

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Long Term Care Survey Process conducted at Martha and Mary Health Service on 09/10/18, 09/11/18, 09/12/18, 09/13/18, 09/14/18, 09/17/18 and 09/18/18. A sample of 57 residents was selected from a census of 168. The sample included 52 current residents, and the records of five former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>Diana Tiliano, RN, BSN Anna Brown, RN Stefan Brown, MA, CRC Tawny Caldwell, RN Gerald Chambers, RN, BSN Marilyn Edwards, RN, MN Molly McClintock, BS, TRS Donna Palabrica, RN, BSN</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, Region 3 P.O. Box 98907 MS: N27-24 Lakewood, Washington 98496-8907</p> <p>Telephone: 253.983.3800 Fax: 253.589.7240</p>			F000			

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

TITLE

(X6) DATE

Electronically Signed

10/10/2018

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 the 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.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F552 F552 SS=D	<p>Continued From page 1</p> <p>Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5)</p> <p>483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including:</p> <p>483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.</p> <p>483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.</p> <p>483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to provide information on a safety device (transfer pole) for one of 15 residents (Resident #164) reviewed for accidents. Failure to obtain an informed consent of risk and benefits prior to placement of the transfer pole had the potential for the resident or their legal representatives to have a lack of knowledge to make an informed decision.</p> <p>Findings included ...</p> <p>Review of the admission Minimum Data Set (MDS, a required assessment tool) dated</p>			F552 F552	<p>HOW WILL THE NURSING HOME CORRECT THE DEFICIENCY AS IT RELATED TO THE RESIDENT?</p> <p>Resident #164: Unit Manager requested an order from provider for enabling device for transfer pole per therapy recommendation. Risk and Benefits of pole provided to Resident #164 and consent obtained for transfer pole at bedside. Order for transfer pole device received, Care Plan revised for enabling device.</p> <p>HOW WILL THE NURSING HOME ACT TO PROTECT THE RESIDENTS IN SIMILAR SITUATIONS?</p> <p>Medical record audits conducted by Unit Managers of all residents with transfer poles completed. All residents with transfer poles have all required documentation including order, education regarding risks and benefits, informed consent, care plan updates and proper positioning of transfer pole in resident room.</p> <p>HOW THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR?</p> <p>Transfer Pole Policy created to contain processes and guidelines in regards to safe transfer pole implementation and correct documentation requirements.</p> <p>Education will be conducted for all nursing staff regarding transfer pole policy and guidelines, safe transfer pole implementation and correct transfer pole documentation.</p>		11/15/18

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F552	<p>Continued From page 2</p> <p>08/23/18, showed that Resident #164 admitted on 08/16/18 with multiple diagnoses to include high blood pressure, muscle spasms and arthritis. Resident #164 was able to make needs known.</p> <p>During an interview and observation on 09/11/18 at 11:59 AM, Resident #164 stated that she used the transfer pole to transfer in and out of bed. A transfer pole was placed next to Resident #164's bed.</p> <p>Review of the Care plan initiated on 08/17/18 showed that Resident #164 required a two person assist with the use of a mechanical lift for transfers.</p> <p>Review of Resident #164's medical record showed no physician's order for a transfer pole. The medical record further showed no documentation of Resident #164 being provided information of all potential risks and benefits to make an informed decision (consent) regarding the use of a transfer pole.</p> <p>During an interview on 09/17/18 at 2:26 PM, Staff B, Director of Nursing Services, stated that an informed consent should have been obtained for Resident #164, prior to the use of any safety device (transfer pole).</p> <p>Reference WAC 388-97-0260 (1) (a)</p>			F552	<p>Unit Interdisciplinary Team will conduct chart audits to ensure all residents with transfer poles have all required documentation including order, education regarding risks and benefits, and informed consent.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTION ARE SUSTAINED?</p> <p>The Interdisciplinary Team will review resident medical record for required transfer pole documentation and report to Monthly IDT QAA Committee.</p> <p>DATE THAT THE CORRECTIVE ACTION WILL BE COMPLETED?</p> <p>Date of completion will be November 15, 2018</p> <p>THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION?</p> <p>Assistant Director of Nursing, Director of Nursing, Director of Rehab, Administrator</p>		
F554 SS=D	<p>Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)</p> <p>483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by 483.21(b)(2)(ii), has determined that this practice is clinically appropriate.</p>			F554	<p>HOW WILL THE NURSING HOME CORRECT THE DEFICIENCY AS IT IS RELATED TO THE RESIDENT?</p> <p>Resident #36: Completed self-medication assessment, determined by nursing staff safe to self-administer medications.</p>		11/15/18

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F554	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to assess for safe self-administration of medication for two of two residents (Resident #s 36 and 50) reviewed for dialysis. This failure placed the residents at risk for inappropriate and unsafe medication use.</p> <p>Findings included ...</p> <p>The facility's policy titled, "Medication Administration - General Guidelines," dated 03/04/14, stated, "Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications."</p> <p>RESIDENT #36 Review of the quarterly Minimum Data Set (MDS, a required assessment tool) dated 06/18/18, showed that Resident #36 admitted on 12/10/17 with multiple diagnoses to include kidney failure, and required dialysis (the medical process of removing excess water and toxins from the blood in those whose kidneys have lost the ability to perform these functions in a natural way) three times per week. The MDS further showed that Resident #36 was able to make her needs known.</p> <p>In an interview on 09/11/18 at 9:32 AM, Resident #36 stated that she takes her Renvela (a medication which lowers the amount of phosphorus in the blood of patients receiving kidney dialysis) to dialysis with her to self-administer while there.</p>			F554	<p>Provider order authorizing Resident #36 to self-administer medication received. Care Plan updated to state resident safe to self-administer medication at hemodialysis appointments. Reassessment will be completed quarterly or with resident change of condition.</p> <p>Resident #50- Completed self-medication assessment, determined by nursing staff safe to self-administer medications. Provider order authorizing Resident #50 to self-administer medication received. Care Plan updated to state resident safe to self-administer medication at hemodialysis appointments. Reassessment will be completed quarterly or with resident change of condition.</p> <p>HOW THE NURSING HOME WILL ACT TO PROTECT THE RESIDENTS IN SIMILAR SITUATIONS?</p> <p>Resident Self-Administration of Medication Assessment form will be implemented for residents who request to depart facility with medications for outings, medical appointments or Hemodialysis services. Reassessment will be completed quarterly or with resident change of condition.</p> <p>Medical record audits will be completed for all residents that are transported to hemodialysis for self-medication assessment if resident self-medicates outside of facility.</p> <p>HOW THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR?</p>		

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F554	<p>Continued From page 4</p> <p>Review of Resident #36's physician orders, dated 09/12/18, showed that Resident #36 did not have an order authorizing her to take her Renvela to dialysis, nor to self-administer that medication.</p> <p>Review of Resident #36's medical record did not show that a self-administration assessment had been completed or care planned.</p> <p>In an interview on 09/13/18 at 10:12 AM, Staff M, Registered Nurse/Unit Manager (RN/UM), stated that there had not been a self-medication assessment completed for Resident #36.</p> <p>.</p> <p>RESIDENT #50</p> <p>Review of the quarterly MDS dated 06/29/18, showed that Resident #50 admitted on 04/09/18 with multiple diagnoses to include heart disease, anxiety, kidney disease requiring dialysis, and diabetes. This MDS further showed that Resident #50 was able to make his needs known.</p> <p>An observation and interview on 09/12/18 at 11:24 AM, showed that Resident #50 sat in the front lobby and waited for the shuttle to arrive to transport him to dialysis. When asked if Resident #50 took medication with him to dialysis, he stated, "Yes." Resident #50 further stated that he had three pills in a small package in his bag which contained Simethicone (a medication that treats bloating, discomfort or pain from gas), Calcium Acetate (a medication that assists with binding of other minerals), and Renvela.</p> <p>Review of Resident #50's physician's orders dated September 2018 showed that he went to</p>			F554	<p>Education will be conducted to all licensed nurse staff regarding self-medication assessment requirement for all residents that leave facility with medications.</p> <p>Unit Interdisciplinary Team will review daily if any resident requests self-medication assessment. Once capacity for self-medication is determined, documentation will be completed in the medical record. Unit Interdisciplinary Team will continue to monitor residents with self-medication orders, evaluate other residents as needed.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED?</p> <p>Unit Managers will audit medical records of unit residents to determine if documentation is complete for those on a self-medication program, and verify that those who leave facility for appointments with medications have a self-administration of medication assessment complete, orders received and Care Plan updated for authorizing self-medication.</p> <p>DATES THAT CORRECT ACTION WILL BE COMPLETED?</p> <p>Date of completion November 15th, 2018</p> <p>THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION?</p> <p>Unit Manager, Assistant Director of</p>		

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F554	<p>Continued From page 5</p> <p>dialysis on Monday, Wednesday and Friday. However, there was no order that showed Resident #50 was to take medication to dialysis.</p> <p>Review of Resident #50's medical record did not show that a self-administration assessment had been completed or care planned.</p> <p>During an interview on 09/12/18 at 1:14 PM, Staff B, Director of Nursing Services (DNS), stated that she was unable to find that Resident #50 had been assessed to self-administer medications. Staff B, DNS, further stated that her expectation was that a self-medication assessment, physician's order and a care plan should have been completed prior to Resident #50 taking medication out of the facility to dialysis.</p> <p>Reference WAC 388-97-0440</p>			F554	Nursing, Director of Nursing, Administrator		
F578 SS=E	<p>Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir</p> <p>CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)</p> <p>483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.</p> <p>483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).</p> <p>(i) These requirements include provisions to</p>			F578	<p>HOW WILL THE NURSING HOME CORRECT THE DEFICIENCY AS IT IS RELATED TO THE RESIDENT?</p> <p>Resident #110- Advance Directive (AD) information discussed and offered during Care Conference on 9/28/18. Resident declined assistance, stated brother is POA, and she will contact him and request a copy.</p> <p>Resident #125 Advance Directive information discussed during Care Conference 9/12/18. AD packet given to resident and family. Son present and accepted information.</p> <p>Resident #144- Durable Power of Attorney received from residents spouse on 10/5/18.</p> <p>Resident #50- Advance Directives</p>		11/15/18

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBORO, WA 98370			
(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) COMPLETE DATE
F578	<p>Continued From page 6</p> <p>inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.</p> <p>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.</p> <p>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.</p> <p>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review the facility failed to inform and provide written information about the facility's advance directive policy, provide assistance and have periodic reviews for eight of 13 residents (Resident #s 110, 125, 144, 93, 131, 50, 153 and 156). These failures denied the residents and/or representatives the opportunity to direct health care in the event that they were to become unable to make decisions or communicate health care preferences.</p> <p>Findings included...</p>			F578	<p>information discussed and packet offered 10/3/18. Agreed to discuss further with Social Services.</p> <p>Resident #153- Durable Power of Attorney received from resident 9/14/18.</p> <p>Resident #156- Durable Power of Attorney received from resident 9/18/18.</p> <p>Resident #93- Advance Directive information discussed and packet given to resident, agreed to discuss next quarterly Care Conference.</p> <p>Resident #131- Advance Directive information discussed and packet given to resident on 10/4/18.</p> <p>HOW THE NURSING HOME WILL ACT TO PROTECT THE RESIDENTS IN SIMILAR SITUATIONS?</p> <p>An audit of resident charts was completed. Residents who did not have an advance directive on file, their assigned social worker discussed the importance of advance directives and provided an advance directive packet for them to review and consider.</p> <p>Packet includes the following: "Letter from Chief Executive Officer encouraging residents to consider establishing an advance directive "Advance directive facility policy "Template and samples of advance directives to include but not limited to DPOA for Health Care "List of local mobile notaries</p> <p>HOW THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR?</p>		

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2018
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE			STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370	
(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) COMPLETE DATE
F578	<p>Continued From page 7</p> <p>Advance Directives (AD) An AD is "a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated."</p> <p>REGULATION STATEMENT- PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) Federal regulation defined a POLST as "...a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST paradigm form is not an AD."</p> <p>The regulations also stipulated, "If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time."</p> <p>RESIDENT #110 Review of the quarterly Minimum Data Set (MDS, a required assessment tool) dated 08/01/18 showed that Resident #110 admitted</p>	F578	<p>Upon admission, Martha & Mary will identify if the resident has an advance directive. If not, Martha & Mary will determine if the resident wishes to formulate an advance directive. A resident has the option to execute an advance directive, but is not required to do so. Martha & Mary will not condition the provision of care or otherwise discriminate against a resident based on whether they have executed an advanced directive. Martha & Mary will provide the resident, if they so choose, with the opportunity to give written instructions to the staff about their wishes regarding do not resuscitate instructions using a POLST form. If a resident is incapacitated at the time of admission and is unable to receive information or articulate whether he or she has executed an advance directive, Martha & Mary will give advance directive information to the resident representative. If the resident wishes to execute an advance directive, Social Services staff will be available to assist the resident in obtaining needed outside assistance, including copies of forms, witnesses, and outside legal advice. Martha & Mary does not provide legal advice or assistance. For residents who choose not to execute an advance directive, medical decisions are made consistent with policies on Determining Decisional Capacity and the Informed Consent Process. If no decisions are made, Martha & Mary is obligated to treat a resident as full code.</p> <p>Education will be conducted for all licensed nurse staff, Social Services staff and Health Information Manager regarding</p>	

