

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505092	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/02/2014
NAME OF PROVIDER OR SUPPLIER ALDERWOOD PARK HEALTH AND REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 2726 ALDERWOOD AVENUE BELLINGHAM, WA 98225	
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F 000 INITIAL COMMENTS

F 000

This report is the result of an unannounced Abbreviated Survey conducted at Alderwood Park Convalescent Center on 8/29/14 and 9/2/14. A sample of 13 residents was selected from a census of 83. The sample included 11 current residents and the records of 2 former and/or discharged residents.

The following complaints were investigated as part of this survey:

- #3029861
- #3036774
- #3034606
- #3034617

The survey was conducted by:

- Michelle Scollard R.N., B.S.N.
- Steve Kindle, R.N., M.N.
- Joy Kerns, R.N., B.S.N.

The survey team is from:

Department of Social & Health Services
Aging & Disability Services
Aging & Long-Term Support Administration
Residential Care Services, District 2, Unit A
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Telephone: (360) 651-6850
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[Signature] 9/12/14

Modified 10/1/14

Christine Webster RN

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

TITLE

(X6) DATE

[Signature]

Executive Director

9/23/14

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 Residential Care Services Date	F 000	<p align="center">DISCLAIMER CLAUSE</p> <p>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>	
F 333 SS=E	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 3 of 11 sampled residents, (Residents 1, 2 and 4), were free from significant medication errors. This failure placed the residents at risk for potential discomfort and/or potential health complications. Findings include: The facility's policy and procedure for Medication error, dated August 2000, directed the License Nurse (LN) to include the following: - Medication error report will be filled out for any medication error by the LN making the error or the LN finding the error and turned in to the Director of Nursing Services (DNS). - Discontinued medications were discontinued from the Medication Administration Record (MAR) by highlighting the medication entry with a yellow highlighter. This was done to decrease the opportunities for potential errors. In an interview on 8/29/14 at 12:24 p.m., Staff D, Unit Coordinator, stated medications were charted on by exception, (meaning all medication was given, except when the resident was unable, and this would be reflected as such on the MAR). LN's were expected to document on the MAR for	F 333		<p>F-333</p> <p>The medication error for resident #1 was investigated. The LN's involved in this error have been counseled. Resident #1 has been reassessed for pain management, reviewed with physician, and plan of care updated. Resident #2's medication regime was re-evaluated with the pharmacy and packaging adjusted to accommodate dosage variances. Plan of Care updated. Resident #4's blood sugar monitoring and insulin dosage reviewed with the physician and orders received. Plan of care updated.</p> <p>The current facility resident's MAR's and physicians orders have been audited and checked to assure no discrepancies. Any discrepancies found have been corrected.</p> <p>LN's have been in serviced on medication errors and checking the medication regimen.</p> <p>Audits are conducted weekly by the Resident Care Coordinators of the MAR's to assure compliance. The DON will assure compliance by monthly review.</p> <p>Results of audits and trends will be reported to the QAPI committee.</p> <p align="right">9/4/14 + ingray</p>

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F 333	<p>Continued From page 2</p> <p>the following medications when administered: routine and as needed insulin, antibiotics, Coumadin, routine and as needed narcotics, and as needed medications.</p> <p>RESIDENT 1 Resident 1 was admitted [REDACTED] with diagnoses to include, chronic pain, hip dislocation, and dementia. A pain assessment, dated [REDACTED] reported the resident rated pain on a scale of 1 to 10. Resident 1 rated their pain as a 10 at its worst and 4 at its best. The pain assessment indicated Resident 1 had chronic pain syndrome.</p> <p>A progress note, dated 8/11/14, indicated Resident 1 was to see her primary care physician to address her pain medications. The new physicians orders, dated 8/11/14, were noted in the record and on the medication administration record (MAR). Resident 1 was taken off of Oxycodone (narcotic pain medication) and placed on OxyContin (an extended-release narcotic medication given every 12 hours) for chronic pain.</p> <p>A review of the record also revealed a progress note, dated 8/19/14, stated "faxed M.D to notify of med error. Pt received 4 -1/2 (2.5mg) tabs Oxycodone instead of 10mg OxyContin. The Oxycodone was discontinued on 8/11/14."</p> <p>During an interview on 9/2/14 at 10:00 A.M., Staff B reported the process for medication errors was the person who found the medication error started the incident report, informed the Unit Coordinator and the Director of Nursing Services, (DNS). Staff B reported "We do not investigate, the DNS investigates the medication error."</p>	F 333		
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Staff B verified the narcotic medication was discontinued, and should have been destroyed by two nurses as soon as the order had been changed for Resident 1. Resident 1's narcotic medication had been changed on 8/11/14 and the medication error occurred on 8/19/14. Staff B was informed the fax to notify the physician of the error was not in Resident 1's clinical record. Staff B verified the physician notification should be in the clinical record. Staff B also verified that she believed an incident report was sent to the DNS related to this medication error.

