STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	505243	A. BUILDING _____ B. WING _____	06/03/2013

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EVERGREEN NURSING & REHAB CENTER	430 LILLY ROAD NORTHEAST OLYMPIA, WA 98506

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0157 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor and a family member of the resident of situations (injury/decline/room, etc.) that affect the resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** . Based on observation, record review and interview, the facility failed to immediately consult with a physician for a change in condition for 1 of 2 residents (#s 1) reviewed for notification. Failure to immediately consult the physician delayed [DIAGNOSES REDACTED]. Findings include: <Resident #1> Resident #1 was admitted to the facility on [DATE], discharged to the hospital on [DATE] with an anticipated return. Resident #1 readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 6/3/13, the resident was observed sleeping, lying in her bed with a urinary foley catheter. The tubing running from her bladder to the bag collecting the urine contained milky yellow, cloudy, sand like material in it. On 4/22/13 according to the nursing progress notes, Resident #1's urinary catheter bag contained green thick looking pus in it and the physician was going to be faxed. The facility did not consult with the resident's physician immediately. 24 hours later, a fax dated 4/23/13, at 9:45 pm, was sent to the physician after the abnormal findings were identified. On 4/24/13, the physician responded, and ordered a urine culture and sensitivity for Resident #1. On 4/26/13 the physician assessed the Resident #1 and documented the urinalysis was positive, the culture was pending. The physician ordered an antibiotic, [MEDICATION NAME] 100mg per tube twice daily for 7 days. The record indicated doses of the antibiotic were missed. There was no evidence that the physician was consulted when there was a documented omission for the first antibiotic ordered for the UTI, or that the physician was consulted regarding the results of the urine culture which identified antibiotics capable of treating/resolving Resident #1's UTI. The DNS gave no explanation why there were delays consulting with the physician or treatment for [REDACTED].
F 0315 **Level of harm -** Actual harm **Residents Affected -** Few	**Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have a physician's order including medical justification, maintenance and care for use of an indwelling urinary catheter for 2 of 2 (#1 & 2) sampled residents reviewed for urinary care. This failure caused harm to Resident #1 who sustained catheter related complications, including urinary tract infections. Findings include: The Code of Federal Regulations (CFR) 42.483.25(d)(1) identifies that urinary catheters should be reserved for short-term decompression of acute [MEDICAL CONDITION] due to risk of significant complications from the use of indwelling urinary catheters. According to the CFR The assessment should include consideration of the risks & benefits of an indwelling (suprapubic or urethral) catheter; the potential for removal of the catheter; & consideration of complications resulting from the use of an indwelling catheter, such as symptoms of blockage of the catheter with associated bypassing of urine, expulsion of the catheter. All observations and interviews took place on 6/3/13. <Resident #1> Resident #1 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS), an assessment tool, dated 4/26/13, documented the resident required extensive assistance with Activities of Daily Living (ADLs), had a urinary foley catheter (a tube inserted into the urethra to drain urine from the bladder), was always incontinent of stool, received nutrition via a tube placed in her stomach, and was moderately cognitively impaired with long and short term memory deficits. On readmit 3/18/13, the Nursing comprehensive admission data collection and assessment documented the resident had a urinary catheter, but did not document the size of the catheter. Review of the transfers orders from the hospital documented Foley catheter management per nursing protocol-Permanent. Review of the facility admission orders [REDACTED]. On 4/2/13, according to the facility documentation, Resident #1's catheter was removed and an attempt to reinsert it failed. The PCP ordered the resident to go to an emergency room (ER) to have a urinary catheter inserted. The resident returned later in the evening, and was documented as having a urinary catheter placed by the ER staff. On 4/3/13, the signed physician orders for Resident #1 had no orders for a urinary foley catheter. There was no evidence the nursing staff identified the lack of a current faclity order for continuation of it, and did not seek and order for the urinary catheter. On 4/19/13, another Nursing comprehensive admission data collection and assessment was completed. It documented the resident had a urinary catheter size, and the LN documented the medical justification was [MEDICAL CONDITION], although there was no physician diagnosis. On 4/22/13 according to the nursing progress notes, the LN documented Resident #1's urinary catheter bag contained green thick looking pus in it and the physician was going to be faxed. Twenty-four hours later, a fax, dated 4/23/13, at 9:45 pm, was sent to the PCP notifying of the abnormal findings . On 4/24/13, the PCP returned the fax with documented orders for the facility to obtain a urine culture for Resident #1. The urine specimen was obtained at 5:30 on 4/25/13. 