

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

PRINTED: 03/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505290	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/12/2014
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NAME OF PROVIDER OR SUPPLIER STAFFORD HEALTHCARE AT BELMONT	STREET ADDRESS, CITY, STATE, ZIP CODE 560 LEBO BOULEVARD BREMERTON, WA 98310
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Standard Survey conducted onsite at Stafford Healthcare At Belmont on 3/10/14 & 3/12/14. The sample included 4 current residents and 1 former and or discharged resident out of a census of 96.</p> <p>The following are complaints investigated as part of this survey:</p> <p>#2972161</p> <p>The survey was conducted by:</p> <p>Woodetta Owens, RN, MN</p> <p>The surveyor is from:</p> <p>Department of Social and Health Services Aging and Long-Term Support Administration Division of Residential Care Services District 3, Unit A P.O. Box 45819 MS: N27-24 Olympia, WA 98504-5819</p> <p>Telephone: (253) 983-3800 Fax: (253) 589-7240</p> <p><i>Orongen Orumen</i> 3/25/14 Residential Care Services Date</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Robert Washburn</i>	TITLE <i>Administrator</i>	(X6) DATE <i>4/1/14</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 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to consult with the physician when 2 of 5 residents</p>	F 157	<p>The facility will immediately inform the resident, consult with a resident's physician, notify the resident's legal representative or an interested family member when there is an accident, significant change in resident's physical, mental or psychosocial status, or a decision to transfer or discharge a resident from the facility.</p> <p>Resident #1 is not currently in the facility. Resident #2 is deceased.</p> <p>The DNS has informed all LN's on staff of the legal requirements, facility policy and general expectation of physician notification. Written confirmation that the materials were received and understood have been collected. A Medical Records designee will audit at least monthly for ongoing compliance. The DNS will follow up on each instance reported where the policy was not followed to ensure compliance is maintained.</p>	4/15/14
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F 157

Continued From page 2
(#'s 1 & 2) reviewed had a change of condition. This failure prevented the physician from being aware of the change in condition and the opportunity to alter treatment or to commence a new form of treatment in a timely manner. This failure placed residents at risk for unmet medical treatment when Resident #1 admitted to the hospital [REDACTED] most likely secondary to a urinary tract infection and when Resident #2 developed a stage III pressure ulcer.

RESIDENT #1
Resident #1 originally admitted to the facility on [REDACTED] and had multiple diagnoses to include [REDACTED]

The minimum data set (MDS), an assessment tool, dated 1/31/14 identified Resident #1 required extensive assist of one person for toilet use.

Review of the nursing progress notes revealed Resident #1 presented with a temperature of 100.8 on 3/1/14 at 7:29 a.m., and received Tylenol. The nursing progress note did not identify if the Tylenol was effective, only that there were no other symptoms.

On 3/1/14 at 4:00 p.m., the nursing progress note documented the resident had a temperature of 101.7 and received Tylenol. After receiving Tylenol the resident remained febrile, with a temperature of 100.8, and the physician had not been notified.

On 3/2/14 at 11:11 a.m., the resident was noted to continue with an elevated temperature of 100.8. The resident received Tylenol and the temperature decreased to 98.9.

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F 157	<p>Continued From page 3</p> <p>On 3/3/14 at 4:08 p.m., the resident was noted to have chills, shaking aggressively, with thick white discharge in the tubing of his catheter.</p> <p>On 3/3/14, two days later, the ARNP was notified of the resident's change of condition. Staff was directed to obtain the following:</p> <ul style="list-style-type: none"> -CBC and CMP (blood testing) -Remove catheter, collect clean catch urine, then reapply catheter -Start Antibiotics after collection of urine -Anti-nausea medication as needed <p>According to the nursing progress note, when the catheter was removed a large blood clot discharged from the urethra, with blood and sediment in the urine.</p> <p>On 3/4/14 the resident's temperature spiked to 105 and orders received to send the resident to the hospital for further evaluation and treatment.</p> <p>According to the hospital records, the resident admitted to the hospital [REDACTED]</p> <p>On 3/12/14 at 1:30 p.m., during an interview, the ARNP stated 3/3/14, was the first time she was notified of the resident's fever, and if a residents temperature does not go down, would expect to receive a call within an hour or two.</p> <p>On 3/12/14 p.m., at 3:39 p.m., during and interview, staff A (director of nursing) stated according to the facility's policy and procedure, the physician should be notified within 24 hours of a change in a resident's condition.</p>	F 157		
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F 157	<p>Continued From page 4</p> <p>Review of the facility's policy and procedure for "notification of condition changes" dated 8/2009, documented, "Resident's responsible family member or legal representative and the resident's physician will be notified as soon as possible, or within 24 hours, of any changes in the resident's condition."</p> <p>RESIDENT #2 Resident #2 admitted to the facility on [REDACTED] with multiple diagnoses to include [REDACTED]</p> <p>The minimum data set (MDS), and assessment tool, dated 2/22/14, documented the resident required extensive assist of two people for bed mobility, and total assist of two people for transfers.</p> <p>Review of the nursing progress note dated 2/26/14, documented the resident had a 1.5 open area to the right buttock.</p> <p>On 3/10/14 at approximately 11:45 a.m., during an observation with the licensed nurse (Staff B), revealed Resident #2 had a 1.5cm x 2 cm stage III pressure ulcer to the right buttock.</p> <p>On 3/10/14 at 1:40 p.m., Staff B reported she was unaware the resident had developed a stage II pressure ulcer on 2/26/14, and as far as she knew the resident did not present with an open area until 3/4/14, the day she requested a treatment from the physician for the stage II pressure ulcer.</p> <p>During the same interview, Staff B stated the nurses on the floor are responsible for reporting to the physician when a resident has a stage II</p>	F 157		

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F 157	Continued From page 5 pressure sore and also to her. Staff B was unable to provide documented evidence that the physician had been notified on 2/26/14 that the resident had a stage II pressure ulcer to the right buttock which later developed into a Stage III pressure ulcer.	F 157		
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