On 9/2/14, the DNS reported the facility process when a medication error occurred was to have the staff who found, or committed, the error complete the Medication Incident Report, report the error to Staff B and the DNS would conduct the investigation into the error.

The DNS was shown the progress note reporting the medication error, the notification to the MD, the narcotic sign out sheet and the MAR for the date of the error. The DNS was informed Resident 1 had been given 4-1/2 (2.5mg) tablets of Oxycodone instead of OxyContin 10mg, the ordered narcotic. The MAR was initialed for the Oxycontin being given but Oxycodone had been signed out on the narcotics sign out sheet. The DNS confirmed that the medications were two different narcotic pain medications and there had been an error in medication administration. The DNS reported that she was unaware of the medication error for Resident 1 and had not conducted an investigation.

RESIDENT 2

Resident 2 was admitted to the facility [REDACTED]

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 [REDACTED] with diagnoses to include diabetes, hypertension and [REDACTED]

Resident 2's physician orders included routine NPH insulin in the morning, Novolin R insulin at midday and nighttime, daily weights and Metoprolol tartrate, (a high blood pressure medication), twice daily. There was a physician's order directing staff to hold the Metoprolol if Resident 2's systolic blood pressure was below 110 or if the apical pulse was below 60.

Resident 2's August 2014 MAR was reviewed. There were no initials indicated the morning insulin had been given on 8/17/14, the midday insulin had been given on 8/25/14 or the night insulin had been given on 8/11/14. There was no documentation in the medical record indicating the physician was notified of the missed insulin.

Resident 2 was to have his blood pressure and pulse taken prior to the administration of the high blood pressure medication Metoprolol. The Metoprolol was to be held if Resident 2's blood pressure was below 110 or the pulse was less than 60. The medication was administered 14 of 31 days in August with no documentation indicating Resident 2 had had a blood pressure check or a pulse taken.

RESIDENT 4
 Resident 4 was admitted [REDACTED] with diagnosis to include diabetes.

Resident 4's physician orders included the following for diabetic management:

Novolog 70/30 insulin 20 units in the morning and 18 units at midday.

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 Blood sugars checked before each meal and at
 bedtime.
 If the blood sugar was below 60, or above 350,
 notify the physician and initial on the Medication
 Administration Record (MAR) when it was done.

 Additionally, Resident 4 was started on
 nitrofurantoin (an antibiotic) twice daily on 8/2/14,
 which was placed on hold on 8/5/14, and Keflex
 (an antibiotic) three times daily on 8/5/14 for a
 urinary tract infection.

 Resident 4's August MAR was reviewed. There
 were no initials indicating the morning and midday
 Novolog dose had been administered on 8/4/14.
 Resident 4 had had variable blood sugars ranging
 from 188 - 465. On 8/4/14, there was no result
 documented for the midday blood sugar level and
 there was no explanation of why the blood sugar
 had not been done.

 On 8/11/14 the resident's blood sugar was as
 follows:

 Midday: 369
 Evening: 388
 Nighttime: 421

 There was no documentation on the MAR, or in
 Residents 4's clinical record indicating the
 physician had been notified of the elevated blood
 sugars recorded on 8/11/14. Similar findings
 were found on 8/24/14, 8/26/14, 8/27/14 and
 8/28/14.