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F578	<p>Continued From page 8</p> <p>on 04/24/18 with multiple diagnoses to include multiple sclerosis (a disease that may damage nerve cells in brain and spinal cord and cause impairment of speech, muscular coordination, blurred vision and fatigue). This MDS further showed that Resident #110 was able to make her needs known.</p> <p>Review of Resident #110's Electronic Health Record (EHR) showed no documentation of the resident requesting or declining the completion of an AD or that the facility offered assistance in the development of an AD.</p> <p>During an interview on 09/12/18 at 10:18 AM, Staff P, Admission Coordinator (AC), stated that Resident #110 had only signed the POLST but no advance directive. Furthermore, Staff P, AC, stated that an AD brochure was provided in the admission packet but it was not discussed with the resident.</p> <p>During an interview on 09/12/18 at 12:40 PM, Resident #110 stated that she remembered signing the POLST but no facility staff discussed the option to have an AD.</p> <p>During an interview on 09/12/18 at 12:45 PM, Staff Y, Social Service Director/Case Manager, (SSD/CM), stated that the POLST was discussed at care conferences with residents; however, the AD was not discussed.</p> <p>RESIDENT #125 Review of the admission MDS dated 08/22/18 showed that Resident #125 admitted on 08/04/18 with multiple diagnoses to include atrial fibrillation (an abnormal heart rhythm), fracture of the left ankle, muscle spasms, anemia (low red blood cells), high blood pressure and pain. Resident #125 was able to make her needs</p>			F578	<p>change of Advance Directive Policy, process and documentation requirements.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED?</p> <p>Admission staff will inquire if resident has Advance Directives and note on the Admission Checklist & Discharge Planning form if copies of the document are received at time of signing admission paperwork; resident representative will provide documents to Martha & Mary; or Advance Directive packet was provided.</p> <p>After completion of the admission paperwork, if resident or representative agrees to provide documents, the Resident Accounts Department will monitor for submission of completed documents. Resident Accounts will notify Social Services Department bi-monthly on documents that remain outstanding. For those individuals who have been provided an advance directive packet, the residents' social worker will review bi-annually with resident the importance of advance directives and inquire if one has been complete.</p> <p>DATES THAT CORRECT ACTION WILL BE COMPLETED?</p> <p>Date of correction November 15th, 2018</p> <p>THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION?</p>		

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F578	<p>Continued From page 9 known.</p> <p>Review of Resident #125's EHR showed no AD found and no documentation of the resident requesting or declining the completion of an AD or that the facility offered assistance in the development of an AD.</p> <p>During an interview on 09/12/18 at 10:26 AM, Staff Y, AC, stated that no AD or Power of Attorney (POA) was in Resident #125's EHR and that she would call the resident's son to discuss the AD process.</p> <p>During an interview on 09/12/18 at 12:35 PM, Resident #125 stated that no one had discussed the AD process since she had been admitted to the facility or whether she had a POA for health care decisions.</p> <p>RESIDENT #144 Review of the admission MDS dated 08/29/18 showed that Resident #144 admitted on 08/22/18 with multiple diagnoses to include atrial fibrillation, above the knee amputation of both left and right legs, muscle spasms, anemia, high blood pressure, heart disease and pain. Resident #144 was able to make his needs known.</p> <p>Review of Resident #144's EHR showed no AD found and no documentation of the resident requesting or declining the completion of an AD or that the facility offered assistance in the development of an AD.</p> <p>During an interview on 09/13/18 at 10:19 AM, Resident #144 stated that he did not remember anyone from the facility discussing AD's or if he had a POA for health care decisions should he become incapacitated.</p>			F578	Director of Social Services, Chief Clinical Officer and Administrator		

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F578	<p>Continued From page 10</p> <p>During an interview on 09/13/18 at 10:30 AM, Staff J, Assistant Director of Nursing Services/Unit Manager (ADNS/UM), stated that she was aware of the issue of residents not having AD's and that the information should be included in their medical records.</p> <p>RESIDENT #50 Review of the quarterly MDS dated 06/29/18, showed that Resident #50 admitted on 04/09/18 with multiple diagnoses to include heart disease, anxiety, kidney disease requiring dialysis (a process of removing waste, salt and extra water from the body to prevent them from building up in the body) and diabetes. This MDS further showed that Resident #50 was able to make his needs known.</p> <p>Review of Resident #50's EHR showed a hospital had assisted Resident #50 with initiating his durable power of attorney for health care; however, it was never discussed with the brother and/or notarized. There was no documentation that the facility offered assistance to complete the durable power of attorney for Resident #50 on admission, nor did they conduct periodic reviews.</p> <p>During an interview on 09/12/18 at 1:14 PM, Staff B, Director of Nursing Services (DNS), stated that her expectation was that assistance should have been provided to Resident #50 to complete his Power of Attorney paperwork.</p> <p>RESIDENT #153 Review of the admission MDS dated 08/10/18,</p>			F578			

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F578	<p>Continued From page 11 showed that Resident #153 admitted on 08/03/18 with diagnoses to include malnutrition (lack of sufficient nutrients in the body), and dysphagia (difficulty swallowing). Resident #153 was able to make needs known.</p> <p>Review of Resident #153's EHR showed no AD found and no documentation of the resident requesting or declining the completion of an AD or that the facility offered assistance in the development of an AD.</p> <p>During an interview on 09/13/18 at 2:58 PM, Staff A, Administrator, stated that there was no AD for Resident #153.</p> <p>RESIDENT #156 Review of the quarterly MDS dated 08/20/18, showed that Resident #156 admitted on 11/13/17 with multiple diagnoses to include heart failure, arthritis and anxiety disorder. Resident #153 was able to make needs known.</p> <p>Review of the EHR showed Resident #156 had a Durable Power of Attorney (DPOA) for asset (financial) management dated 10/30/14; however, showed no AD for medical/health and no documentation of the resident requesting or declining the completion of an AD or that the facility offered assistance in the development of an AD.</p> <p>During an interview on 09/13/18 at 11:44 AM, Staff A, Administrator stated that she was unable to locate documentation related to Resident #156's AD or evidence of offering to establish AD.</p> <p>.</p> <p>RESIDENT #93</p>			F578			

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F578	<p>Continued From page 12</p> <p>Review of the quarterly MDS dated 07/31/18 showed that Resident #93 readmitted to the facility on 02/26/18. The MDS showed that Resident #93 was able to make her needs known.</p> <p>Review of Resident #93's medical record showed no advanced directive and no documentation of the resident or responsible party being offered assistance in the development of one.</p> <p>In an interview on 09/14/18 at 11:15 AM, Staff B, DNS, stated that there was not an advanced directive or documentation for Resident #93 that showed assistance was offered in the development of one.</p> <p>RESIDENT #131</p> <p>Review of the quarterly MDS dated 08/10/18 showed that Resident #131 readmitted to the facility on 11/04/17. The MDS showed that Resident #131 was able to make her needs known.</p> <p>Review of Resident #131's medical record showed no advanced directive and no documentation of the resident or responsible party being offered assistance in the development of one.</p> <p>In an interview on 09/14/18 at 11:15 AM, Staff B, DNS, stated that there was not an advanced directive or documentation for Resident #131 that showed assistance was offered in the development of one.</p> <p>Reference WAC 388-97-0300 (1)(b), (3)(a-c)</p>			F578			

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F584 F584 SS=D	<p>Continued From page 13</p> <p>Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)</p> <p>483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>The facility must provide- 483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</p> <p>483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</p> <p>483.10(i)(3) Clean bed and bath linens that are in good condition;</p> <p>483.10(i)(4) Private closet space in each resident room, as specified in 483.90 (e)(2)(iv);</p> <p>483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81F; and</p> <p>483.10(i)(7) For the maintenance of</p>			F584 F584	<p>HOW THE NURSING HOME CORRECT THE DEFICIENCY AS IT RELATED TO THE RESIDENT?</p> <p>Resident #1: Wheelchair cleaned immediately by nurse manager. Resident #135: Wheelchair cleaned immediately by nurse manager. Resident #91: Cracked wheelchair armrests immediately changed with new set. Unit staff will report identified chairs that are in need of additional cleaning or repair before the next scheduled washing.</p> <p>HOW THE NURSING HOME WILL ACT TO PROTECT THE RESIDENTS IN SIMILAR SITUATIONS?</p> <p>Wheelchairs will be cleaned, disinfected and inspected, following the wheelchair washing procedure and schedule. Unit staff will identify chairs that are in need of cleaning or repair. Unit staff will notify wheelchair washer regarding wheelchairs that are due to be cleaned. Staff will be trained regarding the wheelchair cleaning and inspection process.</p> <p>HOW THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR?</p> <p>Wheelchair cleaning, disinfection and inspection process is updated to ensure cleaning of wheelchairs is scheduled regularly both morning, evening and when needed.</p> <p>Education will be conducted for all nursing</p>		11/15/18

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F584	<p>Continued From page 14 comfortable sound levels.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to provide a sanitary home like environment to include safe and sanitary wheelchairs and cushion for three of seven residents (Resident #s 1, 91 and 135) reviewed for environmental services. These failures placed residents at risk for use of unsanitary and unsafe equipment and a potential for diminished quality of life.</p> <p>Findings included...</p> <p>RESIDENT #1 Review of the quarterly Minimum Data Set (MDS, a required assessment tool) dated 08/23/18 showed that Resident #1 admitted on 06/13/13 with multiple diagnoses to include heart disease, high blood pressure, dementia (a group of thinking and social symptoms that interferes with daily functioning), kidney disease, anxiety and depression. The MDS further showed that Resident #1 had impaired memory.</p> <p>Multiple observation between 09/10/18 through 09/14/18 showed Resident #1's wheelchair had a white dried substance on both armrests of the wheelchair and leg rests. In addition, Resident #1's wheelchair had a buildup coating of dust on the frame.</p> <p>RESIDENT #135 Review of the quarterly MDS dated 08/13/18 showed that the Resident #135 admitted on 09/17/12 with multiple diagnoses to include heart disease, high blood pressure, dementia, anxiety and depression. The MDS further</p>			F584	<p>staff and environmental staff in regards to wheelchair cleaning and disinfection process, cleaning schedule and inspection procedure.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED?</p> <p>Monitoring of wheelchair cleaning and maintenance will be managed by staff licensed nurse assigned to wheelchair cleaning and inspection. Assigned nurse will audit the wheelchair washing binder to ensure regular cleaning and inspection of wheelchairs is completed. Assigned nurse will report audits to Monthly IDT QAA Committee.</p> <p>DATE THAT THE CORRECTIVE ACTION WILL BE COMPLETED?</p> <p>Date completed will be November 15, 2018</p> <p>THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION?</p> <p>Unit Manager, Director of Nursing, Administrator</p>		

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F584	<p>Continued From page 15 showed that Resident #135 had impaired memory.</p> <p>Multiple observation between 09/12/18 through 09/14/18 showed Resident #135's wheelchair had a white dried substance on the outer side of the right armrest, cushion and leg rests. In addition, Resident #135's wheelchair had a buildup coating of dust on the frame.</p> <p>During an interview on 09/14/18 at 10:15 AM, Staff B, Director of Nursing Services (DNS), stated that her expectation was that wheelchairs would be cleaned and maintained. Staff B, DNS, further stated that wheelchairs were to be cleaned weekly and as needed.</p> <p>RESIDENT #91 Review of the quarterly MDS dated 07/30/18, showed that Resident #91 admitted on 12/13/16 with multiple diagnoses to include heart failure, arthritis and cancer. The MDS further showed Resident #91 was able to make his needs known.</p> <p>During an observation and interview on 09/10/18 at 1:53 PM, both of Resident #91's wheelchair arm rests were torn with cracks in the material (a non-cleanable surface and increase risk for skin tears). Resident #91 stated that he did not know how long the arm rests had been that way.</p> <p>During an interview on 09/17/18 at 9:25 AM, Staff J, Assistant DNS/Unit Manager, stated that the cracks and tears on Resident #91's wheelchair armrests were a safety concern, not a cleanable surface and should be changed right away.</p>			F584			

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F584	Continued From page 16 Reference WAC 388-97-0880 (1)			F584			
F636 SS=D	<p>Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii)</p> <p>483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>483.20(b) Comprehensive Assessments 483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:</p> <ul style="list-style-type: none"> (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). 			F636	<p>HOW THE NURSING HOME CORRECT THE DEFICIENCY AS IT RELATED TO THE RESIDENT?</p> <p>A Significant Correction Assessment will be initiated by MDS Nurse to appropriately address Resident #45's strengths and weaknesses, and achievement of her highest practicable level of well-being with the use of the Merry Walker. Care planning will be updated to include a thorough assessment and evaluation of Resident #45 functional status, safety and response to the Merry Walker. With the review of the care planning approaches, the MDS Nurse will include the failed attempt to wean Resident #45 out of the Merry Walker in January 2017, and resulted in further decline and weight loss. The care planning will note the improvement in the amount of pureed diet consumed with use of Merry Walker to hold her attention for better feeding during meals.</p> <p>Care planning will be updated to include the assessment and evaluation of the effectiveness of approaches by Staff V, Social Services and Staff F, Activities, to address her socialization needs and emotional well-being, for example, her need to be able to wander freely about the unit related to restlessness. Collaborative approaches with Hospice will be included in the care planning to ensure psychosocial and emotional needs are met as terminal restlessness is treated and/or progresses.</p> <p>HOW THE NURSING HOME WILL ACT</p>		11/15/18

