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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385049	A. BUILDING ______ B. WING ______	01/11/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA BASIN CARE FACILITY	**1015 WEBBER ROAD** **THE DALLES, OR 97058**

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F 000	INITIAL COMMENTS The findings of the recertification and licensure health survey and complaint survey (intake #3082) conducted 1/8/07 through 1/11/07 are documented in this report. The survey was conducted to determine compliance with the 42 CFR Part 483 Requirements for Long Term Care Facilities and the OARs 411 Division 85 through 89.	F 000	DISCLAIMER CLAUSE Preparation and / or execution of this plan of correction does not constitute the provider's admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by the provisions of Federal and State Law.	
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to provide adequate care and services following physician orders related to diabetic management, therapeutic diets and lab orders, for 3 of 13 sampled residents (#s 1, 10 & 12)	F 309		

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

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

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F 309	Continued From page 1 whose care and services were reviewed. Findings included: 1 Resident 10 was admitted on 12/19/06 with a diagnosis of insulin dependent diabetes. The resident received long acting Insulin twice a day, Lantus 50 units every morning and before sleep in the evening. In addition, the physician ordered two short acting sliding scale insulin orders, each four times a day. The first sliding scale order was, Novalog insulin 1 unit for every 10 increments in blood glucose above 150, before meals and at hour of sleep. The insulin records indicated from 12/19/06 through 1/3/07 the facility administered the wrong dose of insulin seven times. The second sliding scale insulin order was. Novalog insulin 1 unit per 15 grams of carbs 0-15 minutes before each meal and snacks. The insulin records for that order indicated insulin was to be administered prior to three meals and an evening snack based on the carbohydrates served. On 1/6/07 during observation of tray line	F 309	F - 309 1. Licensed staff have been in-serviced on 1/9/07, in regards to the formula for sliding scale coverage, use of a calculator and not rounding up. Diabetic audits are conducted routinely by the Director of Nursing (DNS) / designee. Disciplinary action was taken with staff involved in the medication errors. Registered Dietitian (RD) in-serviced dietary staff regarding carbohydrate servings. The RD also updated the menus to include what each food is worth in carbohydrates. A verbal in-service regarding resident #10's food being delivered to her by only the licensed nurses was held on 1/10/07. (This includes resident's meal trays and all snacks.) This in-service included nursing, dietary staff and resident #10. A written memo went to nursing, dietary and activity department on 2/5/07.	3-1-07

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F 309	Continued From page 2 at dinner, Staff 9, the Dietary Services Manager(DSM), stated the cook wrote down the amount of carbohydrates on Resident 10's tray card which communicates to the nurse the amount of insulin to administer. At 4:45 pm Staff 13, the cook, stated "I hate trying to figure this out." There was no specific therapeutic diet on the menus which indicated the carbohydrate count. Staff 9 reported the registered dietitian (RD) helped write a list of foods with the amount of carbs designated during a telephone conversation between the DSM and RD. A handwritten list of foods was observed noting a carbohydrate ratio of "15 gm = 1 carb serving." The items on that list included: "...any juice, any milk, any desserts, any fruit..." all equaling one carbohydrate serving, without designating the size or type of food. On 1/8/07 at 5:05 pm Staff 6, a CNA, delivered the resident's tray to her bedside and left it within reach of the resident, who stated she was not feeling well and did not want to eat. Staff 6 further stated she usually told the charge nurse when the resident had her tray and	F 309		

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F 309	Continued From page 3	F 309		

how many carbs were noted on the tray card, "but I haven't yet." In response to interview with surveyor at 5:10 pm Staff 2, the Director of Nursing Services (DNS) confirmed with Staff 15, the charge nurse, that the resident had not received insulin. Staff 15 stated, "I got hung up in the dining room," stating she did not give the insulin before the meal. The resident's insulin was held because she did not eat, and her CBG before dinner was 125 at that time. Staff 4, the Registered Nurse Care Manager (RNCM) stated, "She usually eats 100% at every meal and we give her insulin before she eats."

On 1/10/07, prior to breakfast, Staff 15 stated she waited at the kitchen and the cook had told her that the resident had "6 carbs" on her tray for breakfast. Staff 15 then gave the resident 6 units of Novalog insulin. The resident's tray included a cheese omelette, one bowl of oatmeal, one slice of toast, one four-ounce juice, and one eight-ounce milk. There was no amount of carbohydrates written on the tray card. Staff 14, a cook, revealed she incorrectly counted the cheese omelette as a carbohydrate, and erroneously reported the amount of carbs for the rest