 Furthermore, there were no initials on the MAR
 indicating Resident 4 received her scheduled
 antibiotics on 8/4/14, 8/9/14 and 8/10/14. The
 resident began another course of antibiotic

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 therapy on 8/19/14, four days after the completion of Keflex.

Upon further review of Resident 4's medical record, there was no documentation present indicating the missed dosages of insulin and antibiotics, or the elevated blood sugars, had been assessed, the physician had been notified or the medication error process had been followed.

In an interview on 9/2/14 at 1:32 p.m., the DNS confirmed there were no medication error reports done for any of the missed medications, or medications given outside of the physician orders, for either Resident 2 or 4.

F 333

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

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

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.

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Resident #2's medication regimen was re-evaluated with the pharmacy and packaging adjusted to accommodate dosage variances. Plan of Care updated. Resident #4 has been reassessed for appropriate pain management with hospice provider. Record keeping has been updated to monitor dosage and effectiveness.

Current facility resident's medication regimens have been reviewed to assure no discrepancies. Any discrepancies have been corrected. The pharmacy provider has agreed to provide the medications in a single dose form.

The resident care coordinators are reviewing the narcotic medications on a weekly basis. The director of nursing is also reviewing weekly.

Results of audits will be reported to the QAPI committee.

9/4/2014
[Signature]

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F 431	<p>Continued From page 7</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 observations, interviews and record reviews the facility failed to ensure controlled narcotics were store in a manner designed to avoid potential drug diversion in accordance with currently accepted professional standards for 2 of 4 residents (Residents 2 and 3) reviewed. This placed the residents at risk for unavailable medications when needed, to receive ineffective medications or biological supplies with compromised integrity.</p> <p>Findings include:</p> <p>The facility's "Controlled Medication Storage" policy and procedure, dated 5/1/07, stated a controlled medication (scheduled II, III, IV and V) accountability record should include the following information: Prescription number, name/strength/dosage form of medication, and</p>	F 431		

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F 431	<p>Continued From page 8</p> <p>quantity received. Furthermore, at shift change to Licensed Nurses (LN) were to count the physical inventory of all controlled medications.</p> <p>The facility's "Controlled Medication Disposal" policy and procedure, dated 5/1/07, directed the LN when a controlled substance was removed from the container for administration but was not given for any reason it is destroyed in the presence of two LN's and "... documented on the accountability record on the line representing that dose."</p> <p>RESIDENT 2 Resident 2 was admitted to the facility [REDACTED] with diagnoses to include [REDACTED] and arthritis.</p> <p>A review of Resident 2's physician orders revealed three different Vicodin (a schedule III narcotic) orders. The Vicodin orders included: Vicodin 1 tablet three times (at 6 am, midday and hour of sleep) a day routinely, Vicodin 1 tablet as needed every four hours for moderate left lower extremity pain and 2 tablets as needed every four hours for severe left lower extremity pain.</p> <p>Resident 2's controlled medication accountability record (narcotic record) and Vicodin Medication Administration Record (MAR) was reviewed. The following discrepancies were found with prescription number [REDACTED]:</p> <p>1. On 5/13/14 the facility received a pre-filled bubble pack card. The card contained a total of 120 tablets of Vicodin. The card was packaged with 2 tablets per "bubble" equaling 60 total doses. The LN documented 120 tablets were received to equal 60 doses. Each narcotic record</p>	F 431		