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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)		
F636	<p>Continued From page 17</p> <p>(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.</p> <p>483.20(b)(2) When required. Subject to the timeframes prescribed in 413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in 413.343(b) of this chapter do not apply to CAHs.</p> <p>(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)</p> <p>(iii) Not less than once every 12 months.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to comprehensively analyze the use of a safety device for one of three residents (Resident #45) reviewed for the use of a Merry Walker (an enclosed walking and sitting safety device). This placed the resident at risk for unidentified changes in mood, behaviors and decreased physical function status related to the use of the device.</p> <p>Findings included...</p> <p>Review of the significant change Minimum Data Set (MDS, a required assessment tool), dated</p>			F636	<p>TO PROTECT THE RESIDENTS IN SIMILAR SITUATIONS?</p> <p>Residents with use of any enabling safety device will be assessed immediately for ongoing need, functional status, safety and response to the device. Likewise, care planning approaches for these residents will be reviewed to ensure that psychosocial and emotional needs are being addressed if impacted for residents using enabling safety devices.</p> <p>HOW THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR?</p> <p>Unit Manager will receive training on the appropriate implementation of enabling safety devices and how to complete the new Enabling Safety Device Form to ensure documentation is thoroughly and consistently done as part of quarterly care plan review. The results of this review will be shared with residents and family during quarterly care conferences. Lastly, the MDS nurses will ensure that the evaluation of on-going use of enabling safety devices are included in the comprehensive plan of care.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED?</p> <p>The ADNSS will be responsible for auditing the records of any residents who have enabling safety devices, and the reason for the device, and the attempts for</p>		

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F636	<p>Continued From page 18</p> <p>01/03/18, showed Resident #45 was admitted on 11/02/16 with diagnoses including Alzheimer's disease, Parkinson's disease (degenerative disorder of the central nervous system that affected the motor system, with symptoms to include shaking, rigidity, and slowness with movement), dementia (a decline in thinking skills and progressive memory loss that disrupts daily life), depression, and anxiety. The MDS showed the resident had short and long term memory loss, impaired judgement, required two person assistance for transfers, toileting, bathing, dressing, used a restraint (Merry Walker), and was a fall risk. The MDS further showed Resident #45 was prescribed antianxiety medication, an antipsychotic, antidepressant and opioid medication.</p> <p>Review of the Care Area Assessments (CAA), dated 01/03/18, showed Resident #45 triggered for physical restraints. The CAA was incomplete, did not identify the resident strengths and weaknesses, or identify what interventions were in place to support the resident to achieve her highest practicable level of well-being with the use of the Merry Walker. The summary statements referred to social services, activities department assessments and the Physical Therapy assessment dated 01/17/17 for the use of the Merry Walker. The significant change MDS showed the resident had not been reassessed for the Merry Walker since 01/17/17.</p> <p>Review of the document titled, "Physical Therapy Daily Treatment Notes," dated 01/17/17, showed, "Assessment of Patient Response: ...Discharge Recommendations to continue with RA [Restorative Aid] program and the use of the Merry Walker as recommended by PT as per the "Resident Care Guide" which states "Use of Merry Walker within line of sight</p>			F636	<p>reduction of the device as appropriate on a quarterly basis until sustained practice is demonstrated. The results of this audit will be discussed at the next IDT QAPI meeting.</p> <p>DATE THAT THE CORRECTIVE ACTION WILL BE COMPLETED?</p> <p>Corrective action, education and reporting to QA will be accomplished on or before November 15, 2018.</p> <p>THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION?</p> <p>MDS Manager, Assistant Directors of Nursing, Director of Nursing, Administrator.</p>		

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F636	<p>Continued From page 19 supervision at all times. Use Merry Walker for safety if resident attempts unassisted standing or walking. Transfer out of Merry Walker for meals, activities, or if resident is sleeping."</p> <p>In multiple observations during the survey period on 09/10/18 at 10:24 AM, 09/12/18 at 11:12 AM, 09/13/18 at 10:01 AM, 09/14/18 at 1:13 PM, and 09/17/18 at 2:15 PM, Resident #45 was seen in her Merry Walker in the hallways of the unit. During those observations, the resident had little socialization with peers, staff, activities engagement and supervision. Resident #45 walked in the Merry Walker as needed. She would stand, take one to two steps, and sit down. This repeated several times throughout the day. Resident #45 occasionally bumped into walls, doors, other residents and blocked the hallway as other residents attempted to get by in their wheelchairs, or would get stuck on the Merry Walker. Resident #45 frequently sounded tearful, presented with a furrowed brow, and moaned while calling out a person's name.</p> <p>In multiple observations on 9/10/18 at 12:54 PM, 09/12/18 at 12:42 PM, 09/13/18 at 8:47 AM, and 09/14/18 at 9:04 AM, Resident #45 ate her meals while she remained in her Merry Walker, while staff assisted her to eat. Staff did not offer her to sit in a standard chair, and the resident occasionally ate outside the dining room away from other residents.</p> <p>In an interview on 09/14/18 at 9:37 AM, Staff W, NAC, stated Resident #45 stood up in the Merry Walker frequently, but was able to be redirected. Staff W, NAC, further stated that the resident ate all her meals in her Merry Walker and did not attempt to have her sit in a chair.</p> <p>In an observation on 09/14/18 at 11:30 AM, Staff</p>			F636			

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F636	<p>Continued From page 20</p> <p>AA, Activities Assistant (AA), brought Resident #45 into the dining room and applied lotion to the resident's hands and provided strawberry ice cream. Resident #45 remained in the Merry Walker for the duration of the activities.</p> <p>In interview on 09/13/18 at 1:54 PM, Staff E, Licensed Practical Nurse/Unit Manager (LPN/UM), stated Resident #45 was on Hospice, used a Merry Walker and didn't eat much. Staff E, LPN/UM, stated that the resident's physical and cognitive status continued to gradually decline due to her diagnosis of dementia. The resident's routine was to get up and walk in her Merry Walker in the halls. Staff E, LPN/UM, stated that the family did not visit as much. The resident tended to hang outside or on the side of the dining room, and staff brought her in but the resident would not stay long. Staff E, LPN/UM, stated Resident #45 got out of the Merry Walker for naps, used to get out for meals, but did not recall when or why it was discontinued.</p> <p>In continued interview, Staff E, LPN/UM, stated Resident #45 had been in the Merry Walker for approximately a year. The resident used it because she didn't walk well, had a history of several falls and one with an injury. Staff E, LPN/UM, stated the main reason why she was in the Merry Walker was because, "Staff couldn't keep track of her and was always busy." Staff E, LPN/UM, stated the resident was not able to get out of the device on her own due to her cognitive status.</p> <p>In an interview on 09/13/18 at 2:15 PM, Staff BB, MDS Coordinator (MDSC) stated Resident #45 was on a restorative walking program six days a week. Staff BB, MDSC, stated that the resident sometimes walked with assist of two staff, and sometimes stayed in the Merry Walker</p>			F636			

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F636	<p>Continued From page 21 to walk with staff. Staff BB, MDSC, further stated that it was unclear how many times and why the resident remained in her Merry Walker for her restorative program. Staff BB, MDSC, stated the Merry Walker was coded as a restraint in the MDS because Resident #45 could not open the device and voluntarily get out of it or remove it.</p> <p>In an interview on 09/14/18 at 11:47 AM, Staff V, Social Services (SS), stated she was not involved in the review or evaluation of residents' response to restraints or safety devices, to include any potential risks of alteration in psychosocial well-being, mood or behaviors.</p> <p>Review of Resident #45's quarterly Restorative program dated August 2017 and January 2018, showed the program did not evaluate the resident's functional status, safety or response to the Merry Walker.</p> <p>In an interview on 09/17/18 at 2:49 PM, Staff B, Director of Nursing Services (DNS), stated that Resident #45 did not have any additional comprehensive assessments for the use of the Merry Walker, other than the 01/17/17 Physical Therapy evaluation.</p> <p>Reference WAC 388-97-1000(2)(o) .</p>			F636			
F641 SS=D	<p>Accuracy of Assessments CFR(s): 483.20(g)</p> <p>483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.</p> <p>This REQUIREMENT is not met as evidenced by:</p>			F641	<p>HOW WILL NURSING HOME CORRECT THE DEFICIENCY AS IT RELATED TO THE RESIDENT?</p> <p>Resident #169: MDS documentation modified immediately to correct misinformation regarding discharge to hospital and correction transmitted 9/12/2018.</p>		9/26/18

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F641	<p>Continued From page 22</p> <p>Based on interview and record review the facility failed to ensure the discharge comprehensive assessment was accurate for one of two residents (Resident #169) reviewed for hospitalization. This failure caused Resident #169's medical record to reflect inaccurate data related to disposition.</p> <p>Findings included...</p> <p>Review of the discharge Minimum Data Set (MDS, a required assessment tool), dated 08/15/18 showed Resident #169 was admitted to the facility on 08/10/18 with diagnoses to include cancer of multiple systems, nausea and vomiting. The resident showed some limitations in recall and decision making. This MDS showed Resident #169 was discharged to the hospital.</p> <p>Review of the discharge progress note dated 08/15/18 at 12:01 PM showed, "Patient discharged to home via private vehicle with daughter."</p> <p>In an interview on 09/12/18 at 12:40 PM, when asked about the discharge for Resident #169, Staff G, Registered Nurse/MDS (RN/MDS) stated that Resident #169 was discharged home and the MDS was inaccurately coded.</p> <p>Reference WAC 388-97-1000 (1)(a)</p> <p>.</p>			F641	<p>HOW WILL THE NURSING HOME ACT TO PROTECT THE RESIDENTS IN SIMILAR SITUATIONS?</p> <p>MDS documentation audits will be completed for every discharge assessment to ensure accuracy of MDS documentation before submission of MDS data by MDS LN and MDS Manager.</p> <p>HOW THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NO RECUR?</p> <p>MDS Nurse will review MDS data before transmitting data. MDS Nurse will conduct thorough review of each assessment for accuracy before it is locked.</p> <p>Education provided to the MDS LN staff regarding Accuracy of Resident Assessments on 9/26/2018.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED?</p> <p>MDS Manager will conduct random MDS audits and report findings to Monthly IDT QAA Committee. MDS nurses will be offered continuing education regarding accuracy of assessments.</p> <p>DATE THE CORRECTIVE ACTION WILL BE COMPLETED?</p> <p>Date of correction completed September 26, 2018</p>		

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2018
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE			STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370	
(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) COMPLETE DATE
F641	Continued From page 23	F641	THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION? MDS Manager, Director of Nursing, Administrator	
F655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) 483.21 Comprehensive Person-Centered Care Planning 483.21(a) Baseline Care Plans 483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. 483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting	F655	HOW WILL NURSING HOME CORRECT THE DEFICIENCY AS IT RELATED TO THE RESIDENT? There is no opportunity to correct timeliness. The care plans for Resident # 153 and # 270 have been comprehensively done to include all appropriate resident care needs based on their individual medical diagnoses. Necessary care and services were addressed. HOW WILL THE NURSING HOME ACT TO PROTECT THE RESIDENTS IN SIMILAR SITUATIONS? Newly admitted residents will have baseline care plans that include the primary reason for admission within 48 hours. Resident input regarding care plan will be included in baseline care plan by admitting nurse and a copy of baseline care plan will be provided to resident within 48 hours of admission. HOW THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NO RECUR? The admitting nurse assigned will be taught the importance of including a care	11/15/18

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F655	<p>Continued From page 24 paragraph (b)(2)(i) of this section).</p> <p>483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:</p> <ul style="list-style-type: none"> (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to develop a baseline care plan within 48 hours of admission for two of 36 residents (Resident #s 153 and 270) reviewed for care plans. This failure placed newly admitted residents at risk to not receive necessary care and services.</p> <p>Findings included ...</p> <p>RESIDENT #270 Review of the admission Minimum Data Set (MDS, a required assessment tool) dated 09/12/18, showed that Resident #270 admitted on 09/05/18 with multiple diagnoses to include, urinary tract infection, kidney disease, dementia, depression, weakness and pain. In addition, Resident #270 was able to make needs known.</p> <p>Review of Resident #270's Hospital Discharge Summary dated 09/05/18, showed that the resident was recently discharged from a hospital</p>			F655	<p>plan related to the primary reason for admission within the baseline care plan implemented within 48 hours of admission.</p> <p>Education will be provided to admitting nurses and unit managers regarding resident input requirements of baseline care plan and a copy of baseline care plan will be provided to resident within 48 hours of admission.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED?</p> <p>The Health Record Director will audit the chart of newly admitted residents weekly to ensure that baseline care plans include the primary diagnosis for admission and are completed timely within 48 hours of admission. Admitting nurses not meeting this expectation will receive written reminder of this expectation. Results of this audit will be discussed at the next IDT QAPI Meeting.</p> <p>DATE THE CORRECTIVE ACTION WILL BE COMPLETED?</p> <p>Corrective action, education and reporting to QA will be accomplished on or before November 15, 2018.</p> <p>THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION?</p> <p>Health Records Director, Director of Nursing, Administrator.</p>		

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F655	<p>Continued From page 25 after being treated for dehydration and a urinary tract infection. In addition, Resident #270 had a physician order to continue antibiotic therapy for an additional 4 days.</p> <p>Review of the Medication Administration Record (MAR) dated September 2018 showed that Resident #270 received an antibiotic on 09/06/18 to 09/08/18 for urinary tract infection.</p> <p>Review of Resident #270's care plan dated 09/05/18, showed no care plan for the treatment of the resident's urinary tract infection.</p> <p>During an interview on 09/11/18 at 8:57 AM, Staff B, Director of Nursing Services (DNS), stated that it was her expectation that whenever the residents were admitted to the facility, staff would develop a baseline care plan related to the resident's diagnoses within 48 hours.</p> <p>During an interview on 09/12/18 at 9:48 AM, Staff J, Assistant Director of Nursing Services/Unit Manager (ADNS/UM), stated that the residents' care plans were based on the residents' diagnoses and they should have a temporary care plan developed. Staff J, ADNS/UM further stated that after the fifth day the MDS staff were responsible to ensure that the care plans were completed accurately.</p> <p>During an interview on 09/12/18 at 11:01 AM, Staff Z, Registered Nurse/Minimum Data Set (RN/MDS), stated that the residents' care plans were developed by the admission nurse within 48 hours; however, Resident #270's care plan "definitely had holes" in it and that the plan of care for the resident's UTI must have been missed.</p>			F655			

