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

PRINTED: 03/05/2013
FORM APPROVED
1440 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505469		C 03/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TERRACES AT SKYLINE	715 9TH AVENUE SEATTLE, WA 98104

(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	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Survey conducted at The Terraces at Skyline on 03/04/13. A sample of five residents was selected from a census of 30. The following complaints were investigated: #2762837 The survey was conducted by: [redacted] MN, RN The survey team is from: Department of Social and Health Services Aging & Disability Services Administration Residential Care Services, District 2, Unit D 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388 Telephone: (253) 234-6004 Fax: (253) 395-5070 Lois Ramm 3/6/13 Residential Care Services Date	F 000	The Plan of Correction is submitted as required under State and Federal Law. The submission of this Plan of Correction does not constitute an Admission on the part of The Terraces at Skyline as to the accuracy of the Surveyor's findings nor the conclusions drawn there from. The submission of this Plan of Correction does not constitute an admission that the scope and severity of the findings are correctly applied. RECEIVED MAR 18 2013 DSHS/ADSA/RCS Kent	Completion Date for all 4-3-2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Jane Whitaker — Interim Health Service Dir — 3/15/13

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 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This LEVEL B is not met as evidenced by: Based on interview and record review the facility failed to provide pharmaceutical services which ensured accurate administration of medications for four (#s 1, 3, 4 & 5) of five residents reviewed. The facility failed to administer medications according to physician's orders, accurately transcribe/clarify/document dispensation of medications, and/or ensure availability of medication. These failures resulted in residents being over/undermedicated as a result of medication errors, and placed residents at risk for elevated blood pressure, cardiac complications,	F 425	**The Plan of Correction is submitted as required under State and Federal Law. The submission of this Plan of Correction does not constitute an Admission on the part of The Terraces at Skyline as to the accuracy of the Surveyor's findings nor the conclusions drawn there from. The submission of this Plan of Correction does not constitute an admission that the scope and severity of the findings are correctly applied.**	Completi Date for a 4-3-2013

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NAME OF PROVIDER OR SUPPLIER: THE TERRACES AT SKYLINE

STREET ADDRESS, CITY, STATE, ZIP CODE: 715 9TH AVENUE, SEATTLE, WA 98104

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F 425	Continued From page 2 and unmanaged constipation. Additionally, failure to notify the physician of abnormal labs placed Resident #2 at risk for delayed treatment. Findings include: In an interview on 03/04/13 at 10:20 a.m., Staff B (RCM- Resident Case Manager) indicated it was facility practice that for all new admissions, two nurses should check to ensure accuracy of Physician Orders (POs). Staff B further indicated, for all new Telephone Orders (TOs) obtained after admission, the night shift nurse was responsible for reviewing and ensuring accuracy. Staff B indicated staff documented this review via the "24 hour chart review" form located in each resident's chart. RESIDENT #1 Record review revealed Resident #1 was admitted to the facility on [redacted]/13 with multiple medically complex diagnoses. According to admission POs, the resident was to receive, "[redacted] 81 mg ect (enteric coated) one tab each day PRN (as needed) [redacted]. Staff transcribed this order as "[redacted] 81 mg ect each day for [redacted] ([redacted]s) [redacted])." When asked, in an interview on 03/04/13 at 10:50 a.m., when the [redacted] would be administered, Staff D (Medication Nurse) indicated the order was unclear and that "[redacted] is usually given for [redacted]" and that medication for DVTs are usually given daily.	F 425	**F-425 Pharmaceutical SVC-** **Accurate Procedures** **Resident#1, Aspirin orders were clarified and corrected, diagnosis for use is for cardiac prophlaxis. MD and Family were notified of The missed Vit.D order on 3-1-13. His Vit.D was resumed on 3-8-13 Weekly. In regards to his Tylenol Order, this medication was Clarified to include pain scale. LN Was educated to need to complete Pain assessment prior to administering Pain medication. His previous Tylenol Order was discontinued and he was Started on routine Tylenol at HS However Resident continues to Refuse this medication, Resident Denies any pain or discomfort.**	

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F 425	Continued From page 3 Staff E, the facility's Advanced Registered Nurse Practitioner, upon reviewing the order on 03/04/13 stated, "That doesn't make sense" and directed staff to administer the aspirin, "(every day) for [redacted]s." Failure to accurately transcribe and/or obtain clarification for unclear POs placed this resident at risk for medication errors. Review of March 2013 MARs (Medication Administration Records) revealed staff were to administer, "[redacted] 50,000 units PO weekly (Fridays)..." however, staff failed to document this medication was administered. In an interview on 03/04/13 Staff D was unable to confirm or refute the resident received this medication. Failure to document medications were administered detracted from staffs ability to ensure the resident received medications as ordered. Review of physician notes revealed the resident was seen by the practitioner on 02/27/13 with an assessment/plan of: "Muscular pain: start [redacted] 500 mg 1-2 tab (every evening) PRN for pain." According to a Telephone Order (TO) dated 02/27/13 staff were to administer, "[redacted] 500 mg 1-2 tab (every evening) for pain give 1 tablet for pain 4-7 (out of a scale of 1-10) give 2 tab (for) pain 8-10 (out of a scale of 1-10) ok for patient to refuse." According to MARs staff administered [redacted] each evening at 8:00 p.m., but there was no indication of the resident's level of pain or the number of [redacted] the resident received. According to the Pain Management Flow Sheet, located in the MAR, staff had not assessed the	F 425	**Resident #3 Fosamax ordered was Rewritten and boxed out for weekly administration, staff that made the error were educated to review 5 rights of medication administration. MD and family were notified of this error.** **Resident #4 orders for HCTZ were Clarified and rewritten. MD and Resident Were notified of the missed Potassium Medication on 3-1-13** **Resident #5 Senna order was clarified and a new order written in the MAR, Atacand medication is now available and Resident is receiving the medication.**	