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F 309	Continued From page 4 of the food to the licensed nurse. Consequently, Staff 15 administered the wrong dose of insulin based on that information. On 1/10/07 at 2:30 pm, in reviewing what was served to the resident at breakfast, Staff 11 stated that the resident had not received six servings of carbohydrates at her breakfast meal. On 1/10/07 this was discussed with Staff 2 who was unable to provide further information. In addition Staff 2 and Staff 11 confirmed that the system was not adequate to ensure that the resident received appropriate diabetic management. 2. Resident 12 had 2/3/06 physician's orders for a potassium-rich diet and liquid KCl (a potassium supplement) 20 meq daily. The 3/28/06 Annual Nutrition RAP (Resident Assessment Protocol) did not identify nor assess the resident's high potassium diet. An 8/18/06 lab report indicated that the resident's potassium level was below normal limits. There were no further lab tests completed on the resident's potassium level. The 1/06 MAR (Medication Administration Record)	F 309	**F-309 (con't)** 2. Resident #12 physician was in on 1/11/07. Resident's diet order was changed at this time due to refusals. The physician put resident on a regular diet, discontinued the Dyazide and placed resident on a potassium sparring diuretic and scheduled a renal panel for 2/6/07. The results of the renal panel will be available this week for the RD to review. All residents who receive a special Physician ordered diet will be reviewed / assessed by the RD / Resident Care Manager (RCM) in relationship to medication management and the Fine Dining program.	2-7-07

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F 309	Continued From page 5 revealed that the resident had refused her KCl five out of nine days. There was no further documented assessment, nor updated plan to address the resident's low potassium level, including her refusals of the KCl. During the survey, the resident had been identified by dietary as receiving a high potassium diet. On 1/10/07 at 12:20 pm, Resident 12 was observed eating a reguler diet rather than a high potassium diet. In interview on 1/10/07, Staff 9 stated that due to the resident choosing her meal options with the Fine Dining program, the resident chose to not eat the high potassium foods. There was no plan in place to address the resident's physician-ordered diet in relation to the Fine Dining program, or consideration of alternative interventions. In interview on 1/10/07 at 5:05 pm, Staff 4 stated that the resident often refused her medications. Staff 4 was unable to provide any further information. 3. Resident 1 had diagnoses of hypothyroidism and physician's orders for Levothroid 50 mcg daily. There was a 12/28/06 physician's order for the	F 309	**F-309 (con't)** 3. Resident #1 thyroid level (TSH) was drawn on 1/10/07. The thyroid level was in therapeutic range. Licensed nurses have been in-serviced 1/10/07 regarding policy and procedure for lab draws and transcribing telephone orders. Medical Records or designee will audit the transcription of telephone orders to medication administration and treatment sheets for accuracy and omissions. Lab slips are filled out for routine lab at the end of each month during the re-cap process. DNS / RCM will review telephone orders routinely in addition to the Medical Records audits to ensure compliance. Findings will be brought to and reviewed by the Quality Assurance Committee.	3-7-07

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F 309	Continued From page 6 resident's TSH (thyroid test) to be checked. There was no documented evidence in the clinical record that the lab test had been completed as ordered. In interview on 1/9/07 at 1:30 pm, Staff 4 was not aware of the lab order and was unable to provide documented evidence that it had been completed.	F 309		
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose	F 329		

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F 329	Continued From page 7 reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to assess insomnia, and to provide adequate indications for use and/or attempt gradual dose reductions for 3 of 4 sampled residents (5, 7, 8) who received hypnotic medications. Findings include: 1. Resident 8 had physician's orders for Trazodone 150 mg daily, which according to the 10/10/06 Annual Psychotropic RAP, was used for insomnia. There was no documented assessment of the resident's insomnia, including potential causes and non-pharmacological interventions. There was also no documented evidence that the facility had attempted a gradual dose reduction of the Trazodone to determine if a lesser dose would be effective.	F 329	F-329 1. Resident #8 medication was assessed by the interdisciplinary team (IDT) and resident's Trazadone was decreased on 1/19/07. Resident #8 has been placed on alert charting to monitor for adverse reaction to dose reduction. Resident will be reviewed quarterly and PRN by the IDT for further assessment / evaluation of dose reduction.	3-11-07

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F 329	Continued From page 8	F 329		

In interview on 1/9/07 at 2:50 pm, Staff 4, RNCM, confirmed that there was no documented assessment of the resident's insomnia.

2. Resident 5 had been residing at the facility since 12/05 with diagnoses that included dementia. She had a 10/6/06 physician order for Ambien 5 mg. (a hypnotic/sleeping medication) at bedtime PRN (as needed) for sleep. The resident was receiving the Ambien on a nightly basis. There was no evidence of an assessment related to the resident's insomnia, the effectiveness of the Ambien, and/or non-pharmacological interventions considered or attempted. Ambien can cause an adverse side effect of agitation and hallucinations due to central nervous system stimulation. Observations of the resident during the survey revealed that at least daily she became restless and anxious and was talking of things that were not occurring, possibly delusions. The resident's care plan did indicate that on admission in 12/05 there was a history of visual hallucinations and on 9/11/06 a problem of delusional statements was added. The resident was receiving Haldol (an

F-329 (con't)

2. Resident #5 PRN (as needed) Ambien was discontinued on 1/16/07. Resident #5 was monitored via alert charting and has tolerated the dose reduction well. The IDT will continue to monitor resident's behaviors/medications on a quarterly basis. — 3-1-07

Licensed nurses and CMA's were in-serviced on 1/30/07 regarding PRN documentation on back of medication administration record (MAR).

