

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

PRINTED: 02/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/19/2015
NAME OF PROVIDER OR SUPPLIER AVAMERE BELLINGHAM HEALTH CARE & REHAB SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1200 BIRCHWOOD AVENUE BELLINGHAM, WA 98225		
(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 Abbreviated with Partial Extended Survey conducted at Avamere Bellingham Health Care and Rehab Services on 2/11/15 and 2/19/15. A sample of 3 residents was selected from a census of 68. The sample included 2 current residents and 1 former and/or discharged resident.</p> <p>On 2/13/15, an Immediate Jeopardy was identified related to: F309-Provide Care/Services for Highest Well-Being, and F333-Residents Free of Significant Med Errors. The facility abated the jeopardy before the completion of Partial Extended Survey on 02/19/15. The Statement of Deficiency was amended 2/23/15.</p> <p>The following complaint was investigated as part of this survey: 3075090</p> <p>The survey was conducted by: Nadyne Krienke, R.N., M.S.N. Pat Rimar, R.N., M.S.N. Kathy Gold, R.N. B.S.N. Rick Woodrum, R.N. B.S.N. Steve Kindie, R.N, M.S.N.</p> <p>The survey team is from: Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, District 2 3906 172nd Street NE, Suite 100 Arlington, WA 98223 Telephone: (360) 651-6850 Fax: (360) 651-6940</p> <p><i>Kathy Gold</i> 2-23-15 Residential Care Services Date</p>	F 000	<p>RECEIVED MAR 02 2015 ADSA/RCS Smokey Point</p> <p>The Plan of Correction is being submitted in accordance with the Federal and State Regulations, and Statutes applicable to Long Term Care Facilities. This Plan of Correction does not constitute an admission of liability nor agreement of survey findings as written. To assure continuing compliance with all Federal and State Regulations, the facility has taken or will take the action(s) set forth in the following Plan of Correction. This Plan of Correction constitutes the facilities credible allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date(s) indicated on this report.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *D. A. Gold* TITLE *Administrator* (X8) DATE *2/26/15*

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 000	Continued From page 1	F 000		
F 281 SS=G	<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 record review, the facility failed to provide services in accordance to accepted standards of medication administration practices for 1 of 3 sample residents(1). Failure of Licensed Staff to consistently administer</p>	F 281	<p>F281 Resident # 1 is no longer resides in the facility.</p> <p>Resident records have been audited to identify like orders with liquid narcotic medications. Orders have been clarified in the MAR and in the narcotic book.</p>	2/20/15