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F655	<p>Continued From page 26</p> <p>RESIDENT #153 Review of the admission MDS dated 08/10/18, showed that Resident #153 admitted on 08/03/18 with multiple diagnoses to include malnutrition (lack of sufficient nutrients in the body), dysphagia (difficulty swallowing) and gastroesophageal reflux disease (GERD, a long-term condition where acid from the stomach comes up into the esophagus). Resident #153 had a feeding tube (a device inserted into the stomach used to supply nutrition) and was able to make needs known.</p> <p>During an interview and observation on 09/10/18 at 12:23 PM, Resident #153 stated that she had the feeding tube when she admitted to the facility and received tube feedings for about two months. Resident #153 had a tube feeding pump machine next to her bed; however, it was not in use.</p> <p>Review of Resident #153's tube feeding/nutrition care plan showed it was created on 08/20/18 (17 days after admit).</p> <p>During an interview on 09/14/18 at 12:19 PM, Staff B, Director of Nursing Services (DNS), stated that Resident #153's care plan for tube feeding/nutrition should have been created within 48 hours of admit.</p> <p>No Reference WAC</p>			F655			
F656 SS=D	<p>Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)</p> <p>483.21(b) Comprehensive Care Plans 483.21(b)(1) The facility must develop and implement a comprehensive person-centered</p>			F656	<p>HOW WILL NURSING HOME CORRECT THE DEFICIENCY AS IT RELATED TO THE RESIDENT?</p> <p>Resident #155's care plan was reviewed and updated to include a diabetic care</p>		11/15/18

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F656	<p>Continued From page 27</p> <p>care plan for each resident, consistent with the resident rights set forth at 483.10(c)(2) and 483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under 483.24, 483.25 or 483.40; and</p> <p>(ii) Any services that would otherwise be required under 483.24, 483.25 or 483.40 but are not provided due to the resident's exercise of rights under 483.10, including the right to refuse treatment under 483.10(c)(6).</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p>			F656	<p>plan, and Resident #156's care plan was reviewed and updated to include the use of Coumadin therapy as an intervention in the care plan for Atrial Fibrillation. Lastly, Resident #36 and Resident #50's dialysis care plans were updated to include the site of the fistula access site, the name of the Dialysis Center, the name of the assigned Nephrologist, the days of dialysis visits, and the transportation arrangements. The care plan was also reviewed to ensure that it contained the care and monitoring of the Resident #36 and Resident #50's fistula.</p> <p>HOW WILL THE NURSING HOME ACT TO PROTECT THE RESIDENTS IN SIMILAR SITUATIONS?</p> <p>Education will be provided to Licensed Nurse on how to edit care plans immediately when orders that contain new diagnoses and new treatment interventions are received from Providers within the Electronic Health Record. The three other facility Residents who require dialysis have had their care plans reviewed and updated to include site of the fistula access site, the name of the Dialysis Center, the name of the assigned Nephrologist, the days of dialysis visits, and the transportation arrangements. The care plans was also reviewed to ensure that it contained the care and monitoring of the Residents' fistula. Lastly, all newly admitted residents who require dialysis will have the same information included in their care plans.</p> <p>HOW THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NO RECUR?</p>		

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F656	<p>Continued From page 28</p> <p>Based on observation, interview and record review, the facility failed to develop and/or implement comprehensive care plans for four of 36 residents (Resident #s 36, 50, 155, and 156) whose care plans were reviewed. Failure to develop comprehensive care plans placed residents at risk for medical complications, unmet needs and a diminished quality of life.</p> <p>Findings included ...</p> <p>RESIDENT #36 Review of the quarterly Minimum Data Set (MDS, a required assessment tool) dated 06/18/18, showed that Resident #36 admitted on 12/10/17 with multiple diagnoses to include kidney failure that required dialysis (the medical process of removing excess water and toxins from the blood in those whose kidneys have lost the ability to perform these functions in a natural way) three times per week. The MDS further showed that Resident #36 was able to make her needs known.</p> <p>In an interview on 09/11/18 at 9:32 AM, Resident #36 stated that she went to dialysis on Monday, Wednesday, and Friday every week, and that she had a dialysis fistula (surgically joining an artery and a vein, creating a passageway to make the dialysis process easier) in her left upper arm.</p> <p>Review of Resident #36's care plan dated 12/27/17 showed that it was not comprehensive because it did not include the dialysis center, the nephrologist (doctor specializing in diseases of the kidneys), or the care and monitoring needed for the dialysis fistula.</p> <p>In an interview on 09/13/18 at 10:12 AM, Staff</p>			F656	<p>No system changes or alterations are required.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED?</p> <p>The Health Records Manager will audit newly admitted residents base-line care plans within first week of admission to ensure that they include the primary diagnosis with appropriate interventions and that the dialysis information listed above is included in the care plan of new dialysis residents. The MDS nurses will audit the care plans of existing residents who require dialysis to ensure that the aforementioned information is reviewed and updated in their care plans quarterly. During quarterly reviews, the MDS nurses will audit care plans to ensure that new diagnoses and interventions have been included in the care plan as ordered since the last review. The results of the initial audits will be discussed at the next IDT QAPI meeting.</p> <p>DATE THE CORRECTIVE ACTION WILL BE COMPLETED?</p> <p>Staff education, corrective action, and auditing will be initiated on or completed before November 15, 2018.</p> <p>THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION?</p> <p>MDS Manager, Health Records Manager,</p>		

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F656	<p>Continued From page 29</p> <p>M, Registered Nurse/Unit Manager (RN/UM), stated the care plan did not include the specific individualized dialysis care needs for Resident #36.</p> <p>.</p> <p>RESIDENT #50 Review of the quarterly MDS dated 06/29/18, showed that Resident #50 admitted on 04/09/18 with multiple diagnoses to include heart disease, anxiety, kidney disease requiring dialysis and diabetes. This MDS further showed that Resident #50 was able to make his needs known.</p> <p>Review of Resident #50's care plan dated 09/19/17 showed chronic renal failure that required dialysis but did not include where Resident #50 received his dialysis services or contact information in case of emergency. In addition, it did not indicate Resident #50's Nephrologist, or type and location of dialysis access site.</p> <p>During an interview on 09/12/18 at 1:14 PM, Staff B, Director of Nursing Services (DNS), stated that her expectation was that Resident #50's dialysis care plan would include the location of where the resident received dialysis treatment, who the nephrologist was and the type and location of the access site.</p> <p>RESIDENT #155 Review of the quarterly MDS dated 08/17/18, showed that Resident #155 admitted on 11/07/16 with multiple diagnoses to include heart disease, anxiety, kidney disease and diabetes. This MDS further showed that Resident #155 was able to make his needs known.</p>			F656	Director of Nursing, Administration.		

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F656	<p>Continued From page 30</p> <p>Review of Resident #155's care plan dated 11/08/17 showed no documentation for diabetic management.</p> <p>During an interview on 09/13/18 at 9:33 AM, Staff B, DNS, stated that she was unable to locate a diabetic care plan for Resident #155. In addition, Staff B, DNS, stated that her expectation was that residents with diabetes should have a care plan.</p> <p>RESIDENT #156</p> <p>Review of the quarterly MDS dated 08/20/18, showed that Resident #156 admitted on 11/13/17 with multiple diagnoses to include heart failure, atrial fibrillation (an irregular heart rhythm), arthritis and an anxiety disorder. This MDS showed that Resident #156 had received anticoagulant (a blood thinner) medication and was able to make needs known.</p> <p>Review of the physician order dated 03/30/18 showed that Resident #156 was prescribed Coumadin (anticoagulant medication) to be given daily at bedtime related to the diagnosis of atrial fibrillation.</p> <p>Review of Resident #156's care plan dated 01/08/18 did not identify the use of anticoagulation therapy.</p> <p>During an interview on 09/14/18 at 12:09 PM, Staff B, DNS, stated that Resident #156's anticoagulant therapy was not care planned and it should have been as soon as the order was received.</p> <p>Reference WAC 388-97-1020(1), (2)(a)(b)</p>			F656			

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2018
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE			STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370	
(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) COMPLETE DATE
F656	Continued From page 31	F656		
F657 SS=D	<p>Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)</p> <p>483.21(b) Comprehensive Care Plans 483.21(b)(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p> <p>(ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to revise and update the care plans for two of 15 residents (Resident #s 91 & 164) reviewed for accidents. Failure to</p>	F657	<p>HOW WILL THE NURSING HOME CORRECT THE DEFICIENCY AS IT RELATED TO THE RESIDENT?</p> <p>Resident #91: Physical Therapy assessed Resident #91 for transfer pole utilization with nursing staff and requested order for transfer pole from provider per therapy recommendation. Provider order received. Care Plan revised with transfer pole use modification to include nursing staff assistance.</p> <p>Resident #164: Physical Therapy assessed Resident #164 for transfer pole utilization and requested order from provider for enabling device for transfer pole per therapy recommendation. Order for transfer pole device received, Resident #164 Care Plan revised for enabling device.</p> <p>HOW THE NURSING HOME WILL ACT TO PROTECT THE RESIDENTS IN SIMILAR SITUATIONS?</p> <p>Medical record audits conducted by Unit Managers of all residents with transfer poles completed. All transfer poles have correct documentation.</p> <p>HOW THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR?</p> <p>Transfer Pole Policy revised to contain processes and guidelines in regards to safe transfer pole implementation and</p>	11/15/18

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2018
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE			STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370	
(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) COMPLETE DATE
F657	<p>Continued From page 32</p> <p>update care plans for the use of transfer poles placed residents' at risk for injuries, unmet needs and a diminished quality of life.</p> <p>Findings included ...</p> <p>RESIDENT #91 Review of the quarterly Minimum Data Set (MDS, a required assessment tool) dated 07/30/18, showed that Resident #91 admitted on 12/13/16 with multiple diagnoses to include heart failure, arthritis and cancer. The MDS showed that Resident #91 was able to make his needs known and required two person extensive assistance with transfers.</p> <p>An observation on 09/11/18 at 1:01 PM, showed a transfer pole in place next to Resident #91's bed.</p> <p>During an interview on 09/12/18 at 10:25 AM, Resident #91 stated that he used the transfer pole with the help of staff to get out of bed.</p> <p>Review of the physician order dated 08/22/18 showed that Resident #91 was prescribed a transfer pole to be used with therapy only.</p> <p>During an interview on 09/14/18 at 8:57 AM, Staff H, Nursing Assistant Certified (NAC), stated that she assisted Resident #91 with a one person transfer by utilizing the transfer pole and had been doing so for a while, but could not remember an exact date.</p> <p>Review of the care plan dated 08/01/18 showed Resident #91 required the assistance of one to two persons with transfers and did not show the use of a transfer pole.</p> <p>During an interview on 09/17/18 at 9:21 AM,</p>	F657	<p>correct documentation requirements. Unit Interdisciplinary Team will conduct chart audits to ensure all residents with transfer poles have all required documentation including order and Care Plan revisions.</p> <p>Education will be conducted for all LN staff regarding transfer pole policy, safe transfer pole implementation and transfer pole documentation requirements.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED?</p> <p>The Unit Interdisciplinary Team will review resident medical record for required transfer pole documentation and report to Monthly IDT QAA.</p> <p>DATE THE CORRECTIVE ACTION WILL BE COMPLETE?</p> <p>Date of correction is November 15th, 2018</p> <p>THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION?</p> <p>Assistant Director of Nursing, Director of nursing, Administrator</p>	

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F657	<p>Continued From page 33</p> <p>Staff J, Assistant Director of Nursing Services/Unit Manager (ADNS/UM), stated that once therapy had stated that Resident #91 was safe to use the transfer pole then there should have been a new order received and the care plan revised for use of a transfer pole.</p> <p>RESIDENT #164 Review of the admission MDS dated 08/23/18, showed that Resident #164 admitted on 08/16/18 with multiple diagnoses to include high blood pressure, muscle spasms and arthritis. The MDS showed that Resident #164 was able to make her needs known and required two person extensive assistance with transfers.</p> <p>During an interview and observation on 09/11/18 at 11:59 AM, Resident #164 stated that she used the transfer pole to transfer in and out of bed. A transfer pole was placed next to Resident #164's bed.</p> <p>During an interview on 09/14/18 at 9:03 AM, Staff K, NAC, stated that she provided one person assist with the use of a transfer pole to transfer Resident #164 to her wheelchair from her bed and back. She further stated that Resident #164 had used the transfer pole for about two weeks.</p> <p>Review of the care plan initiated on 08/17/18 showed that Resident #164 required a two person assist with the use of a mechanical lift for transfers.</p> <p>During an interview on 09/17/18 at 2:26 PM, Staff B, DNS, stated that her expectations related to transfer poles included an order for therapy to evaluate and treat, then if there was a recommendation from therapy for the use of a transfer pole, nursing would get an order for the</p>			F657			