4/26/13, the PCP assessed the resident and documented the urinalysis was positive, the culture was pending, and diagnosed Resident #1 UTI with associated clinical sequelae. The physician ordered an antibiotic, [MEDICATION NAME] 100mg per tube twice daily for 7 days. On 4/29/13, at 7:01 am, the lab faxed the facility the results of t he urine culture. The lab report documented a list of 5 intravenous medications that werer effective against the identified organisms. On 6/3/13, the resident was observed in bed sleeping and a urinary foley catheter was noted to be drainingmilky yellow, cloudy, urine with what appeared tod be, sand like material in it. A family member of the residsente was prersent and indicated that she comes in to visit and has observed the color of Resident #1's urine to be so dark, almost like tea, I am constantly telling them to give her water in her peg tube. RCM A was asked about Resident #1's urinary catheter. RCM A stated the facility protocol was usually to have orders for a urinary catheter, which included a schedule for the catheter to be changed. RCM A did not respond if the catheter currently inserted in Resident #1 was from 4/2/13 when the resident was sent to the ER and had one inserted then. After the investigation, the facility provided a copy of ONHC Standing Orders; House protocol for Foley catheter care that directed staff to change catheter tube every 6 weeks and prn leaking, change catheter bag every 6 weeks and prn leaking, catheter care every shift. There was no documentation that the house protocol was documented on a MAR/TAR to communicate when the resident required, or received care as per the facility protocol. There was no documentation to support Resident #1 had her urinary catheter changed according to the facility policy and procedure. Resident #1's urinary catheter was changed 9 weeks later, after insertion on 4/2/13 at the ER . In addition, there were no PCP orders from the date of admission in March 2013 up through this investigation in June that indicated the resident was to have a foley catheter continuously or for what on-going medical reason th at it was necessary. <Resident #2> Resident #2 was admitted to the facility on [DATE], discharged on [DATE] with an anticipated return. Resident #2 readmitted on [DATE] with [DIAGNOSES REDACTED]. The MDS dated [DATE], documented the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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 0315 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) resident required extensive assistance with Activities of Daily Living (ADLs), was cognitively intact with no memory deficits, and was always incontinent of her bowel and bladder. Resident #2 was in her bed, observed with a urinary foley catheter. Her family member stated she was visiting as she did every day. The family member voiced her concerns about staff recognizing serious health problems that arose for Resident #2, especially the resident's kidney stones. The medical record was reviewed. The physician orders contained an order for [REDACTED]. The physician's orders were shown to the DNS, who stated they were incomplete and did not contain the required components. .
F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide appropriate interventions, based on resident's specific identified conditions, needs and potential for entrapment, to prevent accidents for 1 of 3 residents (#1) reviewed for accidents. This failure caused harm to Resident #1 who sustained injuries that required emergent care and treatment at a hospital. These failures to adequately assess or monitor resident responses to planned interventions placed the residents at risk of not having their safety care needs recognized and addressed to prevent future injury. Findings include: Resident #1 was admitted to the facility on [DATE], discharged to the hospital on [DATE] with an anticipated return. Resident #1 readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS), an assessment tool, dated 4/26/13, documented the resident required extensive assistance with Activities of Daily Living (ADLs), was moderately cognitively impaired with long and short term memory deficits. On 6/3/13, the resident was observed lying on her right side in a regular bed with a bed rail on the right side of the bed and the left side of the bed against the wall. Resident #1's family member was visiting and stated she visited daily. The family member said she noticed prior to the first fall out of bed, Resident #1's had an air mattress that appeared to be deflated on the left side and she (family member) believed the faulty equipment caused the resident to slide and fall out of bed. Resident #1's plan of care, Fall/injury assessment, dated March 2013, documented the resident had verbal and visual sensory impairment factors, received narcotic and antipsychotic medications that were identified as a potential of risk for falls/injury. The care planned nursing interventions documented to prevent falls were an air mattress (a specialized bed filled with air and has a slick surface), two person transfers with a mechanical lift because of being bed bound and increased supervision, failed to define increased supervision. On 5/4/13, according to the facility documentation, the resident was found by her family lying on the floor. Resident #1 stated she hit her head, and was observed