

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

PRINTED: 02/19/2013  
FORM APPROVED  
OMB NO. 0938-0391

1439

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505431	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 01/24/2013
NAME OF PROVIDER OR SUPPLIER  BOTHELL HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 707 - 228TH SOUTHWEST BOTHELL, WA 98021	
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F 000	<p>INITIAL COMMENTS</p> <p>This report is a result of an unannounced Abbreviated Survey conducted at Bothell Healthcare on 02/06/2013 and 02/08/2013. A sample of 10 current and 7 discharged residents was selected from a census of 81. The following complaints were investigated as a part of this survey:</p> <p># 2744540 #2745465</p> <p>The survey was conducted by: [REDACTED] RN, BSN</p> <p>The survey team is from: Department of Social and Health Services Aging and Disability Services Administration Residential Care Services 20425 72nd. Ave. S, Suite 400 Kent, WA 98032-2388 Phone: 253-234-6083 Fax: 253-395-5070</p> <p><i>Delores Underwood</i> 2-19-2013 Residential Care Services Date</p>	F 000	<p><u>DISCLAIMER CLAUSE</u> PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE 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.</p>	

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

TITLE

(X8) DATE

*Delores Underwood*

Administrator

2/26/13

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.

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F 333 SS=H	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to have a system in place to ensure facility and pharmacy staff identified allergies that could place the residents at risk of significant harm. Resident # 7 and # 8 were given medications that they were known to have allergies to, this caused resident #8 to have an adverse drug reaction and placed him/her at risk for significant side effects, decreased medication benefit, worsening of their condition, and overall decreased quality of life. Additionally, the facility failed to ensure that residents were free of significant medication errors for 5 (Residents #11, 12, 13, 15) of 13 residents sampled for medication administration.</p> <p>Findings include: Upon review of the facility medications incident reports, the following were identified that indicate significant system breakdown. Resident #8</p> <p>Resident #8 was admitted to the facility with [REDACTED] and [REDACTED]. The hospital transfer records revealed the Resident had multiple drug allergies including [REDACTED], an antibiotic. On 04/22/2012 the physician ordered [REDACTED] 500mg twice a day for treatment of a</p>	F 333	<p><b>F-333</b> <b>Correction as it relates to the resident:</b> Resident #8 – The License Nurse receiving the order and administering the medication gave one dose of Cipro on 4/22/2012. The License Nurse immediately recognized her error, notified the resident, physician, and the family. The physician ordered Benadryl 25mg for any adverse reactions. Resident received three doses of Benadryl for minor itching on 4/22/12, 4/23/12 and 4/24/12. Resident had no lasting ill effects. Resident remains in the facility.</p> <p>Resident # 7 – Resident was admitted on 12/31/2012. Transfer hospital information lists allergy to statin with the following note, "listed allergy states with high doses. This is a low dose. Patient also takes statin at home without complications. OK to administer in hospital. This was verified by the hospital pharmacist" Resident received Crestor 5mg. during her hospital stay. The hospital transfer medication list included Crestor 5mg q day. On 1/1/13 the license nurse noted the resident allergies and discussed with MD and the resident. The resident stated she tolerates Crestor ½ tablet daily at home. Daughter also verified that resident has medication at home. As a precaution Crestor was discontinued on 1/4/2013. No side effects related to statins. Resident was discharged on 1/14/2013.</p>	

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F 333	<p>Continued From page 2.</p> <p>██████████. There was no documentation of the time the order was received and what staff member accepted the order.</p> <p>The Resident was given one dose of Cipro on 04/22/2012 and developed a rash to her face along with itching. She then required treatment with ██████████ (an ██████████ medication used for ██████████). Her allergies were not listed on her medication administration record. This facility staff failed to check the Resident's allergies and gave the Resident a medication that she was allergic to, placing the Resident at risk for a severe allergic reaction.</p> <p>Resident #7</p> <p>Resident # 7 was admitted to the facility with ██████████ and recent ██████████. Records revealed the Resident was allergic to "statins" which are medications used to decrease cholesterol levels in the blood. The this allergy, along with others, was noted on the transfer records from the hospital and on the MAR.</p> <p>On 12/31/2012 the physician wrote an order for ██████████ (a statin drug) 5mg. daily. Documentation on the MAR revealed the Resident received this medication for 5 days before the error was discovered. The facility failed to check the Resident's allergies and gave the Resident a medication that she was allergic to, placing the Resident at risk for an allergic reaction.</p> <p>Resident #10</p>	F 333	<p>Resident #10 – Flomax was not given as ordered on the 12/19/12, 12/20/12, 12/21/12, 12/22/12 and 12/23/12. Per facility policy on new admissions post void residuals were done. Resident #10 post void residual for 12/19/12, 12/20/12 and 12/21/12 were zero and he denied discomfort with voiding. Resident #10 was discharged to home with no adverse side effects with voiding.</p> <p>Resident #11- medication error occurred 11/24/12. Resident received the wrong antibiotic. Correct antibiotic was ordered 12/3/12. Potential adverse symptoms did not occur with this resident. Resident remains in the facility C Diff was resolved 12/16/12.</p> <p>Resident #12 – Resident's Atorvastatin 40mg to be given each night was missed on the recapitulation from December 2012 to January 2013. Seven doses were omitted. Resident was discharged home on 2/7/13 with no adverse effects.</p> <p>Resident #13 – Order to hold Coumadin 12/17/12 and recheck INR on 12/18/12 was not followed through. Resident continued to receive Coumadin for four additional doses. Resident did not have any signs or symptoms of bleeding. Resident was discharged home on 1/3/2013 with no adverse effects.</p> <p>Resident #15 - Resident was discharged home on 2/4/13 with no adverse effects. She continued on anticoagulant therapy with follow up at an anticoagulant clinic after discharge.</p>	