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F657	Continued From page 34 transfer pole. She further stated that the resident's care plan should be revised to include the use of the transfer pole. Reference WAC 388-97-1020(2)(c)(d)(4)(ii) .			F657			
F689 SS=D	<p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>483.25(d) Accidents. The facility must ensure that - 483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to ensure hazardous chemicals were safely secured for one of four units (Marina), and ensure a system for transfer poles were in place for two of 15 residents (Resident #s 91 and 164) reviewed for accident hazards. These failures placed residents, family and visitors at risk for avoidable chemical incidents, resident injuries and diminished quality of life.</p> <p>Findings included...</p> <p>UNSECURED SHOWER ROOM Observation on 09/12/18 at 9:07 AM, showed the Marina shower room door was propped open and left unattended. In addition, there were multiple chemicals present that showed, "Keep</p>			F689	<p>HOW WILL THE NURSING HOME CORRECT THE DEFICIENCY AS IT RELATED TO THE RESIDENT?</p> <p>Staff L immediately educated regarding risk to safety of residents and informed of requirement to secure shower door when room unattended due to hazardous chemicals being present in the shower room.</p> <p>HOW THE NURSING HOME WILL ACT TO PROTECT THE RESIDENTS IN SIMILAR SITUATIONS?</p> <p>The facility conducted training on all units/shifts for LN Staff and certified nursing staff in regards to securing unattended shower doors to prevent resident access to hazardous equipment and chemicals. Signage posted inside and outside of all shower room doors to remind staff to close doors upon exit.</p> <p>HOW WILL THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR?</p> <p>Unit Managers will include shower door monitoring during daily unit safety rounds. Education will be conducted for all staff in regards to shower room door security</p>		11/15/18

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F689	<p>Continued From page 35 out of reach of children."</p> <p>Observation on 09/14/18 at 9:12 AM, showed the Marina shower room propped open and left unattended. There were multiple chemicals present that showed, "Keep out of reach of children." In addition, two signs had been posted. A sign on the outside of the door showed, "Keep door closed" and the opposite side of the door showed, "Please close door when exiting."</p> <p>During an interview on 09/12/18 at 9:19 AM, Staff L, Nursing Assistant Certified (NAC), stated she did not realize that she had left the shower door propped opened. Staff L, NAC, further stated that the shower room door should be closed when no one was in the shower room because there were chemicals present.</p> <p>During an interview on 09/12/18 at 10:59 AM, Staff B, Director of Nursing Services (DNS), stated that her expectation was that the shower door should always be closed when unattended because of the safety concern with chemicals that were used.</p> <p>TRANSFER POLES Please refer to F657 for additional information.</p> <p>RESIDENT #91 Review of the quarterly MDS dated 07/30/18, showed that Resident #91 admitted on 12/13/16 with multiple diagnoses to include heart failure, arthritis and cancer. Resident #91 was able to make needs known and required two person extensive assistance with transfers.</p> <p>Review of the physician order dated 08/22/18</p>			F689	<p>requirement to prevent hazardous chemical exposure.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED?</p> <p>Results of daily shower door monitoring by Unit managers will be presented to Monthly IDT QAA Committee. The facility will continue to monitor shower door security routinely to ensure prevention of hazard exposure.</p> <p>DATES THAT THE CORRECTIVE ACTION WILL BE COMPLETED?</p> <p>Date of completion November 15th, 2018</p> <p>THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION?</p> <p>Unit Manager, Assistant Director of Nursing, Director of Nursing, Administrator</p> <p>Transfer Poles</p> <p>HOW WILL THE NURSING HOME CORRECT THE DEFICIENCY AS IT RELATED TO THE RESIDENT?</p> <p>Resident #91: Physical Therapy assessed Resident #91 for transfer pole utilization and requested order for transfer pole from provider. Provider order received. Risk and Benefits of pole provided to Resident #91. Care Plan updated with transfer pole use modification. Floor tape adhered to floor to assist staff with correct position distance</p>		

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F689	<p>Continued From page 36</p> <p>showed Resident #91 was prescribed a transfer pole to be used with therapy only.</p> <p>During an observation on 09/12/18 at 10:03 AM, showed a transfer pole located on the right side of Resident #91's bed. There were no markings/stickers on the floor on the right side by the wheels at the head or the foot of the bed.</p> <p>During an interview on 09/14/18 at 8:57 AM, Staff H, NAC, stated that she did a one person transfer with the use of a transfer pole for Resident #91.</p> <p>RESIDENT #164 Review of the admission MDS dated 08/23/18, showed that Resident #164 admitted on 08/16/18 with multiple diagnoses to include high blood pressure, muscle spasms and arthritis. Resident #164 was able to make needs known and required two person extensive assistance with transfers.</p> <p>Review of Resident #164's medical record showed no physician's order for a transfer pole.</p> <p>During an interview and observation on 09/12/18 at 9:40 AM, Resident #164 stated that she used the transfer pole with the help from staff for all transfers. When asked what the yellow sticker dots on the floor by the transfer pole and the left side of the wheel at the head of the bed was for, Resident #164 stated "Not a clue."</p> <p>During an interview on 09/14/18 at 9:48 AM, Staff Q, Grounds Maintenance (GM), stated that he received a "Transfer Pole Assessment," that provided transfer pole information that included measurements. He further stated that he applied stickers on the floor by the pole and at the foot and the head of the bed on the side of the</p>			F689	<p>between pole and bed. Signage posted above bed with transfer pole placement measurements.</p> <p>Resident #164: Unit Manager requested an order from provider for enabling device for transfer pole per therapy recommendation. Risk and Benefits of pole provided to Resident #164 and consent obtained for transfer pole at bedside. Order for transfer pole device received, Care Plan revised for enabling device. Floor tape adhered to floor to assist with correct position distance between pole and bed. Signage posted above bed with transfer pole placement measurements.</p> <p>HOW THE NURSING HOME WILL ACT TO PROTECT THE RESIDENTS IN SIMILAR SITUATIONS?</p> <p>Medical record audits conducted by Unit Managers of all residents with transfer poles completed. All transfer poles have correct documentation.</p> <p>HOW THE NURSING WILL TAKE OR SYSTEMS IT WILL ALTAR TO ENSURE THAT THE PROBLEM DOES NOT RECUR?</p> <p>Transfer Pole Policy created to contain processes and guidelines in regards to safe transfer pole implementation and correct documentation requirements. Unit Interdisciplinary Team will conduct daily chart audits to ensure all residents with transfer poles have all required documentation including order, education regarding risks and benefits, informed consent, care plan updates and proper</p>		

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2018
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE			STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370	
(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) COMPLETE DATE
F689	<p>Continued From page 37 transfer pole for proper placement.</p> <p>During an interview on 09/14/18 at 9:56 AM staff R, Director of Physical therapy (DPT), stated that when they received an order for a resident evaluation, during the clinical process and assessment if they thought a transfer pole was recommended then they would complete a "Transfer Pole Assessment," sheet. Staff R, DPT, further stated that he would hand that form/sheet to nursing who would get a signed order, and then maintenance would put it up. In addition, Staff R, DPT, stated that the therapist would conduct the measurements and put stickers on the floor where the pole is located.</p> <p>During an interview on 09/14/18 at 1:25 PM, when asked how far the bed should be from the transfer pole, Staff K, NAC, stated that maintenance sets up the transfer pole and she just tried to keep the bed in the same place. Staff K, further stated that if the bed looked like it was too far away from the pole, she would lay the resident back down and move the bed closer because the transfer pole usually should be at arms distance so the resident could reach to be able to pull him or herself up.</p> <p>During an interview on 09/14/18 at 1:28 PM, when asked if there was a system in place to know how far the bed should be from a transfer pole, Staff S, Registered Nurse (RN), stated that she did not know where they document the distance from the bed to the transfer pole however, if she had a concern she would let therapy know.</p> <p>During an interview on 09/14/18 at 1:44 PM, Staff J, Assistant Director of Nursing Services/Unit Manager (ADNS/UM), stated that there was supposed to be a dot where the</p>	F689	<p>positioning of transfer pole in resident room.</p> <p>Education will be conducted for all nursing staff regarding transfer pole policy/process, safe implementation of transfer pole and transfer pole documentation requirements.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED?</p> <p>The Unit Manager will review resident medical record for required transfer pole documentation and report to Monthly IDT QAA.</p> <p>DATE THE CORRECTIVE ACTION WILL BE COMPLETED?</p> <p>Date of correction will be November 15, 2018</p> <p>TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION?</p> <p>Director of Nursing, Director of Rehab, Administrator</p>	

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2018
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE			STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370	
(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) COMPLETE DATE
F689	Continued From page 38 transfer pole was placed and for the bed there were no markings. She further stated that the placement of the transfer pole in relation to the bed depended on the length of the resident's arms, because the resident needed to be able to grab the pole. During an interview on 09/17/18 at 2:26 PM, Staff B, DNS, stated that any resident that utilized a transfer pole required an assessment, a physician's order, an informed consent, and should be care planned. She further stated that the facility did not have a policy and procedure related to transfer poles or anything written down related to a sticker system for the floors however, would be working with therapy and the managers on these issues this afternoon. Reference WAC 388-97-1060 (3)(g) .	F689		
F693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) 483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- 483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and 483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and	F693	HOW WILL THE NURSING HOME CORRECT THE DEFICIENCY AS IT RELATED TO THE RESIDENT? Resident #153: Provider order immediately obtained for feeding tube. Documentation completed in electronic medical record and Care Plan to include type of feeding tube, size of feeding tube catheter and date of insertion. Resident #153 Electronic Medication Administration Record includes monitoring of amount of fluid (ml) intake of supplemental formula each shift. Care Plan updated to include supplemental formula (ml) intake to be documented each shift. HOW THE NURSING HOME WILL ACT TO PROTECT THE RESIDENTS IN SIMILAR SITUATIONS?	10/4/18

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F693	<p>Continued From page 39</p> <p>services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure a system in which resident records were complete and accurate, for one of one resident (Resident #153), reviewed for tube feeding management. Failure to identify the type of feeding tube, insertion date, monitor and document fluid intake, and all risk factors for management of tube feedings, placed resident at risk for medical complications and a diminished quality of life.</p> <p>Findings included...</p> <p>Review of the admission Minimum Data Set (MDS, a required assessment tool) dated 08/10/18, showed that Resident #153 admitted on 08/03/18 with multiple diagnoses to include malnutrition (lack of sufficient nutrients in the body), dysphagia (difficulty swallowing) and gastroesophageal reflux disease (GERD, is a long-term condition where acid from the stomach comes up into the esophagus). Resident #153 had a feeding tube (a device inserted into the stomach used to supply nutrition) and was able to make needs known.</p> <p>During an interview on 09/10/18 at 12:28 PM, Resident #153 stated that she received bolus (gravity feeding with a syringe) twice a day and then tube feedings with pump (machine) all night.</p>			F693	<p>House orders updated to include supplemental formula intake monitoring each shift for tube feeding residents. Admissions Nurses instructed to include enteral feeding tube information in Care Plan and ensure documentation is complete at admission. Training conducted on all units/shifts for LN Staff regarding completion of all documentation in the medical record for residents with enteral feeding tube.</p> <p>HOW THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTAR TO ENSURE THAT THE PROBLEM DOES NOT RECUR?</p> <p>Unit Interdisciplinary Team will discuss cases of residents with enteral feeding tube, audit chart to ensure all documentation is complete.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED?</p> <p>Unit Nurse Managers will report chart audit findings to Monthly IDT QAA Committee.</p> <p>DATES THAT THE CORRECTIVE ACTION WILL BE COMPLETED?</p> <p>Date of completion is October 4, 2018</p> <p>THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION?</p> <p>Assistant director of Nursing, Director of Nursing, Administrator</p>		

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE			STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370		
(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) COMPLETE DATE	
F693	<p>Continued From page 40</p> <p>Review of the physician orders dated 08/03/18 showed that Resident #153 was to have nothing by mouth (NPO), and to receive bolus feedings of 150 milliliters (ml) twice a day with flushes of water and a feeding to run at 80 ml per hour for 10 hours from 8:00 PM through 6:00 AM with flushes of water before and after feedings.</p> <p>Review of Resident #153's physician orders dated September 2018 did not show an order for a feeding tube.</p> <p>Review of Resident #153's Medication Administration Record (MAR) dated September 2018 from 09/01/18 through 09/11/18 showed no amount of fluid intake documented at the end of each shift or at the end of a 24 hour period.</p> <p>Review of the care plan dated 08/20/18 showed the resident required a tube feeding; however, did not include the size or the date of insertion of the feeding tube.</p> <p>During an interview on 09/14/18 at 12:23 PM, Staff B, Director of Nursing Services, stated that she expected residents with a feeding tube to have physician orders that included the tube feeding catheter type, size and date of insertion. She further stated that Resident #153's "fluid intake should be documented every shift."</p> <p>Reference WAC 388-97-1060 (3)(f)</p>	F693			
F697 SS=D	<p>Pain Management CFR(s): 483.25(k)</p> <p>483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such</p>	F697	<p>HOW WILL THE NURSING HOME CORRECT THE DEFICIENCY AS IT IS RELATED TO THE RESIDENT?</p> <p>Resident # 118: Physician order was received and entered into electronic health</p>	10/3/18	

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F697	<p>Continued From page 41</p> <p>services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure staff provided monitoring for potential complications for an internal pain pump that supplied continuous pain management for one of three residents (Resident #118) reviewed for pain management. This failure placed the resident at risk for medical complications and unmet needs.</p> <p>Findings included...</p> <p>Review of the quarterly Minimum Data Set (MDS, a required assessment tool) dated 08/02/18 showed that the Resident #118 admitted on 04/24/14 with multiple diagnoses to include heart disease, quadriplegia (a partial or total loss of use of all four limbs and/or torso), chronic pain and depression. The MDS further showed that Resident #118 was able to make needs known.</p> <p>During an interview on 09/10/18 at 10:31 AM, Resident #118 stated that he received pain management by an internal pain pump that delivered both morphine (a medication that treats pain) and baclofen (a medication that treats spasms).</p> <p>Review of the physician orders dated September 2018, did not show an order that Resident #118 had an internal pain pump, the type of medication being delivered, how much medication the resident was to receive in a 24</p>			F697	<p>record regarding 24-hour delivery of medication and dosage via pain pump, pain pump specific type, and alarm monitoring.</p> <p>Care Plan updated with medication delivery, alarm system, and specific type of pump implanted. Information regarding pain pump device and Operations Manual added to electronic medical record and hard chart. Medical Director ensured of pain pump specific type, alarm system, and Care Plan updates.</p> <p>Training conducted on all units/shifts for LN Staff and Resident #118 in regards to monitoring intrathecal pain pump alarm system and actions required in response to different alarm types, non-critical and critical care alarm.</p> <p>HOW WILL THE NURSING HOME ACT TO PROTECT THE RESIDENTS IN SIMILAR SITUATIONS?</p> <p>No other residents are affected, all medical charts audited. Resident #118 is the only resident with an internal pain pump.</p> <p>The admissions staff will ensure that residents admitting with special equipment that is new or unfamiliar to the staff, have the equipment, and that training is provided to the nursing staff prior to admission of the resident. Unit Managers will report new equipment to daily IDT team. .</p> <p>HOW THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR?</p> <p>Training conducted on all units/shifts for LN</p>		

