

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505059	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/11/2024
NAME OF PROVIDER OR SUPPLIER Panorama City Conv & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 1600 Sleater Kinney Road SE Lacey, WA 98503	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49451</p> <p>Based on interview and record review the facility failed to follow professional standards of practice during medication administration for 3 of 6 residents (Residents 5, 6 & 7) reviewed for medication administration. This failure to ensure services provided met professional standards of practice placed residents at risk for diversion of medication, medication errors and adverse outcomes.</p> <p>Findings included .</p> <p><Policy></p> <p>Review of the facility's policy, Medication Assessment and Documentation, dated 09/10/2015, showed medications were listed on the Medication Administration Record (MAR) and the licensed nurse would initial the MAR after the medication had been administered.</p> <p><Resident 5></p> <p>Resident 5 was admitted to the facility on [DATE] with diagnoses including an infection related to an orthopedic prosthetic and arthritis.</p> <p>Resident 5's MAR, dated 05/03/2024, showed the following medications were prepared, administered and signed by Licensed Practical Nurse (LPN), Staff F:</p> <ol style="list-style-type: none"> 1. CoQ-10 100 mg (milligrams)(vitamin like substance) capsule by mouth 2. Florastor 250 mg (probiotic) capsule by mouth 3. PreserVision AREDS-2 250 mg-90 mg-40 mg-1mg (supplement for eyes), one capsule by mouth 4. Famotidine 10 mg (medication to treat acid reflux) tablet by mouth 5. Miralax 17 gram (laxative) oral powder. Mix with 8 ounces of preferred beverage by mouth 6. Metoprolol Succinate ER 50 mg (medication to treat high blood pressure) tablet extended release (take with 25 mg/ total 75 mg) by mouth 7. Metoprolol Succinate ER 25 mg tablet extended release (take with 50 mg/ total 75 mg) <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><Resident 7></p> <p>Resident 7 was admitted to the facility on [DATE] with diagnoses including diabetes and anemia (reduction in red blood cells or iron)</p> <p>Resident 7's MAR, dated 5/3/2024, showed the following medications were prepared, administered, and signed by LPN, Staff F:</p> <ol style="list-style-type: none"> 1. Miralax 17 gram (laxative) oral powder packet mixed with 6-8 ounces of juice or water by mouth. 2. Senna 8.6 mg tablet by mouth 3. Ferrous Sulfate 325 mg (iron supplement) tablet by mouth 4. Finasteride 5 mg (medication for enlarged prostate) by mouth 5. Mometasone inhaler 2 puffs (steroid) into lungs 6. PreserVision AREDS 4,296 mcg-226 mg-90 mg capsule by mouth 7. Singular 10 mg (medications to treat allergies) by mouth 8. Glimperide 1 mg (medication to treat diabetes) tablet by mouth 9. Men's Multi Plus Prostate Support Vitamin 1 tablet by mouth 10. Buprenorphine HCL 8 mg (narcotic medication) by mouth or sublingual 11. Sodium Chloride 1,000 mg by mouth 12. Hydrochlorothiazide 50 mg (medication to treat excessive fluid) by mouth 13. Prosource 1 pack by mouth <p>On 05/16/2024 at 2:58 PM, by telephone interview, Staff F, LPN said they were assigned to administer medications to residents for A wing. Staff F said Staff D, LPN/Unit Manager would ask for certain residents' medications. Staff F would prepare and sign for the medications and Staff D would take the medications to the residents for administration.</p> <p>On 06/07/2024 at 1:15 PM, Staff E, LPN said they were assigned to administer medications on Unit A and Staff D/Unit Manager would come to the medication cart and ask for the medication for certain residents. Staff E said they would prepare the medication themselves and then Staff D would take the medications to the resident's room. [Staff D] means well, but I don't like it. I am assigned to the cart.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 06/11/2024 at 12:25 PM, Staff J, Registered Nurse, Unit Manager said, the general approach is the same nurse will prepare and administer the medication to the resident. Staff J became aware it was happening on A wing and discussed with Staff B, Director of Nursing/Registered Nurse about revising the medication administration policy. Staff J said it had only happened in a pinch when they were short staffed, I have done it myself a handful of times.</p> <p>On 06/11/2024 at 1:05 PM, Staff I, Registered Nurse, Unit Manager said the nurse that prepared the medication should administer the medication to the resident.</p> <p>On 06/11/2024 at 2:30 PM, Staff D said it had been their regular practice to help nurses on A wing who were behind on the medication pass. Staff D said the nurse assigned to the medication cart would prepare the medications for certain residents and Staff D would take the medications to that resident for administration. Staff D said it had occurred with Staff E, F, G and H. Staff D said on 05/03/2024 in the AM, Staff F/LPN prepared the medications and signed the eMAR for medications for Residents 5, 6 and 7 and Staff D administered the medications to the residents. Staff D said they did not follow the 5 rights of medication administration as the medications were prepared by Staff F and administered by Staff D and the right resident, drug, dose, time and route were not verified by the nurse preparing the medications.</p> <p>On 06/11/2024 at 4:00 PM, Staff B said they had become aware Staff D was administering medications to residents that had been prepared by other nurses on A Wing. Staff B said they were unable to provide a policy related to that practice. Staff B said they had sent an email to all licensed nurses to stop the practice.