

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

PRINTED: 05/09/2013
FORM APPROVED
OMB NO. 0938-0391

1451

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505378	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2013
NAME OF PROVIDER OR SUPPLIER PRESTIGE CARE & REHABILITATION - BURLINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1036 EAST VICTORIA AVENUE BURLINGTON, WA 98233	
(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 Quality Indicator Survey (QIS) conducted at Prestige Care and Rehabilitation of Burlington on 5/1/13, 5/2/13, 5/3/13, 5/6/13, and 5/7/13. A sample of 21 residents was selected from a census of 36. The sample included 18 current residents and the records of 3 former and/or discharged residents.</p> <p>The survey was conducted by: [REDACTED], R.N., B.S.N. [REDACTED], R.N., B.S.N. [REDACTED], R.N., B.S.N.</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and 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> 5/9/13 Residential Care Services Date</p>	F 000	<p>F000 Initial Comments</p> <p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Prestige Care & Rehabilitation - Burlington does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p style="text-align: right;">RECEIVED MAY 23 2013 ADSARCS Smokey Point</p>	6/17/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
[Signature] Administrator 5/22/13

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 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: Based on interview and record review it was determined the facility failed to inform the</p>	F 157	<p>F157</p> <p>Corrective Action for the resident identified to have been affected:</p> <p>A review of resident #20's medical record showed that the MD was notified verbally by nursing staff on 4/5/2013. MD performed a physical examination on resident #20 and made no changes to her POC.</p> <p>Identification of residents with the potential to be affected:</p> <p>Residents having a change of condition have the potential to be affected.</p> <p>Measures to prevent recurrence:</p> <p>LN's will be reeducated on the policy and procedure regarding timely notification to MD by 5/19/13.</p> <p>Monitor for Corrective Action:</p>	6/17/13

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F 157 Continued From page 2
resident's physician in a timely manner regarding a significant change in the medical condition for 1 of 3 former residents (#20) reviewed. This failure had the potential to place the resident at risk for harm.

Findings include:

Resident #20 was admitted to the facility in [REDACTED] of 2008 with diagnoses including [REDACTED] and [REDACTED].

Per the nursing progress notes on 4/1/13 at 9:52 a.m., resident #20 had a loose stool before dinner. She vomited at approximately 8:00 p.m. Further review of the progress notes revealed the resident had a loose stool the next day and 3 episodes of vomiting. On 4/3/13 and 4/4/13, the resident felt weak and tired with intermittent episodes of nausea. There was no record of her physician being notified by facility staff of her deteriorating medical condition.

5/6/13 at 2:30 p.m. during an interview with the Director of Nursing Services, she stated the physician should have been contacted on 4/2/13 about the change in resident's medical condition.

F 157

Managing Acute Change of Condition (MACC) meeting will occur 5 times a week to monitor and review proper MD notification of changes in condition. DNS will report compliance with notifying MD to the QA committee monthly x 3 months.

DNS is responsible to ensure compliance.

F 253 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES
SS=E

F 253

**F253
Corrective Action for the resident identified to have been affected:**

6/17/13

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F 253

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The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

This REQUIREMENT is not met as evidenced by:
Based on observations and interviews, the facility failed to maintain carpeting in a clean and undamaged condition, to provide clean privacy curtains, and to repair damaged walls in resident rooms. These failures had the potential to diminish the quality of life for multiple residents and had the potential to be a tripping hazard in one area of the dining room.

Findings include:

CARPETS
During all days of observations, a brown carpet covered most of the facility's floor with the exception of resident rooms. Numerous stains were equally dispersed throughout the building. The main dining room had an area under a support beam that measured approximately two feet by six inches where the carpet had been cut and removed. The edges of the cut carpet had pulled away from the subflooring and had unraveled, revealing a lip of carpet one inch high, protruding from the floor. Residents were observed to either walk or push their front wheeled walkers over the hole in the carpet.

When interviewed on 5/3/13 at 3:15 p.m., the Administrator and Director of Nursing Services were informed of the observed hole in the carpet located in the dining room. Silver duct tape was placed along the seams to prevent the edges

F 253

Repair/ replace common area flooring.