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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)		
F697	<p>Continued From page 42</p> <p>hour period and the specific type of internal pain pump that had been implanted. In addition, the physician orders did not indicate required monitoring, specify different alarm types (refill alarm [medication volume low] and critical care alarm [medication empty or pump malfunction]) and how to respond to them.</p> <p>During an interview on 09/13/18 at 5:23 PM, Staff N, Medical Director (MD), stated that Resident #118 received a new internal pain pump approximately three years ago but was unsure of the specific type of internal pump that was placed or whether it had an alarm system. In addition, Staff N, MD, stated that most internal pain pumps had a refill alarm and a critical care alarm.</p> <p>During an interview on 09/13/18 at 2:32 PM, Staff O, Registered Nurse (RN), stated that she was unclear about the internal pain pump alarms. Staff O, RN, further stated that she had never heard internal pump alarms before.</p> <p>During an interview on 09/14/18 at 9:40 AM, Staff M, Registered Nurse/Unit Manager (RN/UM), stated that they had not been monitoring the internal pain pump alarm system. Staff M, RN/UM, further stated that he would immediately start training the nursing staff about the alarm system on the internal pain pump to both the refill alarm and critical care alarm and to call 911 as needed.</p> <p>During an interview on 09/14/18 at 8:25 PM, Staff B, Director of Nursing Services (DNS), stated that she was unaware that the internal pain pump had an alarm system. In addition, Staff B, DNS, further stated that her expectation would be that the physician orders would include the medications that Resident #118 was to</p>			F697	<p>Staff and Resident #118 in regards to monitoring intrathecal pain pump alarm system and actions required in response to different alarm types, non-critical and critical care alarm.</p> <p>Education will be conducted regarding equipment use, monitoring, and correct documentation of new or unfamiliar equipment and medical devices that residents are utilizing.</p> <p>Unit Interdisciplinary Team will audit charts during Huddles for new or unfamiliar medical devices. New medical devices will be reported to ADNS and DNS by Unit IDT to assist in development of education that constitutes equipment/device type, management, documentation and monitoring.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED?</p> <p>IDT QAA will collectively review equipment/device needs or usage to ensure education is delivered to staff if equipment is new or unfamiliar. Report of chart review outcomes will be delivered to monthly IDT QAA Committee by Unit Managers.</p> <p>DATE THE CORRECTIVE ACTION WILL BE COMPLETED?</p> <p>The date of correction October 3, 2018</p> <p>TITLE OF THE PERSON RESPONSIBLE</p>		

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F697	Continued From page 43 receive and that the internal pain pump would be monitored as required. Reference WAC 388-97-1060 (1) .			F697	TO ENSURE CORRECTION? Assistant Director of Nursing, Director of Nursing, Administrator		11/15/18
F757 SS=D	<p>Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)</p> <p>483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-</p> <p>483.45(d)(1) In excessive dose (including duplicate drug therapy); or</p> <p>483.45(d)(2) For excessive duration; or</p> <p>483.45(d)(3) Without adequate monitoring; or</p> <p>483.45(d)(4) Without adequate indications for its use; or</p> <p>483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, and record review the facility failed to initiate non-pharmacological interventions prior to the administration of pain medication for one of five residents (Resident #155) reviewed for unnecessary medications. This failure placed residents at risk for receiving</p>			F757	<p>HOW WILL THE NURSING HOME CORRECT THE DEFICIENCY AS IT RELATED TO THE RESIDENT?</p> <p>Resident #155: Resident interviewed using Pain Assessment Tool. Care Plan updated to include resident preferences regarding non-pharmaceutical interventions. Electronic Medication Administration record will be updated to include resident preference for non-pharmacological approaches. Staff nurses will assess residents response to non-pharmacological interventions, and document effectiveness prior to administration of PRN pain medications.</p> <p>HOW THE NURSING HOME WILL ACT TO PROTECT THE RESIDENTS IN SIMILAR SITUATIONS?</p> <p>Training will be completed with all licensed nurse staff regarding weekly pain assessment tool, offering non- pharmacological interventions before PRN pain medications are administered, and documentation of effectiveness of interventions.</p> <p>HOW THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR?</p> <p>Pain Assessment Tool in electronic</p>		

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F757	<p>Continued From page 44 unnecessary medications and a diminished quality of life.</p> <p>Finding included...</p> <p>Review of the quarterly Minimum Data Set (MDS, a required assessment tool) dated 08/17/18, showed that Resident #155 admitted on 11/07/16 with multiple diagnoses to include heart disease, anxiety, kidney disease and diabetes. This MDS further showed that Resident #155 was able to make his needs known.</p> <p>Review of Resident #155's physician's order dated 01/03/18, showed resident was prescribed oxycodone-acetaminophen (a narcotic medication to treat moderate to severe pain) every eight hours as needed for pain.</p> <p>Review of Residents #155's Medication Administration Record (MAR) dated August and September 2018 showed oxycodone- acetaminophen had been provided seven times in August and one time in September. This MAR showed no documented non-pharmacological interventions provided prior to Resident #155 being given oxycodone-acetaminophen.</p> <p>During an interview on 09/13/18 at 9:33 AM, Staff B, Director of Nursing Services, stated that she was unable to locate in the medical record, documentation of non-pharmacological interventions being provided to Resident #155 prior to the administration of oxycodone- acetaminophen. Furthermore, her expectation was that non-pharmacological interventions should be completed prior to administration of Resident #155's pain medication.</p> <p>Reference WAC 388-97-1060 (3)(k)(i)</p>			F757	<p>medical record has been modified to include non-pharmacological pain interventions and residents preferences. Comprehensive pain assessment will be scheduled weekly for each resident and at change of condition or new onset of pain.</p> <p>The Unit Interdisciplinary Team will meet to audit documentation in regards to weekly Pain Assessment Tool usage and verify charting reflects non-pharmacological interventions for those residents on PRN pain medication. Unit IDT will audit all medical charts of residents with PRN pain medication to ensure they are receiving non-pharmacological pain interventions before administration of pain medication.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED?</p> <p>Unit Interdisciplinary Team will report chart audit findings and pain documentation trends to Monthly IDT QAA Committee.</p> <p>DATE THE CORRECTIVE ACTION WILL BE COMPLETE?</p> <p>Date of correction will be November 15, 2018</p> <p>THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION?</p> <p>Assistant Director of Nursing, Director of Nursing, Administrator</p>		

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F757	Continued From page 45			F757			
F758 SS=D	<p>Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)</p> <p>483.45(e) Psychotropic Drugs. 483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that---</p> <p>483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in 483.45(e)(5), if the attending physician or prescribing practitioner believes</p>			F758	<p>HOW WILL THE NURSING HOME CORRECT THE DEFICIENCY AS IT RELATED TO THE RESIDENT?</p> <p>The physician will be asked to elaborate on his re-evaluation 8/15/18 of the risk versus benefit analysis of why in his medical opinion Resident # 33 should remain on both antipsychotics related to the return of combative behaviors, or state under which conditions he would be willing to trial a higher dose of one of the antipsychotics.</p> <p>The care plan for Resident #45 will be updated to include collaboration with Hospice and the use of the psychopharmacological medications used for on-going comfort care.</p> <p>Resident #33's orthostatic blood pressure readings were taken while lying and sitting and were within normal limits. The MARs for Resident #3 were updated to include this evaluation of orthostatic blood pressures monthly as ordered by the physician.</p> <p>The Unit Manager will update the Medication Administration Records (MARs) for Resident #s 3, 33, and 45 to include individualized non-pharmacological interventions such as distraction, redirection, or other appropriate behavioral interventions to be utilized when indicated instead of, or in addition to medication. The effectiveness of these interventions will be charted as (+) effective or (-) not effective, prior to using the prescribed psychotropic medications. The MARs will</p>		11/15/18

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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)		
F758	<p>Continued From page 46</p> <p>that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to provide adequate behavior monitoring for the use of psychotropic medications for two of seven residents (Resident #s 33 and 45), and ensure target behaviors were individualized for each psychotropic medication prescribed for one of seven residents (Resident #33), reviewed for unnecessary medication. Additionally, the facility failed to conduct orthostatic blood pressures (blood pressures taken in a lying, sitting and standing position) for one of six residents (Resident #3) reviewed for use of antipsychotic medication. Failure to consistently monitor resident's behaviors and effectiveness of multiple psychotropic medications, including attempting non-pharmacological interventions prior to increasing or starting a new medication, and monitoring the side effects, placed residents at risk for excessive use and duration of psychotropic medication, increased the risk for medical complications, and decreased quality of life.</p> <p>Findings included...</p> <p>Review of the facility policy titled, "Psychotropic</p>			F758	<p>include the specific target behavior and diagnosis for each medication to clearly distinguish their purpose when two or more psychotropic medications are utilized by the physician or nurse practitioner.</p> <p>HOW THE NURSING HOME WILL ACT TO PROTECT THE RESIDENTS IN SIMILAR SITUATIONS?</p> <p>The assigned licensed nurses will ensure that the MARs for each resident receiving psychotropic medications are updated with the above monitoring entries during the next recapitulation (recaps) review to ensure that the appropriate use of non-pharmacological approaches are utilized and documented prior to the use of prescribed pharmacological approaches.</p> <p>HOW THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR?</p> <p>The Unit Manager and Social Worker of the interdisciplinary team will complete a psychopharmacological quarterly review to address the effectiveness of non-pharmacological approaches, psychopharmacological medications, and the frequency of gradual dose reductions (GDRs) attempted during the quarter as recommended by the pharmacy consultant. This review will include a review of any adverse drug reactions, or changes in overall condition during the quarter reviewed. Residents target behaviors that may return or worsen will be documented within this review and reported to the provider. This will prompt a</p>		

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2018
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE			STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370	
(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) COMPLETE DATE
F758	<p>Continued From page 47</p> <p>Drug Utilization," dated February 2018, showed, "[The facility seeks to provide our residents with an environment of care which enables them to maintain or enhance, the highest practical level, their physical, mental and psychosocial well-being. To this end, [the facility] supports an interdisciplinary team approach incorporating the cooperative efforts of many disciplines (physician, pharmacist, nursing staff, mental health professionals, social service staff, and activities) to develop an individualized comprehensive care plan for each resident... Residents who have not used psychotropic medications shall not be given these medications unless; a. Considerations of alternatives (non-drug) approaches would not afford the resident any improvement in the quality of life and; b. The psychotropic medication is necessary to treat a specifically documented condition... The objective was, to document resident behavior, changes and occurrence patterns on a daily basis with monthly summaries."</p> <p>RESIDENT #33 Review of the admission Minimum Data Set (MDS, a required assessment tool), dated 03/15/18, showed Resident #33 was admitted on 03/07/18, with diagnoses including cataracts, Alzheimer's disease, dementia, anxiety, and depression. The resident had difficulty communicating as she "sometimes" understood others and made needs/wants known. Resident #33 had short and long term memory loss, impaired decision making, occasionally felt down and depressed, had delusions (misconceptions or beliefs that are firmly held contrary to reality), demonstrated wandering behaviors that impacted the privacy of others and the potential to wander in a dangerous place. The resident required one person assistance for dressing,</p>	F758	<p>request for risk versus benefit analysis from the physician or nurse practitioner if it is felt that no changes in the plan are in the best interest of the residents' quality of life.</p> <p>Education will be conducted to licensed nursing staff regarding documentation requirements related to psychopharmacological medications, effectiveness of non-pharmacological approaches, frequency of gradual dose reductions and target behavior monitoring.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED?</p> <p>The ADNss will audit a 10% sample of these reviews from their assigned units to ensure compliance with this new documentation process. The results of this audit will be discussed at the next IDT QAPI meeting.</p> <p>DATE THE CORRECTIVE ACTION WILL BE COMPLETE?</p> <p>Education, corrective action, and auditing will be initiated or completed on or before November 15, 2018.</p> <p>THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION?</p> <p>ADNss, Director of Nursing, and Administrator.</p>	

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F758	<p>Continued From page 48 toileting, eating, and walked independently throughout the unit. The resident was prescribed an antidepressant during the review period.</p> <p>Review of the September 2018 Medication Administration Record (MAR) showed Resident #33 was prescribed Lexapro (antidepressant medication) daily for anxiety (started on 06/14/18), Seroquel (antipsychotic medication) at bedtime for diagnosis of dementia with behavioral disturbance (started 07/04/18), Risperdal (antipsychotic medication) for acute psychosis (started 07/21/18), and lorazepam (anxiety medication) every eight hours as needed for "pain-mild," and "severe agitation" related to anxiety (started 07/25/18).</p> <p>Review of the September 2018 Care Tracker Tasks, a section in the Electronic Health Record (EHR) that nursing assistants tracked and monitored various tasks, showed Resident #33 was monitored for the following behaviors: -Anxiousness/agitation and unable to be redirected for depression/anxiety related to the use of Lexapro -Hallucinations/paranoia/delusions for dementia related to the use of Seroquel -Paranoia/delusions for acute psychosis related to the use of Risperdal -Anxiousness/agitation for anxiety for the use of lorazepam</p> <p>Review of the care plan revised on 08/05/18, showed Resident #33 had behaviors that were to be monitored every shift with the goal to have fewer episodes of agitation by the next review date.</p> <p>Review of the nursing, social service, and physician notes in the EHR, did not show a justification for the changes implemented for</p>			F758			

