

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

PRINTED: 12/03/2013  
FORM APPROVED  
OMB NO 0938-0391

211

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/26/2013
NAME OF PROVIDER OR SUPPLIER  NEWPORT COMMUNITY HOSPITAL LTC		STREET ADDRESS, CITY, STATE, ZIP CODE 714 WEST PINE STREET NEWPORT, WA 99156	
(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 conducted at Newport Community Hospital LTC on 11/19/13, 11/20/13, 11/21/13, and 11/22/13, 11/25/13 and 11/26/13. A sample of 32 residents was selected from a census of 37. The sample included 27 current residents and 5 former/discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████, R.N., B.S.N          ██████████, R.N., B.S.N          ██████████, R.N., B.S.N          ██████████, R.N., B.S.N          ██████████, B.S.W.          ██████████, M.S.W</p> <p>The survey team is from:          Department of Social &amp; Health Services          Aging &amp; Long-Term Support Administration          Division of Residential Care Services, District 1, Unit A          Rock Pointe Tower          316 West Boone Avenue, Suite 170          Spokane, Washington 99201-2351          Telephone: (509) 323-7300          Fax: (509) 329-3993</p> <p><i>[Signature]</i>          Residential Care Services          Date: 12/2/13</p>	F 000	<p>See plan of Correction (P.O.C) attached.</p> <p><b>RECEIVED</b>          DEC 17 2013          DSHS ADSA RCS          SPOKANE WA</p>

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

TITLE

(X6) DATE

CEO/Administrator

12/13/2013

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.

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

PRINTED: 12/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  NEWPORT COMMUNITY HOSPITAL LTC	STREET ADDRESS, CITY, STATE, ZIP CODE 714 WEST PINE STREET NEWPORT, WA 99156
--	--

(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 329 SS=D 483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview and record review it was determined the facility failed to ensure adequate monitoring for side effects for 1 of 5 (#32) residents reviewed for unnecessary medications. Failure to monitor for possible adverse side effects placed the resident at risk for receiving medication that can cause negative health consequences.  
Findings include:

F 329

*See P.O.C attached*

*TW 12/13/2013*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  11/26/2013
NAME OF PROVIDER OR SUPPLIER  NEWPORT COMMUNITY HOSPITAL LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 714 WEST PINE STREET NEWPORT, WA 99156		
(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 329 Continued From page 2

Resident #32 had a diagnosis that included

██████████, ██████████, and ██████████  
██████████

Per record review of the physician's orders the resident received a daily dose of the medication ██████████ to help the heart beat stronger and more regular. The medication had side effects that included lethargy (appearance of deep tiredness), confusion, and blood toxicity. Blood tests are routinely conducted to screen for toxic levels of the drug.

Per review of pharmacy recommendations for October 2012 it was recommended the resident undergo blood tests every 6 months for ██████████ toxicity. The resident's physician agreed with the recommendation and signed the order on 11/7/12.

Per review of the residents laboratory reports, the most current ██████████ screening was dated 11/13/12. No further laboratory values for ██████████ screening were available at time of survey.

The resident was observed on 11/20/13 sitting in his wheel chair, had a thin appearance and lethargic. The resident confirmed to the surveyor " of being tired".

Staff #A confirmed on 11/25/13 that recommendations from the pharmacy are reviewed by the secretary, placed on the order sheets, nursing makes notes and reviews and she keeps a list of the recommendations. She further stated " Resident #32 is to be checked every 6 months." When informed that the physician orders reviewed from the past year till current month did not reflect the November 2012 recommendations she stated " that could be a problem."

F 333 483.25(m)(2) RESIDENTS FREE OF  
SS=D SIGNIFICANT MED ERRORS

F 329

*See P.O.C Attached*

F 333

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  NEWPORT COMMUNITY HOSPITAL LTC	STREET ADDRESS, CITY, STATE, ZIP CODE 714 WEST PINE STREET NEWPORT, WA 99156
--	--

(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 3  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure 3 of 10 residents reviewed for medication management (#19, 32, 46) in a sample of 32 were free from significant medication errors. Findings include:  1. Per record review, Resident #32 had diagnoses including [REDACTED] pain. On 10/10/13, the physician discontinued the order for [REDACTED] and wrote a new order for a [REDACTED] to be applied every 3 days. The first [REDACTED] was applied on 10/11/13. Per record review, on 10/13/13 during the evening shift, the resident complained of increased pain. Staff #B administered a dose of [REDACTED] to the resident and then notified the physician she gave medication dose because she did not know the medication was discontinued. Per record review, on 10/16/13 during the evening shift, the resident complained of severe pain (8 on a pain scale of 1-10). Staff #B discovered the date on the [REDACTED] was out of date & should have been changed on 10/14/13 (dated 10/11/13), applied a new [REDACTED], and administered an [REDACTED] pain [REDACTED] to treat the resident's increased pain. Review of the facility incident reports for the 2 medication errors revealed the following: When the new medication orders were processed on 10/10/13, licensed nurses by mistake destroyed the new pain [REDACTED] instead	F 333	See p.o.c Attached	
-------	--	-------	--------------------	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/26/2013
NAME OF PROVIDER OR SUPPLIER  NEWPORT COMMUNITY HOSPITAL LTC		STREET ADDRESS, CITY, STATE, ZIP CODE 714 WEST PINE STREET NEWPORT, WA 99156	
(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	<p>Continued From page 4 of the [REDACTED]</p> <p>Staff #B stated she made the medication error on 10/13/13 because the [REDACTED] was available, she didn't check the MAR prior to giving the [REDACTED], so didn't know the medication was discontinued.</p> <p>The facility investigation did not address why licensed nurses administering medications to the resident on 10/14, 10/15, and 10/16/13 did not find the pain [REDACTED] was out of date and should have been changed as ordered.</p> <p>In an interview on 11/26/13 at 9:45 a.m., Staff #A stated even though the pain [REDACTED] were destroyed by accident, [REDACTED] would be available in the emergency kit or the pharmacy. On 10/14/13 an agency licensed nurse should have changed the resident's pain [REDACTED]. The agency nurse did not take steps to find a pain [REDACTED] and/or communicate the lack of pain [REDACTED] to the pharmacy or other licensed nurses.</p> <p>Staff #A stated licensed nurses dated pain [REDACTED] when they were applied to the residents' skin, and documented the [REDACTED] placement every shift on the MAR or treatment record. At the request of the surveyor, Staff #A reviewed the resident's November 2013 MAR and confirmed that [REDACTED] placement was still not being monitored on the MAR.</p> <p>The facility's failure to ensure licensed nurses consistently checked the medication orders prior to administering medications, consistently communicated when medication doses were unavailable, and consistently monitored placement of pain [REDACTED] resulted in significant medication errors and placed the resident at risk for worsening pain.</p> <p>2. Resident #46 no longer resided in the facility.</p>	F 333	See p.o.c attached

