

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

PRINTED: 08/07/2013
FORM APPROVED
OMB NO. 0938-0391

1427

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505382	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/02/2013
NAME OF PROVIDER OR SUPPLIER REGENCY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 726 NORTH MARKESON CHELAN, WA 98816	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Regency Manor on 8/02/13. A sample of 3 residents was selected from a census of 42. The sample included 2 current residents and the record of 1 former and/or discharged resident.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#2842490 #2844440 #2845821</p> <p>The survey was conducted by: [REDACTED], R.N.</p> <p>The survey team was from:</p> <p>Department of Social & Health Services Aging & Long-Term Support Administration Division of Residential Care Services, District 1, Unit D 3611 River Road, Suite 200 Yakima, WA 98902</p> <p>Telephone: (509) 225-2800 Fax: (509) 574-5597</p> <p><i>[Signature]</i> 8/2/13 Residential Care Services Date</p>	F 000	<p>This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to Long term Care providers. This Plan of Correction does not constitute and admission of liability on the part of the facility. The submission of this plan does not constitute agreement by the facility that the surveyor's findings and/or conclusions are accurate, or that the scope and severity regarding any of the deficiencies cited are correctly applied.</p> <p>The Plan of Correction constitutes our Credible Allegation of compliance.</p> <p style="text-align: center;">Received Yakima RCS AUG 19 2013</p>	
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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

[Signature] *Administrator* 8/16/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505382	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/02/2013
NAME OF PROVIDER OR SUPPLIER REGENCY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 726 NORTH MARKESON CHELAN, WA 98816		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309 SS=D	<p>Continued From page 1 HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to perform necessary assessments in accordance with physician directives and in response to changes in resident condition for 1 of 3 residents reviewed (#1). Resident #1 was admitted to the facility after falling at home, fell twice at the facility, developed [redacted] swelling, and was diagnosed with a [redacted] fracture directly after transferring to another facility. Findings include:</p> <p>Resident #1: Review of the medical record revealed the resident was admitted from the hospital to the facility on [redacted]/13 with multiple diagnoses including dementia, [redacted], and a fall history. According to the 7/03/13 hospital's Physician Clinical Report, the resident had fallen that day and sustained injuries to his right knee and left knee. X-rays were taken in the hospital of both knees and no fracture was identified.</p> <p>Admission orders, dated [redacted]/13 and signed by the physician on [redacted]/13, included a directive to daily monitor two bruised areas: one on the resident's left lower extremity and one on his left</p>	F 309	<p>F-309</p> <p>Cited Resident: 1. Resident #1, had a diagnosis of [redacted] with [redacted] disturbances, [redacted], joint pain, [redacted] and advanced [redacted] and had been discharged from the facility prior to survey.</p> <p>All Residents: All other residents of the facility have been evaluated and assessed for changes in condition including bruises and acute edema and appropriate follow up has been completed as required.</p> <p>Education/System Review: Licensed nurses have been educated on the facility process of communicating and monitoring changes in condition including bruises and edema to ensure that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being.</p>		

JS

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

PRINTED: 08/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505382	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/02/2013
NAME OF PROVIDER OR SUPPLIER REGENCY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 726 NORTH MARKESON CHELAN, WA 98816		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 2</p> <p>inner foot until the areas were healed. Review of the [REDACTED] 13 Resident Admission Profile noted two bruised areas sketched on the resident's right lower leg, a large bruise on his shin and another area lower on the same leg. The cardiovascular section on the admission assessment did not have documentation of the presence of edema (swelling in the resident's tissue) at the time of admission. The resident's admission weight was 174 pounds. The resident was to receive twice daily morphine and tylenol four times a day.</p> <p>The resident's care plan noted he needed assistance from two persons or the use of a mechanical sit-to-stand lift to transfer him. Safety pressure alarms were initiated as well in the resident's bed and wheelchair.</p> <p>A review of the July 2013 treatment record failed to note any entries documenting daily assessments/monitoring the condition of the resident's leg bruises.</p> <p>According to nursing entries on 7/03/13 and on 7/07/13, the resident had fallen but no injuries were identified except for a skin tear on his left elbow on 7/03/13.</p> <p>Physical Therapy (PT) documentation revealed an evaluation was conducted on 7/08/13 and the resident walked a distance of 100 feet with assistance twice that day. According to the PT notes, on 7/09/13 the resident had a significant decline in his functional ability that day due to severe left knee pain and he was unable to walk that day.</p> <p>There was a new order received on 7/09/13 for an [REDACTED] medication at bedtime "for</p>	F 309	<p>Monitoring: The Director of Nursing or designee will routinely review the status of the resident in the facility through the facilities communication and monitoring processes. Any identified issues will be immediately corrected and identified trends will be brought to the Quality and Performance Improvement Committee (QAPI) as deemed necessary.</p> <p>Responsibility: The Director of Nursing to ensure ongoing compliance.</p>	8/21/13	