with 2 x 3 inch hematoma (blood filled area under the skin) that she said caused her pain. On 5/5/13, a report of the injurious incident documented Resident #1 was positioned on her side too close to the edge of the bed, rather than the middle of the bed. The report documented patient (resident) is able to fidget and might have leaned over and with gravity, the patient rolled out of bed. The final outcome of the report documented patient to be positioned more in the middle of the mattress rather than to the edge of the mattress. The care plan entry dated 5/5/13, documented, Resident had fall with injury the goal was reduce number of falls in 12 weeks and the nursing interventions to prevent future falls was increased visual checks with reminders to use call light for transfers, there was no intervention to position the resident in the middle of the mattress. The May 2013, Treatment Administration Record (TAR) documented a half side rail was implemented on 5/14/13, and LN staff were to monitor proper placement of the rail. On 5/15/13, evening shift, was the first LN initials indicating that was done. According to the facility documentation, on 5/17/13, the resident rolled off the left side of her bed, and sustained a 4 cm (slightly larger than 1.5 inches) laceration above her right eye, a 5 cm (2 inch) abrasion to her right knee that caused her pain and left upper extremity swelling. The resident was sent to a hospital for evaluation and emergent care for her injuries. On 5/20/13, a late entry documented an order was received for the resident to have her left side of her bed against the wall and a half side rail at the right side of the bed to assist with independent bed positioning. The investigation report dated 5/21/13, documented it was the resident's preference was to lie on her back or right side, and had been positioned on her left side after cares were provided and appeared to have rolled out of bed between the bed and the wall. Based on the two fall occurences where the resident was found on the floor to the left side of the bed, the facility identified it was a trend for the resident a trend to roll off the left side of the bed. The bed rail had been identified as malfunctioning in the second fall. According to the facility investigative findings for each injury, improper care delivery or faulty equipment was identified as a contributing factor. The facility was going to revise the plan of care to not position the resident on her left side and place the left side of the bed next to the wall. The care plan entry dated 5/17/13, documented, Fall with injury and the intervention documented to staff to prevent future falls was to place the bed against wall. There was no documentation about positioning the resident on her left side only. Interviews with Nursing Assistants (NA) A, B and C indicated that they were unaware of why the resident was positioned only on her right side and her back but that they knew this was what they were supposed to do. The facility documentation indicated the resident had the half side rail prior to the 5/17/13 incident. The facility findings regarding the injury incident documented the bed rail had malfunctioned which was unknown until the incident occurred. The facility failed to accurately assess the entrapment risk for the resident when it implemented the side rail for Resident #1, based on her observed and staff stated cognitive abilities, dependence on staff for care. .
F 0333 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that residents are safe from serious medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review, interview and observation the facility failed to ensure residents were free of medication errors for 1 of 3 (# 1) residents reviewed. The failure to ensure medication and treatment orders were obtained, accurate and administered as as ordered placed Resident #1 at risk of worsening infection. Findings include: Resident #1 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The April 2013 physician orders [REDACTED].#1 was to receive [MEDICATION NAME]-[MEDICATION NAME] 20-1, a generic form of [MEDICATION NAME] 20mg capsule, via her peg tube every morning before breakfast, [MEDICATION NAME] sulfate (iron supplement) 325 mg tablet given via tube twice daily with breakfast/dinner, and for the tube feeding formula [MEDICATION NAME] 1.2, 55 milliliters(ml) given over an hour, infusing 23hours a day with 150 ml of water given every 4 hours. The Medication Administration Record (MAR) documented the physician order [REDACTED]. Several drugs interfere with the effectiveness of [MEDICATION NAME] including diroin supplements which the resident had ordered. [MEDICATION NAME] was documented as having been administered every am to the resident by the licensed nurses (LN). There was no specific time documenting when the medication was administered to ensure the printed guideline was followed (1 hour before meals), additionally the tube feeding orders with the schedule of administration (including the amount of time the tube feeding was to be off before giving certain medications) were omitted from the MARs. The MAR documented the physician order [REDACTED]. Hand written in the area was 7.5 ml without any initials, or clarification. The documented times of administration were am and pm. There was no evidence the [MEDICATION NAME] and iron supplement were not given together, or the PCP was consulted regarding the potential interaction decreasing the absorption of the iron. <Medication