JHW 12/13/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>505422</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/26/2013</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>NEWPORT COMMUNITY HOSPITAL LTC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>714 WEST PINE STREET NEWPORT, WA 99156</b>
---	--

(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 5

Per record review, the resident had diagnoses including [REDACTED]. Physician orders on admission on [REDACTED]/13 included a medication to treat [REDACTED] to be administered twice daily.

Review of the facility investigation dated 7/27/13 revealed the blood pressure medication was not transcribed onto the new order sheet on 7/15/13. Staff #C discovered the medication error on [REDACTED]/13, 12 days after the resident was admitted.

The investigation did not include statements from the licensed nurses who failed to transcribe the medication orders correctly to determine how the medication error occurred.

In an interview on 11/26/13 at 9:45 a.m., Staff #A stated 2 nurses would have checked the admission order transcription. She had no additional information related to the cause of the medication error.

The facility's failure to ensure licensed nurses accurately transcribed new medication orders resulted in the resident not receiving blood pressure medication for 12 days.

3. Per record review, Resident #19 had physician orders for daily pain pills for [REDACTED]. On 9/30/13 the physician changed the pain pill administration times from 8:00 a.m., 5:00 p.m., and bedtime to 7:00 a.m., 1:00 p.m., and bedtime.

Review of the resident's October 2013 medication administration record (MAR) revealed the medication doses were given as ordered.

The facility's medication error investigation dated 10/8/13 indicated Staff #D administered an additional dose of the the pain pill on 10/1, 10/2, 10/5, 10/6, and 10/7/13, for a total of 5 additional doses.

F 333

*See P.O.C Attached*

*FW 12/13/2013*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  11/26/2013
NAME OF PROVIDER OR SUPPLIER  NEWPORT COMMUNITY HOSPITAL LTC.			STREET ADDRESS, CITY, STATE, ZIP CODE 714 WEST PINE STREET NEWPORT, WA 99156		
(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 6 Per the investigation, Staff #D gave the medication each day without checking the order and documenting on the MAR. Staff #D signed for each dose of medication in the resident's narcotic record without noticing a dose of medication was signed out by a day staff member at 1:00 p.m. each day. Another licensed nurse on 10/8/13 discovered the medication errors when checking the narcotic record. In an interview on 11/26/13 at 4:00 p.m., Staff #D stated she worked intermittently and was not familiar with the electronic documentation system when she made the medication errors. She confirmed she did not check the MAR before administering the pain pills so was not aware the medication orders had changed.	F 333	<i>See p.o.c Attached</i>		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  11/26/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  NEWPORT COMMUNITY HOSPITAL LTC	STREET ADDRESS, CITY, STATE, ZIP CODE 714 WEST PINE STREET NEWPORT, WA 99156
--	--

(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 441 Continued From page 7

(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection

(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.

(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens  
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:  
Based on observation and interview, it was determined that the facility failed to ensure staff used proper hand hygiene to prevent cross-contamination of germs when assisting 2 residents (#32, 43) with their meals in the dining room. Findings include:

On 11/22/13, between 10:45 a.m. and 11:20 a.m. the following observations were made in the dining room:  
Staff #F was feeding Resident #43 at one table and assisting Resident #32 at a different table. Staff #F was observed putting her gloved

F 441

*See P.O.C Attached*

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

PRINTED: 12/03/2013  
FORM APPROVED  
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  505422	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  11/26/2013
NAME OF PROVIDER OR SUPPLIER  NEWPORT COMMUNITY HOSPITAL LTC			STREET ADDRESS, CITY, STATE, ZIP CODE 714 WEST PINE STREET NEWPORT, WA 99156		
(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 441	Continued From page 8 finger in Resident #43's applesauce, to test the temperature, and then feeding it to her. The staff member was also observed wiping food off Resident #43's straw and off her spoon, then feeding her potatoes with the same spoon and using the same straw for the resident to drink her fluids. The staff member used the same gloves in between assisting the two residents and was observed touching Resident #32's wheelchair and not changing her gloves or washing her hands. On 11/26/13 at 1:40 p.m., Staff #G (Director of Nursing) confirmed the staff member did not follow proper handwashing procedures when feeding residents in the dining room. The facility failed to ensure hand hygiene was performed appropriately and effectively which placed residents at risk for acquiring unnecessary germs and/or infection.	F 441	See p.o.c attached		