The privacy curtains in rooms 102/106/107/108/114/123/124 have been replaced and or deep cleaned.

The walls in rooms 102/103/114/115 have been repaired.

Identification of residents with the potential to be affected:

Residents receiving personal care in these rooms have a potential for being affected.

Measures to prevent recurrence:

Bids for flooring repair/ replacement are being collected prior to submission to Construction Review.

Housekeeping staff has been re-educated about the inspection and cleaning

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F 253 Continued From page 4
from being exposed. During an interview with Staff A, the Housekeeping Manager on 5/6/13 at 1:50 p.m., she stated the carpets had just been cleaned but the stains had been there for a long time and could not be removed. "We didn't have enough hours in the budget to do all the floor care that needed to be done". "Now that a new company is managing the facility, we have more to work with".

PRIVACY CURTAINS

Curtains in rooms 102, 106, 107, 108, 114, 123, and 124 were observed to be soiled with organic material, large grease spots in the shapes of hands and/or to have ripped edges. When interviewed on 5/7/13 at 2 p.m., Staff A stated it was the policy for curtains to be checked daily and replaced with clean curtains when soiled.

DAMAGED WALLS

During all days of the survey, damaged walls in rooms 102, 103, 109 115, and 114, were observed. With the exception of room 103, these walls were damaged at the head of residents' beds. Room 103 had an area approximately 4 feet by 5 feet which was gouged by a Hoyer Lift stored along a wall by the window. During an interview with the Administrator on 5/7/13 at 1:45 p.m., she stated damaged walls were starting to be repaired.

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO
SS=D PARTICIPATE PLANNING CARE-REVISE CP

F 253

process when for privacy curtains.

The maintenance department has scheduled repairs and paint to all rooms. 35% of the rooms had been completed prior to this inspection.

Monitor for Corrective Action:

These areas will be monitored during monthly environmental rounds using QA CheckUp and the TELs preventative maintenance program performed by the IDT and maintenance director. The Administrator and Maintenance Director will make rounds weekly x 4 and report completion of repairs to the QA committee for review.

The Administrator is responsible to ensure compliance.

F 280

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F 280	Continued From page 5 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop and/or revise a comprehensive care plan for 1 of 20 sample residents (# 4) reviewed for care plan updates. Failure to establish plans that accurately reflected assessed care needs related to skin conditions (non-pressure related) placed Resident #4 at risk to receive less than adequate care. Findings include: The facility "Skin at Risk/Skin Breakdown" policy revised on 2/13 directed staff to:	F 280	F280 Corrective Action for the resident identified to have been affected: Resident #4 has had a care plan and treatment administration record (TAR) updated. Identification of residents with the potential to be affected: Residents with skin impairment have the potential for being affected. Measures to prevent recurrence: Residents with skin impairment will be identified upon admit and through a weekly skin assessment process thereafter. LN's will be reeducated on the skin impairment policy and procedure by 5/29/13. Skin impairment will be documented on the skin grids and treatments noted on the	6/17/13	

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A. Ongoing assessment will continue weekly with the Licensed Nurse (LN) completing a full body audit. Completion of the skin audit will be documented on the Treatment Administration Record (TAR) with their initials, and either a "+" indicates skin impairment and to proceed with the next step or "-" indicates no skin impairment.

B. Upon discovery of newly identified skin impairment (abrasion, bruise . . .), the License Nurse will:

- Document skin impairment that includes measurements of size color, presence of odor and exudate.
- Notify the Physician and obtain a Treatment Order if needed, document on the TAR after implemented.
- Evaluate environment, mobility equipment, functional and cognitive ability, medications, and labs to identify interventions to promote healing/resolution of skin impairment.
- Implement interventions and document on the resident's Care Plan (CP) . . .
- Initiate Alert Charting through the Managing Acute Conditions Change process.

Resident #4 was admitted [REDACTED] 2008 with diagnoses to include [REDACTED], [REDACTED], [REDACTED] and [REDACTED]. The resident was dependent with transfers, and required extensive assistance of one person for bed mobility, dressing and toileting. The resident required supervision with use of his manual or electric wheelchair.

