

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

PRINTED: 11/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/17/2014
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NAME OF PROVIDER OR SUPPLIER PARK MANOR REHABILITATION CTR	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 PLAZA WAY WALLA WALLA, WA 99362
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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
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INITIAL COMMENTS

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This report is the result of an unannounced Abbreviated Survey conducted at Park Manor Rehabilitation Center on November 14, 2014 and November 17, 2014. A sample of three residents was selected from a census of 76 residents. The sample included 2 current residents and the record of 1 former and/or discharged resident.

The following was a complaint investigated as part of this survey:

#3050243

The survey was conducted by:
Patti Zimmer, R.N.

The survey team is from:
Department of Social & Health Services
Aging & Long Term Support Administration
Residential Care Services, District 1, Unit C
3611 River Road, Suite 200
Yakima, Washington 98902

Telephone (509) 225-2800
Fax: (509) 574-5697

Residential Care Services Date

F 333
SS=D

483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS

F 333

The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:

This Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.

Received
Yakima RCS

DEC 09 2014

Received
Yakima RCS

DEC 10 2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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R. JOENS RN DNS FOR SERGE NEWBERRY ADMINISTRATOR 12-9-14

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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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Continued From page 1

Based on record review and interviews the facility failed to ensure 2 of 10 residents (#'s 1 and 2) were free from significant medication errors. This failure placed residents at risk for potential health complications. Findings include:

Resident #1: Admitted to the facility on [REDACTED] with diagnoses with included heart irregularities and history of pulmonary embolus (blockage of an artery in the lung caused by a blood clot).

Review of the resident's Laboratory Test Sheet noted his INR (International Normalized Ratio - a lab test to determine the ability of blood to be able to clot) between 9/9-10/23/14 noted his levels ranged from 1.2 on 9/9/14 to being over 8.0 on 9/16/14 and 10/21/14. Residents taking [REDACTED] normally have a targeted INR of 2.0-3.0, thus an INR over 8.0 is indicative of thin blood and a longer period of time to clot.

Review of a facility investigation report revealed on 10/23/14 the physician changed the resident's order for [REDACTED] (blood thinner medication), however the previous order for [REDACTED] was not discontinued on the Medication Administration Record (MAR). A medication error occurred on 10/28/14 when the resident received two doses of [REDACTED] 2.5 milligrams (mgs) each (one ordered on 10/23/14 and the other had been previously ordered on 9/25/14). At the time of the physician's order change the resident's INR was 3.0 and after the medication error on 10/28/14 the INR was above 8.0 on 10/29/14. In addition to the physician writing orders on 10/29/14 to hold the [REDACTED], Vitamin K (medication used for blood clotting) was ordered, however the resident refused to take it. In addition, the resident's [REDACTED] order was placed on hold.

F 333

F 333 Residents free of significant med errors

Resident # 1 and # 2 were assessed and medication errors were immediately reported to the physician, family, and residents. International Normalized Ratio (INR) LAB's were ordered and obtained, results reviewed by Physician. Licensed Nurse followed new orders and reviewed Electronic Medication Administration Record (eMAR). Nurse updated the Care Plan and monitored for any complications.

Current residents receiving anticoagulant therapy were reviewed by Resident Care Manager and or designee to ensure orders are entered/ transcribed correctly and Anticoagulant Medications administered per physician orders.

The Director of Nursing (DNS) and or designee will in-service licensed nurses on the administration and plan of care regarding administering [REDACTED] and/or other anti-coagulant medication. Training will include how to take an order and follow through transcribing an order and checking ensuring that the orders are entered correctly and the need to discontinue previous orders as needed when receiving a new order as required. Also, on administering medication using the 7 rights as well as including licensed staff rechecking the telephone orders and comparing it to the eMAR.

12-15-14

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F 333	<p>Continued From page 2</p> <p>On [REDACTED] the resident was found on the floor after falling. He was transferred to the Emergency Room due to concerns about his high INR the previous day and potential for bleeding. His INR in the ER was 8.9, thus he was given Vitamin K and returned to the facility.</p> <p>An interview on 11/14/14 at 2:35 p.m. with Staff A (Licensed Nurse) revealed MARs for residents had changed to electronic on 10/21/14, thus staff was new to the process despite education being given. The new physician order of 10/23/14 had been entered into the computer correctly, however staff failed to discontinue the previous order from the computer.</p> <p>Resident #2: Admitted to the facility on [REDACTED] with diagnoses which included history of pulmonary embolus.</p> <p>Review of physician's orders on 10/28/14 at 4:15 p.m. noted the resident's [REDACTED] 3.0 mgs was to be held for two days, then resume at 3.0 mgs on Monday, Wednesday, and Friday; and 1.5 mgs on Tuesday, Thursday, Saturday, and Sunday. The resident's INR on that day (10/28/14) was 4.8. Despite the above order written at 4:15 p.m. for the [REDACTED] to be held it was administered at 6:00 p.m. that evening and was only held for one day (10/29/14) instead of the ordered two days. The resident's INR was 4.5 on 11/6/14.</p>	F 333	<p>Resident Care Managers (RCM) and or designee will conduct weekly random audits times four weeks to ensure anti-coagulant therapy is implemented per physicians orders including med pass and transcribing orders to ensure the right order is in the eMAR and the right dose of medication has been given. Findings will be given to the DNS for review.</p> <p>DNS and or designee will bring findings to the Quality Assessment & Performance Improvement (QAPI) committee. The QAPI committee will review the audits/findings and make recommendations as needed.</p> <p>The Director of Nursing will ensure compliance.</p>	12-15-14