

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505379	(X2) MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/14/2014
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NAME OF PROVIDER OR SUPPLIER ROYAL PARK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7411 NORTH NEVADA SPOKANE, WA 99208
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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 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Royal Park Care Center on 4/14/14. A sample of 6 residents was selected from a census of 157.</p> <p>The following complaints were investigated as part of this survey:</p> <p>#2989246 #2990662</p> <p>The survey was conducted by: Susan R. Bergeron, R.N.</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging and Long Term Support Administration Residential Care Services, District 1, Unit A Rock Pointe Tower 316 W. Boone Avenue, Suite 170 Spokane, Washington 99201-2351</p> <p>Telephone: (509) 323-7302 Fax: (509) 329-3993</p>  <p><i>Cleo Radford</i> Residential Care Services</p>	F 000	<p>Royal Park Care Center provides the Plan of Correction according to State and Federal Law. Royal Park Care Center neither admits nor denies but provides this Plan of Correction so it may continue to be in compliance with State and Federal Law.</p> <div style="text-align: center;"> <p>RECEIVED</p> <p>APR 29 2014</p> <p>DSHS ADSA RCS SPOKANE WA</p> </div>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE <i>Administrator</i>	(X6) DATE <i>4/29/2014</i>
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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 333 SS=G	<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 interview and record review, the facility failed to ensure 2 of 6 sample residents (#1, 2) were free of significant medication errors. The failed practice resulted in actual harm to Resident #1 who was hospitalized as a result of the incident, voiced emotional distress, and required interventions/monitoring following incident. Findings include:</p> <p>Resident #1 had diagnoses that included diabetes and required insulin to control his blood sugars. Per record review, the physician orders indicated the resident was to receive 18 units of Lantus insulin every morning.</p> <p>On 4/9/14 a licensed nurse mistakenly gave the resident 100 units of insulin instead of the 18 units ordered by the physician. The error resulted in the resident receiving 5.5 times the prescribed dosage of insulin.</p> <p>To prevent a severe hypoglycemic reaction the resident was given sugar based snacks, intravenous fluids containing glucose, and his blood sugars were closely monitored. To ensure the resident would receive appropriate treatment in the event of complications, the physician had the resident transported to the hospital where he was monitored overnight before returning to the facility the next day.</p> <p>Per the facility investigation, the licensed nurse who made the medication error mistook the concentration of insulin (100 units per milliliter),</p>	F 333	<p>How the nursing home will correct the deficiency as it relates to the resident(s) Resident #1 was given sugar based snacks, intravenous fluids containing glucose, and blood sugars were closely monitored every 15-30 minutes. For further monitoring, the resident was sent to the hospital. Resident #1 was closely monitored for emotional distress and this has since resolved. During a follow up interview on 4/28/14 Resident #1 denied emotional harm. Resident #2 did not have any adverse reaction, in fact blood sugars were normal.</p> <p>How the nursing home will act to protect residents in similar situations A house-wide review was completed of all orders for insulin (and similar medication orders) to ensure they were correctly written and administered as ordered.</p> <p>Measures the nursing home will take or systems it will alter to ensure that the problem does not recur A new policy was written to instruct nurses when transcribing a medication solution with a standard concentration (ie: Lantus), the concentration will not be transcribed. Direct education was given to the nursing staff on the importance of thoroughly reading all orders in their entirety.</p> <p>How the nursing home plans to monitor its performance to make sure that solutions are sustained The quality assurance nurse will perform frequent and random medication administration audits for accuracy of</p>	4/29/14	

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F 333	<p>Continued From page 2</p> <p>as the dosage and did not see the physician's order for 18 units listed afterwards.</p> <p>When interviewed on 4/14/14 at 2:10 p.m., the resident stated he no longer trusted the nursing staff and was concerned another medication error would occur. The resident further stated he felt weaker because the incident caused him to miss a day of physical therapy and he worried his discharge from the facility might be delayed as a result.</p> <p>The facility's failure to administer insulin correctly resulted in a significant medication error and actual harm to the resident who endured additional invasive blood sugar monitoring, intravenous therapy, hospitalization, emotional distress, and interruption of therapy services.</p> <p>Due to the medication error identified related to Resident #1, an audit of residents receiving insulin was completed by the facility on 4/10/14. The audit identified a second error on a different unit involving insulin administration.</p> <p>Resident #2 had diagnoses that included diabetes and required insulin to control her blood sugars. Per record review, the physician orders indicated the resident was to receive 30 units of Lantus insulin every morning.</p> <p>Per record review, the resident received 100 units of insulin rather than the 30 units ordered by the physician for 4 days starting on 4/7/14 and extending through 4/10/14. The error resulted in the resident receiving 3.3 times the prescribed dose of insulin for 4 days in a row.</p> <p>The resident, who routinely had extremely high blood sugars, had no adverse effects from the elevated dosage of insulin.</p> <p>During an interview on 4/14/14 at 1:10 p.m. and administrative nurse stated both errors were</p>	F 333	<p>(Continued from page 2)</p> <p>administration. The investigative nurse will perform audits on all new admits for accuracy of transcription of high risk medication orders for the next 30 days and then random audits on a quarterly basis thereafter.</p> <p>Title of person responsible to ensure correction Director of Nursing, Investigative Nurse, Resident Care Managers</p>	

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

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F 333	Continued From page 3 the result of nursing staffs' failure to read the physician's orders thoroughly.	F 333		