The current care plan directed staff to perform daily skin assessments and document a "+" or "-" sign on the TAR, and the Nursing Assistant

F 280

Treatment Administration Record (TAR).

Monitor for Corrective Action:

Weekly skin assessments will be reviewed by the IDT 5 times a week for 4 weeks, then randomly reviewing 4 residents per week for the next month.

DNS will monitor and review TAR's weekly to ensure compliance. DNS will forward her findings to the QA committee for review and further recommendations. DNS is responsible to ensure compliance.

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Certified (NAC) was to report concerns noted during routine care. There were no current skin impairments identified on the care plan.

During an interview on 5/2/13 at 4:58 p.m., the resident was observed to have several dark purple to light purple discolorations on the back of both hands and lower arms (from elbow to wrist).

The TAR was reviewed for the months of March, April, and May 2013. There were no bruises identified on the TAR. There was missing skin assessments on the 29th and 30th of March and April, and May 5th. There were no "+" or "-" signs documented on any of the skin assessments performed.

Staff B and F, LN's, were interviewed on 5/6/13 regarding the facility's skin policy. They stated when a new skin concern was identified, they would assess the concern, notify the doctor, and update the TAR, CP and family. If a bruise was found, an incident report would be done. Staff B and F identified when weekly skin assessments were done they would document a "-" if there were no skin issues and a "+" if there were skin issues. Staff B and F indicated that additional documentation was done either on the last page of the treatment sheet, "skin grid for pressure ulcers" flow sheet or "other skin report" flow sheet. However, this was not done for the resident.

During interviews with four NAC's on 5/6/13, they indicated they would notify the LN of any new skin impairments found.

In an interview on 5/7/13 at 9:29 a.m., the

F 280

F281

Corrective Action for the resident identified to have been affected:

A review of resident #20's medical record showed the MD was notified verbally by nursing staff on 4/5/2013. MD performed a physical examination on resident #20 and made no changes to her POC.

Identification of residents with the potential to be affected:

Residents having a change of condition have the potential to be affected.

Measures to prevent recurrence:

LN's will be reeducated on the policy and procedure regarding timely notification to MD by 5/29/13.

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F 280	Continued From page 8 Director of Nurses confirmed the facility's policy on skin impairment was not followed.	F 280	Monitor for Corrective Action:		
F 281 SS=D	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: Based on interview and record review it was determined the facility failed to assure services provided by licensed nursing staff met professional standards of quality of care. The failure by licensed staff of not informing a resident's physician regarding a significant change in medical condition change in a timely manner for 1 of 3 former residents (#20) reviewed placed the resident at risk of harm. Findings include: Resident #20 was admitted to the facility in [REDACTED] of 2008 with diagnoses including [REDACTED], [REDACTED], [REDACTED], and [REDACTED]. Per the nursing progress notes on 4/1/13 at 9:52 a.m., resident #20 had a loose stool before dinner. She vomited at approximately 8:00 p.m. Further review of the progress notes revealed the next day she had a loose stool and 3 episodes of	F 281	Managing Acute Change of Condition (MACC) meeting will occur 5 times a week to monitor and review proper MD notification of changes in condition. DNS will report compliance with notifying MD to the QA committee monthly x 3 months. DNS is responsible to ensure compliance.	6/17/13	
			F332 Corrective Action for the resident identified to have been affected: Residents #16 and #36 were placed on alert monitoring.		

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F 281 Continued From page 9
vomiting. On 4/3/13 and 4/4/13 the resident felt weak and tired with intermittent episodes of nausea. The medical record had no documentation the facility staff notified the physician of the resident's deteriorating medical condition.

5/6/13 at 2:30 p.m. during an interview with the Director of Nursing Services, she stated the physician should have been contacted on 4/2/13 about the significant change in resident's medical condition.

F 281 **MD and family notified. No adverse reactions noted.**

Identification of residents with the potential to be affected:

Residents receiving pharmacological interventions have the potential to be affected.

F 332 SS=D 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE

The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure a medication error rate of less than 5%. Two Licensed Nurses (Staff D & E) failed to follow physician's orders for two observed medication administrations. These failures placed 2 of 4 (16 and #36) residents observed for medication administration at risk to experience adverse side effects of medications.