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F 281	<p>Continued From page 2</p> <p>narcotic administration in accordance with professional medication administration standards contributed to a significant narcotic medication error for Resident 1 and placed other residents at risk for future medication errors.</p> <p>Findings include:</p> <p>According to LippincottNursing Center.com referencing the Nursing2012 Drug Handbook. (2012). Lippincott Williams & Wilkins: Philadelphia, Pennsylvania, there are at least 5 Rights of Medication Administration:</p> <ol style="list-style-type: none"> 1. Right patient 2. Right medication which includes checking the medication label and the order. 3. Right dose which includes checking the order, confirming appropriateness of the dose using a current drug reference, and if necessary, calculate the dose and have another nurse calculate the dose as well. 4. Right route 5. Right time <p>During an interview with the Director of Nursing (DNS) on 2/11/15 at 9:50 a.m., she verified a significant medication error had occurred on 2/9/15 for Resident 1 involving a narcotic medication, Morphine Sulfate (MS).</p> <p>Review of the facility's event and occurrence conclusion documentation revealed that during change of shift report, the evening licensed nurse (LN3) reported to the night nurse (LN4) that she (LN3) had administered 1.0 milliliter (ml) of MS liquid concentrate to Resident 1 during the evening shift. At that time, LN4 questioned the dose of MS given to Resident 1 by LN3. LN3 and</p>	F 281	<p>Residents will receive medications in accordance to nursing standards of medication administration practices. Any liquid medication from the-Ekit will be put into the MAR and labeled with both the dosage in mg and in ml identified. When entering a new liquid narcotics into the narcotic book there will be two nurses signing as complete and accurate.</p> <p>Competency testing have been completed with nursing staff on medication administration to include calculation of dosing.</p> <p>Disciplinary actions completed with both LN's related to documentation in the narcotic book.</p> <p>LN making the medication error has been terminated.</p> <p>Initial quarterly performance for LN3 was due on April 1st 2015.</p> <p>Routine audits will be completed to ensure double signature in narcotic book and that liquid narcotic medications</p>	
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F 281	<p>Continued From page 3</p> <p>LN4 checked the order for 2mg of MS and LN4 calculated the dose of MS that should have been administered. The correct dose of MS was calculated to be 0.1 ml, rather than 1.0 ml. LN3 had erroneously administered 10 times the prescribed narcotic dose to Resident 1.</p> <p>Review of written event and occurrence statements by LN3 and LN4 indicated LN3 had not recognized she had administered the wrong dose of MS until change of shift when LN4 told LN3 that 1 ml of MS was "too much" and (LN4) calculated the correct dose to be administered.</p> <p>In addition, the documentation revealed LN3 was asked the reason why she gave (1.0 ml of MS), "Because it was just in my mind 1.0 ml" (rather than actually calculating the correct dose of medication prior to administration).</p> <p>Review of personnel information revealed State Department of Health documentation indicating LN3's current credential status was "Active on probation" related to previous alleged violations of unprofessional conduct and standards of nursing conduct or practice. The documentation indicated the credential to practice ...shall be on probation for at least 24 months and LN3 shall comply with listed terms and conditions that included such things as having the employer(facility) submit quarterly performance reports to the state.</p>	F 281	<p>have both dosage in mg and in ml identified in body of the order.</p> <p>Audits will be reviewed at facility Quality Assurance Committee monthly for 3 months and periodically thereafter.</p> <p>To prevent future incidents, ongoing education on conversion competency, assessments, monitoring and medication administration will be done with newly hired licensed nurses. Annually will complete clinical competency reviews of current staff.</p> <p>Medication pass audits will be done periodically, and reviewed in the QA committee. The Pharmacist or representative will participate in on going education on medication administration.</p> <p>DNS will ensure compliance.</p>	
F 309 SS=J	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,</p>	F 309	<p>F309</p> <p>Resident # 1 no longer resides in this facility.</p> <p>Current residents have been reviewed during stand up for</p>	2/20/15

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F 309	<p>Continued From page 4</p> <p>mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to consistently monitor, evaluate, and/or consider immediate interventions to reverse the possible effects of an avoidable narcotic medication error for one of one sample resident (1). This failure resulted in Resident 1 not receiving all possible emergency interventions to reverse the effects of the narcotic medication error and likely contributed to Resident 1's decline and death. Findings:</p> <p>Resident 1 had diagnosis of [REDACTED]. Her most recent Minimum Data Set (MDS) assessment, dated 1/14/15, revealed she required staff assistance with bed mobility and transfers, was 66 inches in height and weighed [REDACTED] pounds.</p> <p>Review of the nursing notes, dated 2/8/15 at 23:12, revealed Resident 1 was placed on alert due to an elevated temperature, low blood pressure (88/52), increased heart rate (135) and low oxygen level (82% on room air). Documentation revealed the family was present and oxygen was started and that the resident would be monitored.</p> <p>The next entry, dated 2/9/15 at 2:57 a.m., documented Licensed Nurse (LN) and nursing assistants were checking on resident frequently</p>	F 309	<p>those on alert or with a change of condition to ensure consistent monitoring of that condition and evaluating response to interventions.</p> <p>Residents will receive the necessary care and services to attain or maintain the highest practicable, physical, mental and psychosocial well-being in accordance with comprehensive assessment and plan of care. Nursing staff was re-educated on alert documentation, and physician notification to include thorough objective data and ongoing assessment of a resident with change of condition.</p> <p>LN's have been educated on assessment and monitoring of a resident that has experienced a medication error. Competency testing has been completed with nursing staff on medication administration to include calculation of dosing.</p> <p>LN who made the medication error has been terminated. Residents with a change in condition will be reviewed in am clinical stand up and RCM or</p>	