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F 333	<p>Continued From page 3</p> <p>Resident # 10 was admitted to the facility with [REDACTED] and [REDACTED]. The Resident also suffered from an [REDACTED] which made it difficult for him to [REDACTED] and empty his bladder. The Resident was prescribed [REDACTED] a medication used to treat [REDACTED] to be taken daily. The order was written on 12/18/2012 and records show the medication was delivered to the facility on that date. The medication was on the MAR to be given at 08:00 AM. A review of the MAR revealed the medication was not given from 12/18-23/2012 resulting in 4 missed doses. This facility staff did give the medication that was ordered, resulting in the potential to cause the Resident to suffer discomfort and [REDACTED] urinating.</p> <p>Resident #11</p> <p>Resident #11 was admitted to the facility with [REDACTED], [REDACTED], and [REDACTED]. He was assessed to be at risk for malnutrition, dehydration, skin breakdown, and received all nutritional support and medications via a [REDACTED] (a [REDACTED] inserted into the [REDACTED]).</p> <p>On 11/15/2012 a stool sample revealed the resident had C.diff ([REDACTED] difficile, a bacterial infection causing severe [REDACTED] and potentially life threatening complications). Records revealed the Resident was having loose stools and had an excoriation on his buttocks. On 11/24/2012 an LN (licensed nurse) took a phone order from the physician which was written as "[REDACTED]" (an antibiotic) 500 mg. TID (three</p>	F 333	<p><b>Action taken to protect residents in similar situations:</b></p> <p>All current residents' allergy statements were audited to current medication and dietary orders. Allergy statements are listed on the physician orders, MAR, TAR, face sheet and an allergy sticker is on the resident's chart. When notifying physicians verbally and in writing allergies are read and verified. Allergy statement has been added to the admission assessment. These will be reviewed and verified with resident/resident responsible party. New fax sheet has been initiated to specifically list allergies. Daily audit of new orders will include allergy review. Current residents' medical records were recapped. The physician orders including medication administration records/treatment administration records were reviewed to assure accuracy of orders, labs, diets, and allergies.</p> <p><b>Measures taken or systems altered to ensure problem does not recur:</b></p> <p>On February 6, 2013 the facility instituted a 24 hour audit on all current resident medical records to verify that all orders have been processed.</p> <p>On February 6, 2013 the facility instituted a daily audit of all Telephone Orders/Physician Orders comparing them to what is on the Medication administration record(MAR) and the Treatment administration record(TAR). Any orders for lab/xray are compared to what is in the lab/xray book to verify orders were processed.</p>	

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F 333	<p>Continued From page 4</p> <p>times a day) for 14 days per tube feeding for C.diff. " (██████s not used to treat C.diff and can make the infection worse). Records revealed the Resident received 17 doses of ██████. The Resident continued to suffer from loose stools.</p> <p>On 12/03/2012 the physician wrote on a lab slip " not correct. ██████ TID was never ordered. " The order was then changed to ██████ (one of the two ██████s used to treat C.diff) for 14 days. The facility staff did not administer the correct antibiotic, causing a delay in treating the Resident's infection. According to the Mayo Clinic's most recent data related to C.diff treatment, untreated C.diff infections place residents at risk of dehydration, ██████, and ██████ (distension of the bowel when it is unable to pass gas or stool, which can result in bowel perforation).</p> <p>Resident #12</p> <p>Resident # 12 was admitted with heart disease, ██████, ██████, and a ██████. The Resident was ordered to have ██████ (a medication that lowers ██████ and helps prevent ██████ with ██████ action) 40 mg. each night. The medication was ordered on 11/26/2012. Records revealed that during the recapitulation of orders from December 2012 to January 2013 the " time code was omitted on the MAR by the Health Information Manager, Staff L. Staff I checked the orders and also failed to find the error. " Two evening nurses, Staff J and K also missed the order and failed to administer the medication. As a result of this significant error, the Resident missed 7 doses of the medication. The facility</p>	F 333	<p>On February 6, 2013 the facility initiated the process where the nurse receiving the order was responsible for following the order through completion.</p> <p>February 8, 2013 The facility instituted a 2 nurse process to review all new orders with medication and treatment sheets during shift to shift report. The facility initiated the "read and verify" process on all orders from physicians or practitioners. Nurses were in serviced to reeducate them on the acceptable guidelines for telephone and verbal orders. Which includes "verify that an order was transcribed correctly, verify the accuracy of the MAR and make sure that your client's MAR corresponds exactly with the prescriber's order. All errors have been identified and analyzed for factors that may have caused the errors. Personnel corrective action has occurred as appropriate. Facility will follow the decision tree and Medication Errors F Tag for "potential for" significant errors. Any errors rising to this level will be reported to the hotline as required. All medication errors are reported to Director of Nursing for corrective action.</p>		