F 332 **Measures to prevent recurrence:**

LN's will be reeducated on medication administration including those with special instructions or parameters by the DNS by 5/29/13.

Monitor for Corrective Action:

Pharmacy and Regional Nurse consultant will perform medication pass audits quarterly.

DNS will perform random medication administration audits 1 time per week for the next 4 weeks. The results

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Findings include:

Resident #16

During a medication observation on 5/2/13 at 4:00 p.m. Staff D, a License Nurse (LN), was observed to administer [redacted] eye drops to the resident. Staff D placed one drop in each eye. Review of physician orders revealed an order directing staff to administer a [redacted] eye drop to the left eye every day. Staff D confirmed an eye drop was administered to both eyes.

Resident #36

During a medication observation on 5/6/13 at 7:45 a.m., Staff E, a LN, was observed to administer [redacted] 2.5 mg (a [redacted] medication) to the resident. Review of physician orders directed staff to check the systolic blood pressure (SBP) daily and "hold" the medication if the SBP was below 100. Staff E was asked if the resident's blood pressure had been monitored prior to administration of the medication. Staff E responded she did not check the resident's blood pressure.

F 332

of these audits will be forwarded to the QA committee for review and suggestions for further education as needed.

F431

Corrective Action for the resident identified to have been affected:

The 3 expired medications were immediately returned to the pharmacy or destroyed.

Identification of residents with the potential to be affected:

Residents receiving emergency IV interventions had the potential to be affected. No resident's received expired medication.

6/17/13

F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS
SS=D

The facility must employ or obtain the services of a licensed pharmacist who establishes a system

F 431

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F 431	<p>Continued From page 11</p> <p>of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to dispose of expired and/or return medications to the pharmacy in a timely manner. This failure had the potential to</p>	F 431	<p>Measures to prevent recurrence:</p> <p>LN's will be re-educated regarding medication safety and storage by 5/29/13. LN's will monitor for expiration dates before administering IV's from the emergency IV kit.</p> <p>Monitor for Corrective Action:</p> <p>Pharmacy will automatically ship new Emergency kits monthly to insure all IV solutions and meds are not expired.</p> <p>DNS and pharmacist will perform medication room audits monthly including checking the emergency IV kit. Results of the audit will be reviewed by the QA committee for review with consultant pharmacist or pharmacy representative.</p> <p>DNS is responsible to ensure compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505378	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2013
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place residents at risk.

Findings include:

On 5/7/13 at 9:05 a.m. the medication room contained several medications that were past their expiration date. The expiration dates were confirmed by Staff B and the Surveyor. The following medications had expired:

3 vials of ampicillin powder expired 2/13
1 liter container of dextrose 5% and 1/2 normal saline intravenous solution expired 3/13.

The Medicare medication cart contained one bottle of expired eye drops. The expiration dates were confirmed by Staff C and the Surveyor.

Dorzol/Timol eyedrop solution label on the bottle was written to be expired on 4/30/13.

F 431

F458

Corrective Action for the resident identified to have been affected:

Resident's health and safety was not adversely affected by the room size.

Identification of residents with the potential to be affected:

Residents residing in rooms 102/104/105/107/108/109/110/112/114

Measures to prevent recurrence:

Facility has an ongoing waiver for the following rooms:

F 458 483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT
SS=B

Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.

This REQUIREMENT is not met as evidenced by:
Based on observation and record review, 9

F 458

102/104/105/107/108/109/110/112/114

Monitor for Corrective Action:

Residents are monitored quarterly for negative outcomes related to room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505378	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/07/2013
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F 458	<p>Continued From page 13</p> <p>resident rooms did not meet the size requirement for square footage.</p> <p>Findings include:</p> <p>Rooms 102, 104, 105, 107, 108, 109, 110, 112, and 114 failed to meet the minimum space requirements of 80 square feet per resident in multiple resident bedrooms and at least 100 square feet in a single resident room as required.</p> <p>During interviews, no resident stated they had concerns regarding the size of their room. The interviewed residents said they liked their rooms and felt their needs were met regardless of the size of their room. A review of care plans for these residents indicated the facility was monitoring for any negative outcomes</p>	F 458	<p>size through the care planning process.</p>	