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F 309	<p>Continued From page 5</p> <p>to ensure her oxygen tubing was on per family request and " her pulse remains WNL (within normal limits) and she had no pain".</p> <p>The following entry at 5:53 a.m., on 2/9/15 documented the family was with Resident 1 and her pulse alternated between 132 and 156 and all other vital signs WNL. The vitals summary form revealed her blood pressure was 94/67, heart rate 156 and respirations 22 per minute.</p> <p>Even though Resident 1 had a change in her vital signs, a decreased blood pressure or oxygen level on the night of 2/8/09 and the morning of 2/9/15, there was no documented evidence the physician or ARNP was notified.</p> <p>On 2/9/15, the family requested the Advanced Nurse Practitioner's (ARNP) see the resident. The ARNP documented Resident 1's appetite was poor with progressive weight loss and "has been noted to be more short of breath with increased restlessness". The ARNP 's note indicated the resident was cachectic-appearing, (weight loss, wasting of muscle, loss of appetite, and general debility that can occur during a chronic disease). arouses to voice, does not answer questions, and respiratory rate had been between 22 and 28 breaths per minute with oxygen saturation low 90's. During the ARNP's visit, she had discussed the resident's condition with the family member who was in agreement with palliative care and for air hunger and/or signs and symptoms of pain, an order was written to administer morphine sulfate (MS-a narcotic medication).</p> <p>On 2/9/15, the Medication Administration Record (MAR) revealed Resident 1 received her initial</p>	F 309	<p>designee will follow up on status and audit records to ensure thorough assessment, delivery of care and documentation is completed.</p> <p>To prevent future incidents, ongoing education on conversion competency, assessments, monitoring and medication administration will be done with newly hired licensed nurses. Annually will complete clinical competency reviews of current staff.</p> <p>Medication pass audits will be done periodically, and reviewed in the QA committee. The Pharmacist or representative will participate in on going education on medication administration.</p> <p>DNS will ensure ongoing compliance</p> <p>Audits will be reviewed at facility Quality Assurance Committee monthly for 3 months and periodically thereafter.</p>		

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F 309	<p>Continued From page 6</p> <p>dose of MS at 9:55 a.m., for "air hunger". Prior to the administration of the MS, a chart note entry documented the resident's methadone was held as her blood pressure would not register on the blood pressure machine. There was no documented evidence regarding the Resident's vital signs, cognitive status after the MS was administered.</p> <p>The following note for 2/9/15 at 6:44 p.m., documented LN3 held the resident's ensure (a liquid supplement) because the resident was "very lethargic" but 9 minutes later the same LN administered an incorrect amount of MS to Resident 1 which was 10 times the ordered dose. (LN3 administered 1cc instead of 0.1 cc).</p> <p>Another entry for 2/9/15, during LN3's shift revealed Resident 1's bladder medication was held due to her lethargy and inability to swallow.</p> <p>Even though Resident 1's condition had significantly changed, there was no documented evidence vital signs were taken and recorded and consistently monitoring was in place for a resident who had been placed on alert status.</p> <p>The next nursing progress note for 2/9/15 at 11:32 p.m., revealed LN 3 was informed by LN 4, a night shift nurse, that the dose of MS was incorrect and the ARNP and family were notified. At 11:35 p.m., the Resident vital signs were obtained. The blood pressure was 87/60; heart rate 96; respirations 16. LN3 documented that Resident 1 would be "monitored closely".</p> <p>Review of the facility's occurrence report on 2/11/15 revealed that when LN3 called the ARNP, no further orders were obtained and LN3 had</p>	F 309		