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F 333	<p>Continued From page 5</p> <p>staff did not give the medication that was ordered, which placed the Resident at risk for harmful effects related to his [REDACTED]</p> <p>Resident #13</p> <p>Resident # 13 was admitted to the facility with [REDACTED] (a [REDACTED] disorder that can result in the formation of blood clots), and [REDACTED]. The Resident required [REDACTED] (a blood thinning agent) 3.5 mg. (milligrams) per day.</p> <p>On 12/17/2012 the Resident had an INR (a measure of the blood clotting ability) of 3.7 (therapeutic level is 2.0-3.0). The physician wrote an order to hold the 12/17/2012 dose of [REDACTED] and to recheck an INR on 12/18/2012. Records revealed the INR was not checked on 12/18/2012 and the Resident continued to receive [REDACTED] on 12/17-12/20/12 for four additional doses. On 12/20/2012 the INR was 4.33. This facility staff did not hold the [REDACTED] as ordered, placing the Resident at risk for bleeding.</p> <p>Resident #15</p> <p>Resident #15 was admitted with [REDACTED] and [REDACTED]. She was assessed to be high risk for blood clot formation in her legs and was prescribed [REDACTED] 18,000 units daily by injection to prevent clot formation. Records revealed the Resident failed to receive [REDACTED] as ordered on 01/25-01/27/2013. The facility staff did not administer the [REDACTED] as ordered, placing the Resident at risk for blood clot</p>	F 333	<p><b>Plans to monitor performance to ensure solution is sustained.</b></p> <p>Nursing management will conduct ongoing audit of allergy statements to current medications monthly. Quality Assurance nurse will present the results to Continuous Quality Improvement committee for three months. Nursing management will continue ongoing 24hr audit and the daily audits of physician orders and telephone orders. Quality Assurance nurse will analyze trends and submit to Continuous Quality Improvement Committee monthly.</p> <p>2 Nurse shift to shift review of the Medication administration records/Treatment administration records will continue.</p> <p>Staff Development Nurse will in service License Nurses on medication processes monthly for 3 months.</p> <p><b>Person Responsible for Compliance:</b> Director of Nursing will maintain compliance.</p> <p><b>Date of Compliance:</b> February 28, 2013</p>	2/28/13

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F 333	<p>Continued From page 6 formation.</p> <p>On 02/06/2013 at 11:30 AM, Staff C, Assistant Director of Nursing, stated that the RCM 's (Resident Care Managers) check all orders the next day and two nurses check the MAR to ensure that it is correct.</p> <p>On 02/06/2013 in an interview with Staff F, LN (licensed nurse), RCM at 11:00 AM, she stated that the new orders get on the MAR either by the RCM or the LN who is assigned to that resident. When asked how she verifies that the orders are transcribed correctly onto the MAR she stated " you have to trust the nurses. " She verified there is no 24 hour chart check process to verify orders. She stated that sometimes she puts the order on the MAR and sometimes she just gives the yellow carbon copy to the nurse to do it. She stated that the Health Information staff put the orders into the computer. She verified that the person who does this is not a nurse or a pharmacist.</p> <p>On 02/06/2013 when asked how orders are transcribed, both Staff J and K, LN 's stated that sometimes the RCM transcribes the order and sometimes they transcribe the orders themselves. They stated that the process is different on the evening and night shift because the RCM is not there. Both verified that there was no consistent process to check orders for accuracy.</p> <p>On 02/06/2013 at 4:30 PM, in an interview with Staff A,B, C and I, they stated that according to their investigations, these medication errors were</p>	F 333		

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F 333	<p>Continued From page 7.</p> <p>not significant because none of the residents had suffered actual harm. They verified that none of these errors had been reported.</p> <p>In an interview with Staff B on 02/08/2013, when asked about the facility policies and procedures for medication administration, she stated the facility uses the text Nursing Interventions and Clinical Skills, 4th Edition, by Elkin, Perry and Potter. A review of the text revealed that professional nursing practice requires that nursing staff " verify that an order was transcribed correctly ", verify the accuracy of the MAR, and " make sure that your client ' s MAR corresponds exactly with the prescriber ' s order " , along with other medication administration requirements. The text goes on to say that " when repeated medication errors occur within a work area, identify and analyze the factors that may have caused the errors and take corrective action. "</p> <p>In each case, the facility failed to implement a medication pass system that could prevent these errors that could cause the resident discomfort or jeopardize their health and safety. The facility also failed to establish why the errors had occurred and failed to formulate a plan of corrective action to prevent further errors.</p>	F 333			