</p> <p>Reference WAC 388-97-1620(2)(b)(i)(ii)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49451</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents were free from avoidable accidents during a resident transfer for 1 of 3 residents (Resident 1) reviewed for accidents. Resident 1 experienced harm when facility staff did not follow the resident's individualized care plan for safe transfers and the resident sustained a fracture requiring hospitalization . This failure placed residents at risk for injury and a diminished quality of life.</p> <p>Findings included .</p> <p><Facility Policy></p> <p>Review of the facility's policy Mechanical Lift Usage, revised 05/08/2017, showed residents that require maximum to total assistance with transfers were not to be lifted without the aid of a mechanical lift. Those residents who did not bear weight or were unable to hold on to the lift bar were to be lifted with Hoyer lifts (lifts that utilize a sling and lift the resident's entire body). The specific lift used by the resident would be written on the resident's care plan and nursing care directives.</p> <p><Resident 1></p> <p>Resident 1 was admitted to the facility on [DATE] with diagnoses including multiple sclerosis (the body attacks protective covering of nerves), hemiplegia (weakness to one side of the body) and hemiparesis (abnormal feeling on one side of the body) following a stroke. The Admission Minimum Data Set (MDS), an assessment tool, dated 03/10/2024, showed Resident 1 had cognitive impairment, was dependent on staff for toileting and bathing and used a wheelchair (w/c) for mobility.</p> <p>Resident 1's care plan, dated 04/25/2024, showed Resident 1 required two-person dependent (fully dependent on two people) assistance with a Hoyer lift for all transfers from w/c to bed and bed to w/c. The care plan documented, do not attempt two-person dependent assist for toileting. Due to Hoyer lift status, resident will use bedpan for toileting.</p> <p>Investigation/follow-up documentation for an incident regarding Resident 1 on 05/06/2024, dated 05/09/2024, showed Collateral Contact (CC) 1, resident's family member, reported that a staff member had transferred Resident 1 onto the toilet resulting in left shoulder pain. The investigation documented, at the time of the event, the care plan read to use a mechanical lift for toileting. Staff C, Nursing Assistant, brought the sit-to-stand machine [lift device that requires some weight bearing by the resident) into room to see if that would work for Resident 1 and it became clear this would not work because Resident 1 was unable to participate with transfers and could not bear weight. Resident 1 was unable to grip the handles with her left hand and Resident 1 was then helped to bed. The investigation showed, fracture appears to have occurred while on the sit-to-stand lift. Resident 1 reported increased pain while on the sit-to-stand.</p> <p>Resident 1's radiology report, dated 05/07/2024, showed an acute fracture (result of traumatic injury that causes a clean break) at the proximal left humeral neck (near the arm/shoulder joint).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 1's interdisciplinary note, dated 05/08/2024 at 8:42 PM, showed the resident returned to the facility from the hospital via stretcher with a sling to their left arm.</p> <p>Resident 1's hospital record, dated 05/08/2024, showed Resident 1 was seen in the emergency department for fracture of the left upper arm and was discharged back to the facility with pain medication and instructions to follow up with an orthopedic surgeon.</p> <p>On 05/22/2024 at 11:20 AM, during an interview, CC 1 said Resident 1 had used a bedpan for toileting as the resident's left arm and leg were non-functional and there had always been two staff to assist Resident 1 with toileting prior to the incident. CC 1 said they were present during the transfer with Resident 1. Resident 1 was in a w/c and wanted to go to the toilet so CC 1 asked Staff C to find another staff member to help toilet the resident and Staff C said they would get a lift because the other staff were busy. Staff C came into Resident 1's room with a different lift [the sit-to-stand] and attempted to put the resident in the lift. CC 1 said Resident 1 complained this was hurting and Staff C placed Resident 1 back in the w/c, left the room and then returned with another staff member. Staff C lifted Resident 1 up from the w/c without a gait belt and placed her on the toilet. After Resident 1 was finished toileting, Staff C, again, lifted Resident 1 without a gait belt and placed the resident back in the w/c. CC 1 said they reported the incident to a staff member and the facility ordered an x-ray and found there was a fracture. Resident 1 was sent to the hospital and returned to the facility with a sling to their left arm. CC 1 said the facility used ice and pain medication to relieve the resident's pain.</p> <p>On 06/06/2024 at 12:05 PM, during an interview, Staff C said on 05/06/2024 they had transferred Resident 1 to the bathroom and back to the resident's w/c and did not use the mechanical lift as directed on the resident's care plan. Staff C said it was not the appropriate way to transfer the resident, as the care plan had indicated the resident required a Hoyer lift with two staff members. Staff C said Resident 1 did tell CC 1 their arm hurt after the transfer.</p> <p>On 06/11/2024 at 4:10 PM, Director of Nursing, Registered Nurse, Staff B said when transferring a resident that required the use of Hoyer lift, two staff were required to be present. Staff B said staff could retrieve resident information from the care directive in the resident's room or from the care plan. Staff B said Resident 1 required a Hoyer lift for transfer and Staff C did not use the correct lift to transfer the resident and Resident 1 sustained a fracture, was transferred to the hospital for medical care but did not require surgical intervention.</p> <p>Reference WAC 388-97-1060(3)(g)</p>		