JL

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

PRINTED: 08/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505382	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/02/2013
NAME OF PROVIDER OR SUPPLIER REGENCY MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 726 NORTH MARKESON CHELAN, WA 98816		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 3</p> <p>agitation." Prior documentation on the July 2013 Behavioral Flow Sheet noted that on 7/07/13 the resident was setting off his alarms all day trying to get out of his chair. Entries on 7/08/13 documented the resident was transferring without assistance and he had reached out to slap the Speech Therapist when approached for therapy.</p> <p>The Physician evaluated the resident on 7/10/13 at the facility. The Physician noted the resident's history of advanced [REDACTED] in his [REDACTED] knee and ordered another pain medication to be used when needed. There was a plan to change the prescribed [REDACTED] medication to an as needed basis with the addition of the [REDACTED] medication. The Physician documented that the resident had no edema in his extremities on 7/10/13.</p> <p>Nursing documentation on 7/11/13 noted lower extremity edema was present. The 7/12/13 nursing entry documented the resident had edema/swelling present (up) to his left knee. The 7/12/13 PT note documented the resident walked 50 feet that day.</p> <p>Despite documentation of edema, there was no documentation of further assessment of the edema by nursing staff or notification of the physician. No further resident weights were located by staff.</p> <p>Review of the 7/15/13 PT entry, the resident demonstrated "significant edema from left leg distally (down toward his feet)." There was also documentation about "L (left) LE (lower extremity) heaviness from edema." The resident was only able to tolerate 25 feet "then completely buckles."</p>	F 309		

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

PRINTED: 08/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505382	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/02/2013
NAME OF PROVIDER OR SUPPLIER REGENCY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 726 NORTH MARKESON CHELAN, WA 98816		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 4</p> <p>When interviewed on 8/02/13 at approximately 1:45 p.m., 2:45 p.m., and at 2:55 p.m., Staff Member A, a Registered Nurse, stated she was unable to find documentation of staff monitoring the lower extremity bruises on a daily basis. She recalled hearing about Resident #1 having/developing some swelling in his left lower extremity but did not recall the details. The physician was aware of the resident's (chronic) knee problems, but Staff Member A was unable to locate documentation that the physician had been notified about the resident developing edema in his left leg.</p> <p>A 7/16/13 nursing entry documented the resident was discharged from the facility at 9:30 a.m. He was being transferred to another facility via private car by a family member. The resident was transferred into the private car by facility staff (including Staff Member B, a Nursing Assistant) and Therapy Staff Member A.</p> <p>On 8/02/13 at approximately 12:30 p.m., Therapy Staff Member A, stated the resident fluctuated with his transfers based on his alertness and pain management. On 7/16/13, the day of discharge, three individuals assisted. The resident was lethargic but the transfer was performed into the car without any problems. "It all looked good."</p> <p>Staff Member B, a Nursing Assistant, was interviewed on 8/02/13 at approximately 1:50 p.m., about the 7/16/13 transfer and the resident's condition at that time. Staff Member B recalled the resident was having his "worst day". He was "stuporous...leaning over forward, and slobbering from his mouth." Reportedly, the transfer into the car "went excellently well." Staff had practiced the transfer.</p>	F 309			

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

PRINTED: 08/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505382	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/02/2013
NAME OF PROVIDER OR SUPPLIER REGENCY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 726 NORTH MARKESON CHELAN, WA 98816		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 5</p> <p>On 8/05/13 at approximately 1:20 p.m., the resident's Family Member stated the resident's condition had declined over the course of his stay. She arranged for placement at an alternative nursing facility due to her concern about his care. On 7/16/13 the Family Member transported the resident (with another person also present) via private car to the new facility. The resident was "like dead weight during the transfer and his eyes were glazed over." The resident remained in the car without incident during the entire time of the transport.</p> <p>According to an interview on 8/06/13 at approximately 12:25 p.m., PT #2 stated she had performed a transfer for Resident #1 with another caregiver, out of the Family Member's car, at the new facility. The transfer went "fairly well" but the resident was only bearing weight on his right leg. There was a significant amount of edema in the left leg. His whole left leg was swollen.</p> <p>Review of documentation from the second facility revealed that therapy and nursing staff identified abnormal findings for the resident at the time of transfer and throughout the nursing admission assessment. There was no evidence of trauma at the new facility. After notification of the physician, the resident was transported to the hospital the day of admission. X-rays revealed a fractured left hip and hip surgery was performed the following day. A review of the 7/17/13 Operative Report noted that x-rays showed a left displaced femoral (leg/hip) neck fracture that appeared to be sub-acute in nature and was consistent with a history of the resident's fall early in July 2013.</p>	F 309			

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

PRINTED: 08/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505382	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/02/2013
NAME OF PROVIDER OR SUPPLIER REGENCY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 726 NORTH MARKESON CHELAN, WA 98816		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 6 Although the exact timeframe (or which fall was the cause) of the fracture remained an unknown, there was a notable decline in the resident's mobility status as documented in the original PT notes. Additionally, the resident evidenced evolving edema in his left leg. Despite recognition of the edema by PT and some nursing staff, there was no ongoing assessment process over time to quantify the changes (measurements and/or weight assessment) or notification of the physician to facilitate further treatment/follow-up. Agitation, often associated with wanting up/a change of position, was considered behavioral and an order for an anti-psychotic medication was obtained. The resident consequently experienced fluctuations in his mental status/lethargy as well. The facility failed to provide comprehensive care/services necessary to recognize resident injury and facilitate timely care.	F 309			