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F 425	Continued From page 4 resident's level of pain. Failure to administer medication based on a pain assessment as directed by POs placed the resident at risk for over/under medication and failure to document the number of pain pills received, as directed by POs, detracted from staffs ability to reconcile the amount of medications consumed by the resident. In an interview on 03/04/13 at 12:45 p.m., the resident stated he had "occasional mild pain" but indicated he didn't believe he required pain medication every evening. RESIDENT #3 Resident #3 was admitted to the facility on [redacted]13 and record review revealed no "24 hour chart review" which would indicate night shift staff checked the admission orders to ensure accuracy. Review of POs indicated the resident was to receive, [redacted] ....weekly...", however, when staff transcribed the order, they did not box off/indicate which day of the week the medication was to be administered. Review of 03/13 MARs revealed staff administered this medication on 03/01, 03/02 and 03/03/13. Failure to ensure accurate transcription of this medication order resulted in the resident receiving more than the prescribed dose, constituting a medication error. Additional review of 03/13 MARs revealed facility staff were directed to hold the medication [redacted] (a [redacted]) if the pulse was below 60. However, on 03/01/13 at 5:00 p.m., staff documented a pulse of 58 and administered the medication, contrary to POs, which constituted a medication error. In an interview on 03/04/13 at	F 425	Resident #2 MD was informed on low Vit D Level immediately once the error was identified. To identify other residents potentially affected with this deficient practice, facility has audited all residents admitted in the last 30 days for accuracy of their medication transcription. To prevent reoccurrence, Facility has implemented a new 24 hour Physician Order audit form to identify any errors in transcription on any new Residents admitted to the Health Center. Policy on Physician Order transcription, notification of physician on abnormal labs, recaps were reviewed and updated to reflect current practice. Continued to next page	

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F 425	Continued From page 5 11:50 a.m., Staff B confirmed this was an error. RESIDENT #4 Resident #4 was admitted on [redacted]13 with multiple complex medical diagnoses. Record review revealed night shift staff documented on 03/01/13 a chart review was completed to ensure accuracy of POs. According to TO's dated 03/01/13 staff were directed, "If [redacted](Systolic Blood Pressure) greater than 160 or > increase HCTZ (hydrochlorothiazide- a medication impacting the cardiovascular system) to 25 milligrams each day" and "KCL 10 meq (each day)." There was no indication staff attempted to clarify what the physician intended by "or >". Review of 03/13 MARs revealed staff documented a BP of 176/75 on 03/01/13, 185/79 on 03/02/13 and 197/83 on 03/03/13. There was no indication staff increased the HCTZ as directed or notified the physician of a significantly elevated BP. In an interview on 03/04/13 at 12:10 p.m., Staff C (RCM) confirmed this was an error and the HCTZ should have been increased as directed by the PO. Staff C elaborated the error might have been prevented if the 03/01/13 parameters were written into the body of the medication order, rather than written on a separate page. Further review of 03/13 MARs revealed that while the KCL was ordered on 03/01/13, it was not administered until 03/03/13. In an interview on 03/04/13, Staff C stated, "It should have been given (on 03/02/13), we have it (KCL) in the ekit (emergency drug supply kit)."	F 425	Two nurses are now required to verify admission orders for accuracy of transcription. Also, medication reconciliation will be reviewed with Resident and Family at initial care conferences. DNS to monitor compliance and will conduct spot audits on Mars for transcription accuracy and report findings to QA	

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F 425	Continued From page 6 RESIDENT #5 Resident #5 was admitted to the facility on [redacted]/13 and according to the "24 hour chart review" staff documented on 03/02 and 03/03/13 the record was reviewed for accurate transcription of POs. Record review revealed Resident #5 had an order for "[redacted] 1 or 2 tabs ...at (bedtime) but hold for diarrhea". Staff transcribed this order but did not provide direction to document how many tabs were administered. Facility staff failed to ensure the PO provided clear instructions as to when and under what circumstances one or two tablets should be administered. In an interview on 03/04/13 at 12:20 p.m., Staff C indicated the order could be clarified stating, "They should document how much they are administering." Additionally, a TO dated 03/02/13 directed staff to administer [redacted] (a [redacted]) at bedtime. The medication was not administered on 03/02 or 03/03/13. When asked why the medication wasn't administered, Staff C indicated the facility might not have been able to obtain the medication for the 03/02/13 dose, but was unsure why it wasn't administered more than 24 hours after the order on 03/03/13 stating, "They should have satelited it." Failure to ensure medication availability detracted from staff's ability to administer medications as ordered. RESIDENT #2 Record review revealed a PO dated 02/27/13 directing staff to obtain a [redacted] 250H level. According to lab results dated 03/01/13, the resident's [redacted] level was abnormally low at	F 425		

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F 425	Continued From page 7 13.7 (normal range 30.0-100.0). As of 03/04/13 there was no indication facility staff notified the physician of the abnormal result. In an interview at 11:40 a.m., Staff B stated staff should notify the physician at the time an abnormal result is noted. Staff B stated, "It looks like it (this lab) was glossed over, we had some agency nurses working this weekend." Failure to ensure prompt physician notification of abnormal labs placed the resident at risk to received delayed treatment.	F 425		

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