 was admitted to the facility on [REDACTED]/13 with multiple diagnosis and had a history of falls. The clinical record found on 03/13/13 the resident was transported to the hospital after the staff noted a change in condition. The resident was admitted to the hospital and remained until 03/20/13. The active problem listed indicated the resident had [REDACTED] of the leg or [REDACTED].</p> <p>Review of the "Skilled Nursing Facility Transfer Orders" provided to the facility found two of the medications the resident was receiving prior to being hospitalized were discontinued. The discharge instructions said to stop taking 75 mg of "[REDACTED]" and a sleep aide 15 mg of "[REDACTED]". The discharge orders noted two new medications and included "[REDACTED]" which is also a blood thinner, and "[REDACTED]" an anti-psychotic medication which were implemented. Nor was there any evidence the nursing home physician altered any of the admission orders.</p> <p>Although discharge orders indicated the resident should stop taking the two medications the facility continued to dose each one, until the resident was hospitalized again on 03/31/13 after the resident fell. During the hospitalization a stent was placed to treat the blood clots in the leg. According to the discharge summary, "[REDACTED]" therapy was discontinued and [REDACTED] was restarted.</p> <p>On 4/18/2013 during an interview the Director of Nursing Services was asked about the admission</p>	F 329	<p>Resident 1 is now receiving Medications that reflect current physician orders.</p> <p>All residents that have been Readmitted from the hospital have Had their orders reviewed. Their Medications reflect current physician Orders.</p> <p>Resident Care managers and staff Nurses have been re-inserviced on Having two nurses check orders and both co-sign all re-admission orders and all new admission ordes.</p> <p>Audits will be done for one month on all readmissions and all new admissions to verify correct medication are given per physician orders. Then findings will be presented to monthly quality improvement meeting.</p> <p>Director of Nursing to monitor.</p>	5-17-13	

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F 329	Continued From page 3 orders. He stated he was not certain why the hospital discharge orders were followed. He stated the Nurse who re-admitted the resident missed the stop orders for the two medications. He reported at the time of the interview that he was not aware of the medication error and could not explain why the medication was administered. Review of the March Medication Administration record showed that even though the hospital discharge instructions indicated two medications which should have been discontinued were administered for 11 days without a physician order. This increased the risk for health complications associated with uncontrolled bleeding.	F 329			