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F758	<p>Continued From page 49</p> <p>each antipsychotic, effectiveness of the interventions, and an interdisciplinary team or comprehensive review documented.</p> <p>In an interview on 09/13/18 at 11:00 AM, Staff U, Licensed Practical Nurse (LPN), stated behaviors were documented in the progress notes when there was a change, or the behavior impacted resident safety. Staff U, LPN, stated if a baseline behavior was exhibited, the doctor was already aware of it, so it was not charted. Staff U, LPN, further stated, the NACs reported the behaviors to the nurses, and was not aware if or where they charted on their own.</p> <p>In an interview on 09/13/18 at 1:54 PM, when asked how staff coordinated and communicated residents' frequency, severity and worsening behaviors and determine which non-pharmacological interventions were effective, Staff E, LPN/Unit Manager (UM), stated target behaviors were documented by exception with both the licensed nurses (LN) and NACs, when the behaviors were out of the ordinary. The LNs documented in the progress notes, and was not certain where the NACs documented. Staff E, LPN/UM, stated she was not aware of any way to document frequency of behaviors. Staff E, LPN/UM, further stated that the Interdisciplinary Team (IDT) psychotropic meetings were held monthly. Social services reviewed the NACs' and the LNs' documentation in the meetings, and the team based the information to determine if the medications needed to be adjusted. When asked how frequency of the behaviors were determined if staff charted by exception, and which interventions were effective, Staff E, LPN/UM, stated she was aware of what happened on her unit as she was on the unit frequently, "We know what goes on."</p>			F758			

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F758	<p>Continued From page 50</p> <p>In interview on 09/14/18 at 9:37 AM, Staff W, NAC, stated that the NACs charted behaviors by exception, when something occurred out of the ordinary for that resident. Staff knew what the baseline behaviors were and "generally" knew the frequency, but didn't always know the triggers, "Sometimes there is none at all."</p> <p>In an interview on 09/17/18 at 1:24 PM, Staff V, Social Services (SS), stated that she reviewed the behaviors documented in tasks and progress notes for the IDT psychotropic review meetings. Resident #33 was first admitted on an antidepressant. When asked how the target behaviors were for each medication and ensure efficacy of each, Staff V, SS, stated it was the review of the target behaviors that were documented and reviewed with the IDT. Staff V, SS, further stated that the target behaviors for Seroquel was hallucinations and delusions, and the use of Risperdal was for the delusions and paranoia. Additionally, Staff V, SS, stated it was "hard to say that someone is experiencing a hallucination when they are not interviewable." Staff V stated that the target behaviors were the same for both lorazepam and Lexapro. Mental health services had not been attempted as the family member thought the resident was still adjusting to placement.</p> <p>Review of the Medication Regimen Review (MRR) dated 07/27/18, showed the pharmacy identified, "This resident receives two antipsychotics: Risperidone... for delusions related to acute psychosis and Seroquel... for dementia with behaviors. The concerns with antipsychotic polypharmacy include short and long term adverse effects... difficulties in determining the effect of each treatment, and the general lack of evidence for the effectiveness and safety of antipsychotic polypharmacy.</p>			F758			

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F758	<p>Continued From page 51</p> <p>Antipsychotic polypharmacy is generally only endorsed as last treatment strategy in practice guidelines and treatment recommendations that is after failure of multiple attempts of antipsychotic monotherapy." The physician responded, "Re-evaluated currently therapy-current therapy needs to stay in place. Often has combative behavior."</p> <p>In an interview on 09/17/18 at 2:49 PM, Staff B, Director of Nursing Services (DNS), stated that the target behaviors were charted by exception, anything out of the ordinary baseline behavior, and adverse side effects. Staff B, DNS, stated that the target behavior of delusions and delusions/hallucinations for the use of more than one antipsychotic medication, was confusing and could made it difficult for staff to determine the difference. Resident #33 had not had a mental health consult as the physician did not see it being beneficial to the resident. Staff B, DNS, further stated that the physician did respond with a rationale for dual antipsychotic therapy, but did not explain if Resident #33 had a failed trial on a higher dose of one antipsychotic, what non-pharmacological interventions that were attempted prior to the addition of the second antipsychotic, and the specific and individualized target behaviors for each medication to clearly identify medication and dosage efficacy.</p> <p>RESIDENT #45 Review F636 for additional information and resident history</p> <p>Review of nursing progress notes dated 01/22/18 showed an IDT Psychotropic Committee Meeting," that reviewed psychotropic medications for Resident #45. The resident was prescribed Mirtazapine (antidepressant) for</p>			F758			

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F758	<p>Continued From page 52</p> <p>depression, Risperdal (antipsychotic) for dementia with behavioral disturbances, and Ativan (antianxiety) for anxiety and agitation. Additional diagnoses included Alzheimer's disease, Parkinson's disease, insomnia, and cognitive communication deficit (problems with communication that have an underlying cause in cognitive deficit rather than a primary language or speech deficit). Target behaviors symptoms included yelling at others, anxiousness, constant movements- walking, standing/sitting, periodic aggression. The IDT review further showed, "Resident has signed on with hospice. She exhibits ongoing episodes of anxiety which is likely related to advanced nature of Parkinson's, dementia as well as other comorbidities [multiple medical conditions]. IDT recommends: no change at the time due to signing on with hospice and ongoing behaviors. Meds appear to provide some relief. Comfort is the goal. Target behavior review- resident signed on hospice."</p> <p>Review of nursing progress notes dated 01/23/18 at 7:44 AM, showed Resident #45 was on alert for an unwitnessed fall and elevated temp."</p> <p>Review of nursing progress notes dated 01/24/18 at 8:10 PM, showed Resident #45 was on alert for an "increase in Risperdal."</p> <p>Review of nursing progress notes dated 01/26/18 at 5:33 AM, showed Resident #45 was on alert for start of Ativan every hour as needed (PRN). "Resident slept through the night, no restlessness, no yelling out. Low grade temp."</p> <p>Review of the nursing progress notes dated 01/26/18 at 10:47 PM, showed Resident #45 remained on alert for the increase in Risperdal dose, "[Resident #45] was calm, asleep most of</p>			F758			

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F758	<p>Continued From page 53 shift. Unable to take bedtime pills, groggy and too sleepy to swallow meds."</p> <p>Review of nursing progress notes dated 01/27/18 at 1:49 PM, showed Resident #45 "... had no adverse side effects related to increase in Risperidone, such as sedation, lethargy, or SOB [shortness of breath]... Resident was reported to be restless through the night and was sleepy this shift, rested in bed quietly today and was assisted with her meal in her room."</p> <p>Review of nursing progress notes dated 01/28/18 at 1:40 PM, showed Resident #45 had a "... Temperature of 101.3 degrees Fahrenheit and having upper respiratory symptoms, such as unproductive cough and congestion. Resident has been sleepy today and rested in bed after lunch... "</p> <p>Review of the EHR showed no coordination with Hospice, mental health or IDT to show the rationalization for the increase in Risperdal dose and the PRN lorazepam, prior to non-pharmacological interventions, while Resident #45 showed signs and symptoms of increased lethargy and change in medical status.</p> <p>In an interview on 09/17/18 at 1:24 PM, Staff V, SS, stated that she was not certain why the medication increases occurred as she could not recall and could not locate documentation of the discussion.</p> <p>In an interview on 09/17/18 at 2:49 PM, Staff B, DNS, stated that behaviors were charted by exception, was uncertain of the justification for the increase in the antipsychotic medication and addition of the antianxiety medication, while staff documented that Resident #45 was "unable to take bedtime pills, groggy and too sleepy to</p>			F758			

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F758	<p>Continued From page 54 swallow meds," had a temperature, and no changes in behaviors were identified or documented.</p> <p>MONITORING OF ANTIPSYCHOTIC MEDICATION SIDE EFFECT Review of Resident #3's admission MDS dated 05/30/18, showed that the resident admitted on 05/23/18 with diagnoses to include dementia with behaviors and depression. The MDS assessment showed Resident #3 was on an antipsychotic medication.</p> <p>Review of Resident #3's Care Area Assessment (CAA) dated 05/30/18, showed that the resident was on Haldol (an antipsychotic medication) to treat behaviors including agitation and delusions.</p> <p>Review of Resident #3's physician's orders dated 05/23/18, showed an order for Haldol and to monitor the side effects of the antipsychotic medication that included the monitoring of postural hypotension (sudden drop of the blood pressure [BP] brought about by position change). The physician's orders included an order to monitor the resident's orthostatic blood pressure once a month.</p> <p>Review of Resident #3's care plan dated 06/06/18, showed that the facility identified the resident's use of Haldol and indicated in the resident's plan of care to observe for significant side effects of the medication to include postural hypotension.</p> <p>An observation and interview on 09/14/18 at 1:20 PM, showed Resident #3 in her room, calm</p>			F758			

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2018
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE			STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370	
(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) COMPLETE DATE
F758	<p>Continued From page 55</p> <p>and relaxed in her wheelchair with both feet propped up on the bed. The resident's spouse was with the resident in the room. The spouse stated that Resident #3 was unable to stand up and needed assistance with transfers. The spouse further added that the resident had no problems with dizziness but had episodes of falls.</p> <p>Review of Resident #3's MAR from May 2018 to August 2018, showed that orthostatic BP had not been monitored monthly. The MAR from June 2018 to August 2018 did not reflect the physician's order to monitor orthostatic BP monthly.</p> <p>Review of Resident #3's vital signs record from 05/23/18 to 09/13/18, showed no documentation of orthostatic BP being monitored.</p> <p>During an interview on 09/14/18 at 1:30 PM, Staff E, Licensed Practical Nurse/Unit Manager (LPN/UM), stated that licensed nurses were expected to check orthostatic BP monthly for residents on antipsychotic medication. Staff E, LPN/UM, stated that Resident #3 was unable to stand and further added, "I don't think we have done one [orthostatic BP] on her. We can go get it while she is lying down and sitting."</p> <p>During an interview on 09/14/18 at 1:54 PM, Staff B, DNS, stated that the expectation was for the licensed nurses to monitor orthostatic BP monthly for residents on antipsychotic medication.</p> <p>Reference WAC 388-97-1060(3)(k)(i)</p>	F758		
F759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)	F759	HOW WILL THE NURSING HOME CORRECT THE DEFICINECY AS IT	10/3/18

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F759	<p>Continued From page 56</p> <p>483.45(f) Medication Errors. The facility must ensure that its-</p> <p>483.45(f)(1) Medication error rates are not 5 percent or greater;</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to ensure that medications were administered in a timely manner, in accordance with physician's orders, for one of five residents (Resident #40) reviewed for medication administration. Six medication administration errors were observed, in 25 opportunities, resulting in a medication error rate of 24%. This failure placed the resident at risk for decreased therapeutic effects of medications and posed health and safety risks.</p> <p>Review of the quarterly Minimum Data Set (MDS, a required assessment tool) dated 06/27/18, showed that Resident #40 admitted to the facility on 10/20/14 with diagnoses to include high blood pressure, diabetes, multiple sclerosis, seizure disorder and depression. The MDS further showed that Resident #40 had moderately impaired thinking, but was able to make her needs known.</p> <p>Review of the facility's policy titled, "Medication Administration - General Guidelines," dated 03/04/14, showed, "Medications are administered within 60 minutes on either side of scheduled time."</p> <p>During an observation on 09/17/18 at 11:48 AM, Staff T, Licensed Practical Nurse (LPN), administered Keppra (seizure medication),</p>			F759	<p>RELATED TO THE RESIDENT?</p> <p>Resident #40: Provider notified immediately to request order for medications administered later than scheduled. Verbal order received by Staff T to administer medications AM shift at later time.</p> <p>HOW WILL THE NURSING HOME ACT TO PROTECT THE RESIDENTS IN SIMILAR SITUATIONS?</p> <p>Training conducted on all units/shifts for LN staff in regards to timely medication administration, no earlier than one hour before, and no later than one hour after scheduled administration time. Training conducted to all licensed nursing staff regarding communicating with the Provider if medications not administered at scheduled administration times.</p> <p>HOW THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR?</p> <p>Scheduled Medication Pass Audits include timely medication administration. Daily chart reviews of electronic medication administration will be conducted by Unit Managers.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED?</p> <p>Assistant Director of Nursing and Unit Managers will report audit findings and</p>		

