

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

PRINTED: 01/17/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  50A263	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 01/03/2013
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NAME OF PROVIDER OR SUPPLIER  LAKELAND VILLAGE NURSING FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE STATE HIGHWAY 902 & SALNAVE ROAD MEDICAL LAKE, WA 99022
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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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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Lakeland Village Nursing Facility on 1/2/13 and 1/3/13. A sample of 11 resident was selected from a census of 84 residents. The sample included all current residents.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#2728581 ✓ #2727523 ✓ #2727534 ✓ #2728502 ✓ #2727795 ✓ #2728030 ✓</p> <p>The survey was conducted by:  Danielle McLain R.N., B.S.N.</p> <p>The survey team is from:</p> <p>Department of Social &amp; Health Services Aging &amp; Disability Services Administration Residential Care Services, District 1, Unit B 316 West Booane Avenue, Suite 170 Spokane, Washington 99201-2351</p> <p>Telephone: (509) 327-7303 Fax: (509) 329-3993</p> <p><i>Louise Hemenway</i> 1/23/13 Residential Care Services Date</p>	F 000	<p style="text-align: center;"><b>RECEIVED</b> JAN 28 2013 DSHS HEALTH SERVICES SPOKANE WA</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Danielle McLain</i>	TITLE  1/23/2013	(X6) DATE
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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 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=D	<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 failed to ensure that residents were free of any significant medication errors for 2 of 7 residents (#1, 3) in a sample of 11 related to insulin and seizure medications. Findings include:</p> <p>1) Resident #1, had diagnoses of severe developmental disabilities and diabetes. He was dependent on nursing staff for medication administration. Per record review, the resident's doctor ordered blood sugar testing before breakfast, dinner, and at bedtime. The resident was to receive 2 units of insulin before breakfast and dinner for blood levels 131 milligrams (mg)/deciliter (dl) to 150 mg/dl and 3 units of insulin for blood levels 151 mg/dl to 200 mg/dl. At dinner he was to receive 2 units of insulin for blood levels 151 mg/dl to 200 mg/dl.</p> <p>Per record review, there were 7 incorrect doses of insulin from September 2012 through December 2012. In September 2012, there was 1 insulin error. On 9/27/12 at 8:00 p.m., the resident's blood sugar was 155 mg/dl. Staff #B did not give any insulin to the resident. He should have received 2 units of insulin.</p> <p>Per record review, there were was 1 insulin error in October 2012. On 10/19/12 at 5:00 p.m., the resident's blood sugar was 146 mg/dl. Staff #C did not give any insulin to the resident. He</p>	F 333	<p>Plan of Correction for F333</p> <ol style="list-style-type: none"> <li>Lakeland Village Nursing Facility will ensure that all residents are free from any significant medication errors by having all NF nursing staff inserviced on the need for careful review of the details of the orders documented on resident MARs. The first inservice is focused on the specifics of resident #1 and the details of their diabetic orders emphasizing the importance of careful review of the orders on the MAR for sliding scale insulin as well as documentation on both the diabetic record and the MAR. The second inservice is focused on the specifics of orders on all residents campus wide with emphasis placed on careful review of the details of the orders on the MARs.</li> <li>Specialized training will be completed for Staff #F on the Lakeland Village Medication Administration policy.</li> <li>The facility has established and hired a Registered Nurse for Staff Development. This individual has developed a training program for nursing staff on medication administration.</li> <li>The Nursing Facility will review medication errors and this citation as an agenda item for Quality Assurance Committee meetings on at least a quarterly basis for the next six months.</li> </ol> <p>Corrective action will be completed by February 2, 2013.</p> <p>Nursing Home Administrator and Director of Nursing will ensure compliance.</p>	

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F 333	<p>Continued From page 2</p> <p>should have received 2 units of insulin.</p> <p>Per record review, there were 3 insulin errors in November 2012. On 11/4/12 at 8:00 p.m., the resident's blood sugar was 156 mg/dl. Staff #C gave 3 units of insulin to the resident when he should have received 2 units of insulin. On 11/7/12 at 4:45 p.m., the resident's blood sugar was 156 mg/dl. Staff #D gave no insulin when he should have received 3 units of insulin. On 11/25/12 at 5:00 p.m., the resident's blood sugar was 167 mg/dl. Staff #C did not give any insulin and the resident should have received 3 units of insulin.</p> <p>Per record review, there were 3 insulin errors in December 2012. On 12/7/12 at 8:30 p.m., the resident's blood sugar was 160 mg/dl. Staff #F gave 3 units of insulin and should have given 2 units of insulin. On 12/8/12 at 7:30 a.m., the resident was eating breakfast and so Staff #G checked him at 11:30 a.m. and his blood sugar was 134 mg/dl. The resident should have received 2 units of insulin, but Staff #G gave 3 units of insulin. Per the facility investigation dated 12/16/12, on 12/14/12 at 8:00 p.m. Staff #E obtained a blood sugar of 150 mg/dl. She administered 2 units of insulin and later realized the resident should not have received any insulin and changed the MAR to match the insulin she administered.</p> <p>On 1/3/13 at 1:35 p.m., Staff #A reported he was not aware of the other insulin errors by all of the different nurses and agreed with the concerns.</p> <p>There was no negative outcome noted for the resident however, the facility failed to ensure that residents were free of any significant medication errors and placed the residents at risk for harm.</p>	F 333		
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F 333	<p>Continued From page 3</p> <p>2) Resident #3, per record review, had profound developmental disabilities and seizures. She was dependent on nursing staff for medication administration.</p> <p>Per record review, the resident was on scheduled medications for her seizures. She also had prn (as needed) medications for seizures that lasted greater than 5 minutes. The order read, "Give [REDACTED] 5-10 mg prn seizures. Give 10 mg rectal prn for seizure activity lasting greater than 5 minutes. May repeat x 1 dose. Not to exceed 2 doses. Call provider if continued."</p> <p>Per the facility investigation dated 12/16/12, at 9:45 a.m. the resident had a seizure that lasted longer than 5 minutes and Staff #F administered 5 mg of [REDACTED]. At 10:10 a.m., the resident had another seizure that lasted 5 minutes and Staff #F administered another 5 mg of [REDACTED]. The seizure activity continued and the nurse notified the doctor and received orders to transport to a local hospital. The investigation revealed the doctor's order was not followed and unclear.</p> <p>On 1/3/13 at 1:35 p.m., Staff #A reported Staff #F thought the dose ordered was a range and gave the lower amount because the resident had a smaller body type. He agreed the order was confusing. He also said he had discussed with pharmacy and was told the dose had to be included to satisfy the prescription labeling requirements and billing requirements.</p> <p>The facility failed to ensure that residents were free of any significant medication errors and may have placed the resident at risk for unnecessary hospitalizations.</p>	F 333			