omissions> On 4/26/13, the PCP assessed the resident and documented the urinalysis was positive and a culture was pending. The physician ordered an antibiotic, [MEDICATION NAME] 100mg per tube twice daily for 7 days. On 4/27/13, a telephone order (TO) documented a pharmacy interchange of [MEDICATION NAME] 100mg four times a day for 7 days to replace the previous order of [MEDICATION NAME]. The MAR revealed the resident did not receive two doses of the new antibiotic on 4/28/13, one dose on 4/29/13, and two doses on 4/30/13. The MAR revealed the resident was to receive [MEDICATION NAME] 250ml/5 ml, give 2.5 ml (125 mg) per tube every other day for one week starting on 4/30/13. The MAR revealed the resident did not receive her first dose on 4/30/13. On 5/1/13 at 4 pm, a LN documented on the final lab report, the physician gave a verbal telephone order [MEDICATION NAME] ([MEDICATION NAME]), 1 gram IV x 7 days and start 5/2/13. A telephone order was written with the same data in the medical record and sent to the pharmacy. The antibiotic written as being ordered, [MEDICATION NAME], was not one of the five antibiotics identified by the lab as capable of resolving the organisms grown in Resident #1's urine. The medical record did not contain evidence the PCP saw the final lab result with the 5 IV medications listed as being able to resolve the infectious organisms. On 5/2/13, the MAR documented the resident received her first dose of the IV antibiotic [MEDICATION NAME], that was not identified by the lab report as an antibiotic that could treat the organisms in the resident's urine. On 5/8/13, according to the facility nursing documentation, a dose of the antibiotic was not given by the day shift nurse on 5/7/13. On 5/10/13, a Telephone Order (T.O.) documented for Resident #1 to receive [MEDICATION NAME] 1 gram IV x 1 for missed IV abo (antibiotic) dose 5/7/13. <Failure to implement orders in a timely

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F 0333 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) manner> On 3/21/13 the Registered Dietician (RD), documented a Nutrition Risk Data Collection and assessment, identified the resident had abnormal lab values, a Stage 2 coccyx wound and a stage 1 right heel pressure wound. The RD documented recommended add 45 milliliters (ml) of Pro Stat 101 (protein supplement) during 1 hour off formula (the physician ordered tube feeding schedule) x 30 days as a goal to improve the resident's skin issues, abnormal lab values, and weight. The RD documented she would continue to monitor the resident. On 5/21/13, the RD documented, skin-coccyx Stage 2 re-occurrence, add 30 ml of Pro-stat 101 via the feeding tube during the 1 hour off the tube feeding formula for 30 days, with vitamin D 1000 iu (international units) and that the recommendations not put in place. On 5/25/13, 72 days after the RD's initial recommendation, for the protein supplement be given to improve the resident's wounds and abnormal labs, and 4 days after the RD identified and documented the supplement had not been implemented, a telephone order was written, but omitted the parameter given by the RD (during the 1 hour off tube feeding). <Incorrect/omission transcription of the MAR> (Tube feeding formula) The admission orders [REDACTED]' s tube feeding formula [MEDICATION NAME] 1.2 at 55 cc/hour for 23 hours daily and 150 cc of water to be given every 4 hours. The LN documented the feeding should start at 11 p.m. and end at midnight. The order as transcribed would only ensure the resident would get 1 hour of nutrition, instead of 23 hours. There was no evidence any of the order was transcribed to the MAR. The April and May 2013 physician orders [REDACTED]. There was no evidence of it being transcribed to the MARs. (Stomach medication) A physician telephone order, dated 4/16/13, documented change [MEDICATION NAME]-[MEDICATION NAME] 20-1,100 cap (capsule) when supply runs out to [MEDICATION NAME] CE 20mg. There is no existing medication per the RPh (registered pharmacist) interview. The April 2013 MAR documented the [MEDICATION NAME]-[MEDICATION NAME] (generic for [MEDICATION NAME]) order. A large yellow sticky note was placed on the MAR that read Please use other med until gone then start [MEDICATION NAME] CE. The MAR was not properly transcribed with the telephone order received 4/16/13 a sticky note is not legal documentation for medication changes. According to a progress note entry on 5/17/13, the Licensed Nurse (LN) documented the pharmacy was called notifying them the generic [MEDICATION NAME] had run out. The [MEDICATION NAME] covered by the resident's insurance that was delivered contained large granules (inside the capsule) that the LN was unable to get the granules down the resident's very small opening of the feeding tube. The LN documented the pharmacy would contact the insurance company. The June MAR documented the LN's had dispensed [MEDICATION NAME] 20 mg capsule, in the am with the same warning regarding dispensing an hour before a meal. The medication cart was observed, and contained a medication card, labeled with the resident's name and the medication [MEDICATION NAME] 20 mg capsule, that LN B stated was being dispensed for the [MEDICATION NAME]. The MAR documented a medication as being administered that had not been dispensed, and the medication given was not documented on the MAR, and was given at the same time as nutrition was being delivered, not as the parameters ordered 1 hour before meals. .