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2018
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE			STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370	
(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) COMPLETE DATE
F759	<p>Continued From page 57</p> <p>Metformin (diabetic medication) and Trileptal (seizure medication) to Resident #40 approximately four hours past the scheduled administration time of 8:00 AM, and Lexapro (antidepressant), Gilenya (multiple sclerosis medication) and Lisinopril (blood pressure medication) approximately two hours past the scheduled administration window of 6:00 AM to 10:00 AM.</p> <p>During an interview on 09/17/18 at 11:54 AM, Staff T, LPN, stated that he had administered Resident #40's medications later than they were ordered to be given, and that there was not a physician's order to administer them at a later time.</p> <p>During an interview on 09/17/18 at 2:02 PM, Staff B, Director of Nursing Services (DNS), stated that her expectation was that medications would be administered no earlier than one hour before, and no later than one hour after, the scheduled time. Staff B, DNS, further stated that if a nurse knew that medications were going to be given late, her expectation was that the nurse would call the doctor to request an order for the medication to be given later than scheduled.</p> <p>Reference WAC 388-97-1060(3)(k)(ii)</p>	F759	<p>chart review reports to Monthly IDT QAA Committee.</p> <p>DATE CORRECTIVE ACTION WILL BE COMPLETED?</p> <p>Date of completion October 3, 2018</p> <p>TITLE OF PERSON RESPONSIBLE TO ENSURE CORRECTION?</p> <p>Assistant Director of Nursing, Director of Nursing, Administrator</p>	
F761 SS=D	<p>Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)</p> <p>483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p>	F761	<p>HOW WILL THE NURSING HOME CORRECT THE DEFICIENCY AS IT IS RELATED TO THE RESIDENT?</p> <p>Resident #113: Medication belonging to Resident #29 removed immediately by Staff C and secured in medication cart. Investigation found no evidence of Resident #113 being administered medication belonging to Resident #29. No</p>	10/3/18

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F761	<p>Continued From page 58</p> <p>483.45(h) Storage of Drugs and Biologicals</p> <p>483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to ensure that a resident's medication was safely secured for one of four units (Marina) reviewed for medication storage. This failure placed residents, staff and visitors at risk for having unauthorized access to resident's medications.</p> <p>Findings included...</p> <p>Review of the quarterly Minimum Data Set (MDS, a required assessment tool) dated 06/12/18, showed that Resident #29 admitted on 04/04/18 with multiple diagnoses to include dementia (a group of thinking and social symptoms that interferes with daily functioning), diabetes, breathing difficulty and heart disease. This MDS showed that Resident #29 had</p>			F761	<p>evidence of medication error.</p> <p>HOW WILL THE NURSING HOME ACT TO PROTECT THE RESIDENTS IN SIMILAR SITUATIONS?</p> <p>To prevent risk and keep all residents safe, training conducted on all units/shifts for LN Staff regarding safe medication storage. Instruction included, not entering a residents room with medication belonging to a different resident, and securing medication in a locked medication cart before entering another residents room.</p> <p>HOW THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTAR TO ENSURE THAT THE PROBLEM DOESN NOT RECUR?</p> <p>Scheduled Medication Pass Audits will include correct storage of drugs and biologicals.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED?</p> <p>Medication Pass Audit findings will be reported to Monthly IDT QAA Committee.</p> <p>DATE THAT THE CORRECTIVE ACTION WILL BE COMPLETED?</p> <p>Date of completion October 3, 2018.</p> <p>THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION?</p>		

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

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

PRINTED: 10/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
F761	<p>Continued From page 59 memory difficulty.</p> <p>During an observation and interview on 09/10/18 at 12:25 PM, a medication fluticasone propionate (a medication to treat asthma or respiratory concerns) was on the counter near the sink in Resident #s 113 and 132's shared room. When asked if this was her medication, Resident #113 stated, "No." In addition, Resident #113 stated that this medication was for Resident #29.</p> <p>Review of the physician's order dated 04/17/18 showed Resident #29 had an order for fluticasone propionate.</p> <p>During an interview on 09/10/18 at 12:28 PM, Staff C, Registered Nurse (RN), stated that medications were not to be kept in residents' rooms unless they have been assessed for safety and had a physician's order to do so. In addition, Staff C, RN, stated that the medication that was found on the counter was for Resident #29 who did not reside in the room where it was found.</p> <p>During an interview on 09/10/18 at 12:46 PM, Staff B, Director of Nursing Services (DNS), stated that Resident #29's medication should not have been left unsecured in another resident's room.</p> <p>Reference WAC 388-97-1300 (2),-2340</p>			F761	Assistant Director of Nursing, Director of Nursing, Administrator		

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

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2018	
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE				STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370			
(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) COMPLETE DATE
L000	<p>WAC - Initial Comments</p> <p>Note: According to RCW 18.51.060, the Department is authorized to deny, suspend or revoke a license and/or assess monetary fines for deficiencies cited in this report.</p> <p>This report is the result of an unannounced Washington Licensing Survey conducted at Martha and Mary Health Service on 09/10/18, 09/11/18, 09/12/18, 09/13/18, 09/14/18, 09/17/18 and 09/18/18. A sample of 57 residents was selected from a census of 168. The sample included 52 current residents and the records of five former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>Diana Tiliano, RN, BSN Anna Brown, RN Stefan Brown, MA, CRC Tawny Caldwell, RN Gerald Chambers, RN, BSN Marilyn Edwards, RN, MN Molly McClintock, BS, TRS Donna Palabrica, RN, BSN</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, Region 3 P.O. Box 98907 MS: N27-24 Lakewood, Washington 98496-8907</p> <p>Telephone: 253.983.3800 Fax: 253.589.7240</p>			L000			

State Form 2567

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

TITLE

Electronically Signed

(X6) DATE

10/10/2018

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2018
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE			STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370	
(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) COMPLETE DATE
L980 L980	<p>Continued From page 1 WAC 388-97-0980 Pets</p> <p>(1) Each resident must have a reasonable opportunity to have regular contact with animals, if desired.</p> <p>(2) The nursing home must:</p> <p>(a) Consider the recommendations of nursing home residents, resident councils, and staff;</p> <p>(b) Determine how to provide residents access to animals;</p> <p>(c) Determine the type and number of animals available in the facility, which the facility can safely manage. Such animals should include only those customarily considered domestic pets;</p> <p>(d) Ensure that any resident's rights, preferences, and medical needs are not compromised by the presence of an animal; and</p> <p>(e) Ensure any animal visiting or living on the premises has a suitable temperament, is healthy, and otherwise poses no significant health or safety risks to residents, staff, or visitors.</p> <p>(3) Animals living on the nursing home premises must:</p> <p>(a) Have regular examinations and immunizations, appropriate for the species, by a veterinarian licensed in Washington state; and</p> <p>(b) Be veterinarian certified to be free of diseases transmittable to humans.</p> <p>(4) Pets must be restricted from:</p> <p>(a) Central food preparation areas; and</p> <p>(b) Residents who object to the presence of pets.</p> <p>This Washington Administrative Code is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to ensure two facility birds were free of diseases transmittable to</p>	L980 L980	<p>HOW WILL THE NURSING HOME CORRECT THE DEFICIENCY AS IT RELATED TO THE RESIDENT?</p> <p>Veterinarian immediately contacted. Birds examined by Veterinarian 9/21/2018, Certificate of Health provided for facility records. Birds were free of diseases transmittable to humans. Veterinarian information is on file with the bird records for annual health check. Residing animal health records located in the Resident Life Services office.</p> <p>HOW THE NURSING HOME WILL ACT TO PROTECT THE RESIDENTS IN SIMILAR SITUATIONS?</p> <p>Residing Animal Policy updated to reflect annual veterinarian health check for residing animals.</p> <p>HOW THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR?</p> <p>The Activities Director is to ensure residing animals receive a veterinary exam at the minimum of once every 12 months to ensure good health.</p> <p>Education conducted for staff responsible for care of residing birds regarding Residing Animal policy and process, veterinary health check information/requirements and documentation requirements.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO</p>	11/15/18

State Form 2567

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

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2018
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE			STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370	
(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) COMPLETE DATE
L980	<p>Continued From page 2</p> <p>humans by receiving routine veterinary care. This failure placed residents and staff at risk for exposure to diseases spread by animals to humans.</p> <p>Findings included...</p> <p>Record review of an undated facility policy titled, "Visiting Pet Policy," showed that all animals must be pre-authorized prior to the first visit to the facility. The document further showed that a pet/veterinarian attestation (verification) form must be completed and signed by a licensed veterinarian to certify the animal was free of infectious diseases that are transmittable to humans.</p> <p>In an observation on 09/17/18 at 12:53 PM, two parakeets were observed in a large wood, glass and screen mesh bird cage. The bird cage was located on the 2nd floor hallway where both residents and staff had access.</p> <p>Review of the facility's binder titled, "Pets" showed several Pet authorization/ Veterinarian Attestation forms had been completed; however, no document was shown for two parakeets that lived in the facility.</p> <p>During an interview on 09/17/18 at 12:54 PM, Staff F, Activities Director (AD), stated that he was not aware until recently that the birds did not have any veterinary records and were only taken to the veterinarian if they were sick. Staff F, AD, further stated that the birds required a yearly check up by a veterinarian and one would be scheduled.</p>	L980	<p>MAKE SURE THAT SOLUTIONS ARE SUSTAINED?</p> <p>Activities Director will report to the Interdisciplinary Team monthly of residing animal examinations, and audit health record log to ensure compliance.</p> <p>DATE THE CORRECTIVE ACTION WILL BE COMPLETE?</p> <p>Date of correction will be November 15, 2018</p> <p>THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION?</p> <p>Director of Activities, Director of Nursing, Administrator</p>	
L1500	WAC 388-97-1500 Tuberculosis—Positive Test Result	L1500	HOW WILL THE NURSING HOME CORRECT THE DEFICIENCY AS IT	11/15/18

State Form 2567

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

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2018
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE			STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBORO, WA 98370	
(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) COMPLETE DATE
L1500	<p>Continued From page 3</p> <p>When there is a positive result to tuberculosis skin or blood testing the nursing home must:</p> <p>(1) Ensure that the person has a chest X ray within seven days;</p> <p>(2) Evaluate each resident or person with a positive test result for signs and symptoms of tuberculosis; and</p> <p>(3) Follow the recommendation of the person's health care provider.</p> <p>This Washington Administrative Code is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure tuberculosis (TB, a communicable disease) testing was performed in accordance with standards set by Centers for Disease Control (CDC) and applicable state law for one of five residents (Resident #153) reviewed for TB testing. This failure placed the residents, staff and visitors at risk for exposure to a communicable disease.</p> <p>Findings included...</p> <p>Review of the facility's policy and procedure titled, "Tuberculosis Screening and Testing," revised July 2017, showed "All newly admitted residents will be screened for TB during the admission process. All newly admitted residents will be tested using the two-step TST [Tuberculin Skin Testing] unless they have a documented history of a positive TST or have documentation of completion of TB treatment." The policy and procedure further showed that if a resident had a positive TST a chest x-ray must be done within seven days of admission.</p> <p>Review of Resident #153's Medication Administration Record (MAR) dated August</p>	L1500	<p>RELATED TO THE RESIDENT?</p> <p>Resident #153: Unit Manager requested order from provider for chest xray to rule out tuberculosis infection. Order received, chest xray result was negative of active tuberculosis. Medical record updated with lab result information.</p> <p>HOW THE NURSING HOME WILL ACT TO PROTECT THE RESIDENTS IN SIMILAR SITUATIONS?</p> <p>Upon admission the admission nurse will follow Admission Checklist to ensure all documentation regarding TB/PPD information is included in the resident health record. All residents with history of positive tuberculosis testing will have a chest xray documented.</p> <p>HOW THE NURSING HOME WILL TAKE OR SYSTEMS IT WILL ALTER TO ENSURE THAT THE PROBLEM DOES NOT RECUR?</p> <p>Education will be conducted for licensed nursing staff in regards to PPD/CXR documentation for all new admissions. Training will include assessment of signs/symptoms of TB, screening for positive test results, CXR requirements and documentation within 7 days of admission if positive PPD test or history of positive PPD test and correct MAR documentation for all new admissions.</p> <p>The Health Information Manager will perform an Admission Record audit on all admissions within the first week of an admission to review for completion utilizing</p>	

State Form 2567

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

State of Washington

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505474	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/18/2018
NAME OF PROVIDER OR SUPPLIER MARTHA AND MARY HEALTH SERVICE			STREET ADDRESS, CITY, STATE, ZIP CODE 19160 FRONT STREET NORTHEAST POULSBO, WA 98370	
(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) COMPLETE DATE
L1500	<p>Continued From page 4</p> <p>2018, showed that the resident admitted on 08/03/18 with diagnoses to include chronic obstructive lung disease and indicated that the resident had a history of being screened for respiratory TB. The MAR reflected the physician's order to do a two-step TB testing; however, there was no documentation that showed the two-step TB testing had been done.</p> <p>Review of Resident #153's progress note dated 08/04/18, showed that no TB test was given as the resident previously tested positive for TB and a chest x-ray was required.</p> <p>During an interview on 09/17/18 at 10:41 AM, Staff B, Director of Nursing Services, stated that the expectation was for licensed nurses to do a two-step TB testing for newly admitted residents on admission and if a resident refused TB testing and/or had a positive TB test, the facility would obtain a chest x-ray.</p> <p>During an interview on 09/18/18 at 8:17 AM, Staff B, DNS, stated that the facility determined Resident #153 had a history of a positive TB test and a chest x-ray should have been done. According to the DNS, Resident #153 had no chest x-ray record since admission so a chest x-ray was obtained on 09/17/18 and the result showed no active TB.</p>	L1500	<p>the updated Admission Checklist that included TB/PPD documentation. Any missing or incomplete documentation will be noted on the Admission Checklist by the Health Information Department and forwarded to Unit Nurse Manager to address with staff. When completed, the updated Admission Checklist shall be forwarded back to the Health information Manager for a second admission chart audit. If second admission chart audit proved incomplete, the document shall be forwarded to the Assistant Director of Nursing or the Director of Nursing.</p> <p>HOW THE NURSING HOME PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED?</p> <p>Admission Chart Audit Information will be reported to the IDT Monthly QAA Meeting by HIM to ensure compliance.</p> <p>DATE THE CORRECTIVE ACTION WILL BE COMPLETE?</p> <p>Date of correction November 15th, 2018</p> <p>THE TITLE OF THE PERSON RESPONSIBLE TO ENSURE CORRECTION?</p> <p>Health Information Manager, Director of Nursing, Administrator</p>	

State Form 2567

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