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F 431	<p>Continued From page 9</p> <p>page had documentation indicating the date, time, dose, LN signature and remaining doses for each specific narcotic. There were a total of 30 opportunities per page to sign out the narcotic. Throughout the documentation for this prescription number, totaling 3 pages, there was conflicting documentation from the LN of 1 tablet, 1 dose, or 2 tablets being removed.</p> <p>2. On 6/23/14 at "06," 7/5/14 at 8:00 p.m., 7/21/14 at 9:30 a.m., 8/14/14 at 7:45 p.m., and 8/16/14 at 11:50 a.m. 1 dose (2 tablets) were signed out of the narcotic record. There was no correlating documentation on the MAR to indicate when and why the resident received the Vicodin.</p> <p>3. On 7/16/14 at 11:45 a.m., the LN documented 1 tablet was given with no reason except for an arrow pointing up sign. The narcotic record had 2 tablets signed out at 12:30 p.m. There was no documentation in the narcotic record found of 1 tablet being wasted or if an extra dose was given to the Resident with the routine Vicodin. Furthermore there was no explanation documented for the discrepancy between the time the Resident was to receive and the time the Vicodin was removed from the narcotic record.</p> <p>4. On 8/9/14 at 4:15 a.m., the LN documented 1 tablet was given due to bottom wound pain. The narcotic record had 1 dose (2 tablets) signed out. There was no documentation in the narcotic record of 1 tablet being wasted.</p> <p>5. On 8/16/14 at 11:50 a.m., the LN removed a dose of Vicodin and documented the count to be 3 doses left. At 1500 (3:00 p.m.) the LN documented bubble pack with "2 tabs/dose, 4th dose only 1 given, destroyed 2nd one." There were two LN signatures verifying the second tablet being destroyed. The count was documented as 3 doses left. There should have</p>	F 431		
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 been 2 doses left since the count was 3 doses after the 11:50 a.m. dose was given. There was no documented explanation of the discrepancy.

Resident 2's narcotic ledger with prescription number [REDACTED] was reviewed. On 8/9/14 at 10:50 a.m., the LN documented on the MAR 1 tablet was given due to bottom wound pain. The narcotic record had 2 tablets removed at 11:30 a.m. There is a discrepancy in the time and dose given to the Resident with no documented explanation.

In an interview on 8/29/14 at 1:20 p.m., Staff C, LN, stated the LN is responsible for the accuracy of the narcotic record. This includes documenting the required elements listed on each narcotic record page. At each change of shift, two LN's counted the scheduled II and III's narcotic to ensure there were no discrepancies. If a discrepancy was noted, the LN's were to initiate the investigation. If the medication was not located, the LN was to notify the Director of Nursing Services (DNS) to continue the investigation. If the DNS was not available, the LN notified the Resident Care Coordinator or Quality Assurance Nurse.

In an interview on 9/2/14 at 1:32 p.m., Staff A, DNS, was asked regarding the discrepancy with Resident 2's Vicodin. Staff A was not aware of the discrepancies and would investigate. Staff A confirmed there was no medication error report filled out regarding the errors. Additionally, Staff A was asked why the narcotic record did not accurately reflect the total quantity of Vicodin regarding prescription number [REDACTED]. Staff A was not able to and stated the documentation would have to be investigated.

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F 431	<p>Continued From page 11</p> <p>RESIDENT 3 Resident 3 was admitted to the facility [REDACTED] with diagnoses to include dementia. Resident 3 began hospice services August 2014.</p> <p>A review of the physician orders the resident received 3 mg of liquid morphine routinely.</p> <p>Resident 3's narcotic record was reviewed. On page 10 of the schedule II narcotic record, prescription number 12115677, there was a discrepancy of the resident's liquid morphine.</p> <p>On 8/23/14 at 5:00 a.m., the LN gave 3 mg (.15 milliliters). The LN documented there was 3.90 (milliliters) left.</p> <p>On 8/23/14 at 7:15 a.m., the next entry on the narcotic record, two LN's documented the count was correct and had the total quantity as zero. There was no documentation on what happen to the remaining 3.90 milliliters of liquid morphine.</p> <p>In an interview on 9/2/14 at 1:32 p.m., Staff A, DNS, was asked regarding where the documentation was to support where the remaining morphine went. Staff A stated the dosage for the morphine was very small and how the morphine was removed there was chance for the morphine to evaporate. Staff A was not able to provide documentation of the missing 3.90 milliliters of morphine.</p>	F 431		
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