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F 309	<p>Continued From page 7</p> <p>been directed to notify the Director of Nursing (DNS). LN3's written statement, dated 2/10/15, revealed she had notified the DNS of the medication error and that Resident 1's ARNP had been notified and directed her to "call the DNS and tell her situation".</p> <p>Even though LN3 had notified both the ARNP and DNS, there was no documented evidence that there was any direction or consideration regarding immediate intervention such as calling 911 and/or the administration of narcan to counteract the narcotic effect from the excessive dose of MS. There was no documented evidence the LN3 had discussed the significant risks of the medication error with the family member.</p> <p>During a telephone interview on 2/12/15 with LN3, she "insinuated the resident could have died" due to medication error but stated she believed the family member "knew she could expire from the medication".</p> <p>In addition, even though the LNs documented Resident 1 would be monitored closely after the excessive dose of MS was administered, documentation only included the following entries even though LN3 after discovering the medication error wrote: "monitor closely".</p> <p>-2/10/15 1:30 a.m., read "Resident on comfort care, was checked more frequently this shift, changed q 1 hours, oral care provided Q hour r/t resident breathing through her mouth, VS checked at this time BP-was 88/60, R-14/min, P-86, T-99.0 orally, O2 sat-89-91% on 2L of oxygen. Resident seems comfortable Skin on both extremities warm".</p>	F 309			

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F 309	Continued From page 8 -the following entry at 3:30 a.m., documented the resident was "checked by LN more frequently , r/t decreased respiration rate Q 15min, respiration on this time was 10/min, resident has cold extremities, P-86, t-99.0 -the next entry dated 2/10/15 at 0447: "resident was in bed. Oxygen 3 L /min, O2Sat was 89-91%, HR-102, R-12/min, resident was unresponsive, at 0330 a.m., no breathing noted, no apical pulse. LN called (ARNP), has order to release body to ... funeral home grandson notified. -an addition note dated [REDACTED] 15 @ 10:37 read: Clarification of note, At 0300am, LN was checked resident more frequently, r/t (related to) decreased respiration rate, at that moment respiration was 10/min, P-86, t-99.0 at 0330 am no breathing and no apical pulse noted. Resident time of death 0330 a.m. The facility failed to consistently assess, monitor Resident 1's status after a significant medication error or considered the need for possible interventions due to the medication error despite her medical condition, age and/or palliative care.	F 309			
F 333 SS=J	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 interview and record review, the facility failed to ensure the correct dose of medication was administered to 1 of 3 sample residents (1)	F 333	F333 Resident #1 is no longer in the facility. Resident records have been audited to identify like orders with liquid narcotic medications. Orders have been clarified in the MAR and in the Narcotic book to include both mg dosage as well as ml dosage.	2/26/15	

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F 333	<p>Continued From page 9</p> <p>who had orders for a liquid narcotic medication. Failure of a Licensed Nurse to administer the correct dose of a narcotic medication resulted in a significant medication error that resulted in death.</p> <p>Findings include:</p> <p>Record review revealed Resident 1 received a new order for a liquid narcotic medication on 2/9/15. The Advanced Nurse Practitioner's (ARNP) order was written as MS (morphine sulfate) 2 mg (milligrams) SL (sublingual-under the tongue) or P.O (oral by mouth) every 4 hours as needed for air hunger and or pain, 20mg/ml. (Indicating the medication's concentration was 20 mg of morphine per each 1 ml of liquid).</p> <p>Resident 1's Medication Administration Record (MAR) for February 2015 read: Give 2 mg sublingually (SL) every 4 hours as needed for air hunger/pain. MS 20mg/ml., Give 2mg SL q (every) 4 hours as needed.</p> <p>The Medication Administration Record (MAR) for February 2015 revealed Resident 1 received her initial dose of MS at 9:55 a.m., and a second dose administered at 18: 53 (6:53 p.m.).</p> <p>Review of the Individual Narcotic Record for the MS on 2/11/2015, revealed 3 entries, 2/9/15 at 0900, dose 1ml, signature of LN; the second 2/9/15 at 1853, dose 1ml and the third entry read 2/9/15 at 0955, dose 0.1 ml. A hand written line was drawn across 2/9/15 entry for 0900, dose 1 ml. with an undated notation made by the RCM that read: "error in documentation".</p> <p>During an interview with the Director of Nursing</p>	F 333	<p>Residents will be free of significant medication errors.</p> <p>Any liquid medication from the E-kit will be put into the MAR and labeled with both the mg dosage and the ml dosage identified.</p> <p>When entering a new liquid narcotic into the narcotic book there will be two nurses signing as complete and accurate.</p> <p>Competency testing has been completed with nursing staff on medication administration to include calculation of dosing. Disciplinary actions completed with LN's related to documentation in the narcotic book.</p> <p>LN who made the medication error has been terminated. Routine audits will be completed to ensure double signature in narcotic book and that liquid narcotic medications have both dosage in mg and in ml identified in body of the order.</p> <p>Audits will be reviewed at facility Quality Assurance Committee monthly for 3 months and periodically thereafter.</p>	