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F 329	Continued From page 10 the resident's insomnia indicated that the resident was sleeping well. However, there was no indication that the facility had considered a dose reduction, or assessed the continued need of the Trazodone. Staff 4 confirmed during an interview on 1/9/07 that the resident had been taking the Trazodone at that same dosage for almost a year, without a dose reduction.	F 329		
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that staff washed their hands after providing direct resident contact to prevent the spread of infection, in accordance with accepted professional practice. Findings include: On 1/8/07 at 4:45 pm, two staff were	F 444	F-444 Nursing staff have been in-serviced on 1/9/07 and also on 1/10/07 during an all staff meeting on hand-washing. Random, direct-care observations of hand-washing / peri -care have been done by the DNS/designee to ensure compliance. Random, direct-care observations of hand-washing / peri-care by the DNS / designee will continue as a part of ensuring ongoing compliance. Results of observations will be reviewed at the Quality Assurance Committee meeting.	3-1-07

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F 444	Continued From page 11 observed to be providing care for Resident 1. Staff 6, CNA, and Staff 5, CNA, who was in her first day of training. Staff 6 was observed to check the resident's peri-area, then without changing her gloves or washing her hands, she assisted the resident with a transfer to her wheelchair and put a lapbuddy in place. Staff 6 observed that the resident's eyes had "goop" in them and began opening dresser drawers to locate a washcloth. After not locating a washcloth, Staff 6 obtained a paper towel to wipe the resident's eyes. Prior to wiping the resident's eyes, the surveyor stopped Staff 6, and she then changed her gloves. On 1/9/07 at 9:45 am, Staff 7, CNA and Staff 8, CNA were observed to provide peri-care to Resident 1. After the care was provided, without changing their gloves or washing their hands, Staff 7 and 8 were observed to arrange pillows for the resident, place her padded boots on her feet and gave her a stuffed animal to hold. In interview on 1/9/07 at 3:50 pm, Staff 1, Administrator and Staff 2, DNS, were provided with the above information.	F 444		

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F 518	Continued From page 12	F 518		
F 518 SS=F	483.75(m)(2) DISASTER AND EMERGENCY PREPAREDNESS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to train employees on accessing emergency power in the event of a power loss, and to designate their emergency outlets throughout the facility. Findings include: The facility had a generator which supplied emergency electrical power to designated outlets on the first and second floors. Staff 12, the Maintenance Supervisor, reported those outlets should be designated with a red outlet plate. There were no emergency outlet plates observed on the second floor. On 1/9/07 at approximately 5:00 pm , Staff 15,	F 518	**F - 518** Outlets that are supplied by the emergency generator had new red plates installed on 1-11-07. Maintenance Director audited all known electrical outlets served by emergency generator and created a map of their locations. Staff were trained on 1-10-07 re location and meaning of red electrical plates; staff will be trained again on 2-9-07 re location and meaning of red electrical plates. Staff will be trained at time of new employee orientation by Maintenance Director and semi-annually during All-Staff meetings. Training will be documented. The Maintenance Director will audit presence of red outlet covers during monthly preventative maintenance rounds. Any missing or damage plates will be replaced immediately. The Maintenance Director will report the status of red outlet covers and staff awareness at quarterly CQI committee meetings.	3-9-07

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F 518	Continued From page 13 charge nurse for first floor, and Staff 10, charge nurse for second floor, were unable to identify where to access emergency power in the event of a power loss. Both nurses looked for the red outlet covers. Staff 3, the second floor RNCM, stated some outlets used to have a red cover which identified them as emergency plugs. Staff 12, the Maintenance Director, reported that after the remodel was completed on the second floor several months ago, the emergency plugs had not been redesignated per the facility protocol. Staff 2, the DNS, was able to identify emergency outlets on the first floor; however, she confirmed that outlets had not been appropriately identified in the locations on both the first and second floors that had been remodeled.	F 518		

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F9999	Continued From page 14	F9999		
F9999	FINAL OBSERVATIONS The facility must operate and provide services in compliance with all applicable State and local laws, regulation and codes. This requirement is not met as evidenced by: OAR 411-86-110 Nursing Services: Resident Care Refer to F309, F329 *** OAR 411-86-310 Employee Orientation and In-Service Training Refer to F518 *** OAR 411-86-330 Infection Control and Universal Precautions Refer to F444	F9999		