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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	
F 333	Continued From page 10 (DNS) on 2/11/15 at 9:50 a.m., she verified a significant medication error had occurred for Resident 1 involving MS. The facility's event and occurrence conclusion sheet revealed that during change of shift report, LN3 informed the night nurse (LN4) that she had administered 1cc of MS liquid to Resident 1. At this time, LN4 questioned the dose of MS given to Resident 1 by LN3. LN3 and LN4 checked the order for 2mg of MS and calculated the correct dose that should have been administered. The correct dose of MS was calculated to be 0.1 cc and not 1.0 cc., 10 times the prescribed narcotic dose.	F 333	To prevent future incidents, ongoing education on conversion competency, assessments, monitoring and medication administration will be done with newly hired licensed nurses. Annually will complete clinical competency reviews of current staff.		
F 490 SS=G	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility's administration failed to effectively and/or efficiently use its resources to maintain the highest practicable well-being for residents. Failure of the Administrator to identify the need to provide oversight for safe administration of medications, to ensure accurate monitoring, and/or to assess or consider alternative treatment(s) affected the quality of care for Resident 1.	F 490	Medication pass audits will be done periodically, and reviewed in the QA committee. The Pharmacist or representative will participate in on going education on medication administration. DNS will ensure compliance. F490 Resident #1 no longer resides in the facility. Administration will ensure that medications are administered in accordance to professional standards utilizing the 5 rights of medication administration.	2/20/15	

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F 490	<p>Continued From page 11</p> <p>Findings include:</p> <p>1. The Administration failed to ensure medication administration was performed in accordance to professional standards. Not utilizing the five rights for medication administration resulted in a significant medication error for Resident 1.</p> <p>Refer to CFR 483.20(k)(3), F-281- Services Provided Meet Professional Standards</p> <p>2. The Administration failed to ensure licensed staff monitored Resident 1 when there was a documented condition change and knowledge of a significant medication error.</p> <p>Refer to CFR 483.25,F-309 - Provide Care/Services for Highest Well Being.</p> <p>3. The Administration failed to ensure resources were available to calculate medication dosage. Lack of this resouces and not following standard of medication administration resulted in a significant medication error.</p> <p>Refer to CFR 483.25 (m)(2), F-333- Residents Free of Significant Med Errors</p>	F 490	<p>Administration will ensure that licensed staff are monitoring a resident with a condition change or who has experienced a significant medication error.</p> <p>Administration will ensure resources are available to assist nursing in calculation of medication dosages. Competency testing has been completed with nursing staff on medication administration to include calculation of dosing.</p> <p>Nursing staff was re-educated on alert documentation, and physician notification to include thorough objective data and ongoing assessment of a resident with change of condition or knowledge of a significant medication error.</p> <p>To prevent future incidents, ongoing education on conversion competency, assessments, monitoring and medication administration will be done with See attached</p>		

newly hired licensed nurses.

Annually will complete clinical competency reviews of current staff.

Medication pass audits will be done periodically, and reviewed in the QA committee. The Pharmacist or representative will participate in on going education on medication administration.

Refer to:
CFR 483.20(k)(3), F 281 Services to meet Professional Standards.

CFR 483.25, F 309 Provide Care/ Services for the Highest Practical Well Being.

CFR 483.25 (m)(2), F 333 Residents Free of Significant Med Errors.