

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

PRINTED: 05/08/2014  
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 04/24/2014
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 4/23/14 and 4/24/14. A sample of 8 residents was selected from a census of 46. The sample included 7 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>#2986581</p> <p>The survey was conducted by: Priscilla Becker, R.N. Lisa Herke, R.D.</p> <p>The survey team is from: Department of Social &amp; Health Services Aging &amp; Long-Term Support Administration 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>Received Yakima FCS JUN 9 2014</i></p> <p><i>Residential Care Services. Date 5/8/14</i></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> <ol style="list-style-type: none"> <li>How the nursing home will correct the deficiency as it relates to the resident.</li> <li>How the nursing home will act to protect residents in similar situations.</li> <li>Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur</li> <li>How the nursing home plans to monitor its performance to make sure that solutions are sustained</li> <li>Dates when corrective action will be completed</li> <li>The title of the person responsible to ensure the correction.</li> </ol>	<p><i>5/5</i> <i>per T.C.</i> <i>W/Levy on 6/10/14</i></p>
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *6/10/14*

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 323	Continued From page 1  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide adequate supervision to prevent incidents of resident-to-resident aggression for 6 of 8 sampled residents (#1-#6) who were involved in aggressive incidents with other residents. Resident #1, a resident with cognitive impairment, was intolerant of others entering his personal space and demonstrated episodic verbal and physical aggression in response to his displeasure. Although the facility implemented some interventions to address Resident #1's problematic behaviors, they continued to allow the resident to remain in close proximity to other residents in the dining room without direct staff supervision. Staff were not positioned in a manner that allowed for effective protection of the other residents. Findings include but were not limited to:  According to a 1/13/14 facility investigative report, Resident #2 reported that over the past 3-4 months he had experienced three incidents when Resident #1 had yelled at him when (Resident #2) accidentally bumped Resident #1 in the LE (lower extremity) with his wheelchair when he rolled himself up to the table (in the dining room).	F 323	F-323 <b>Cited Resident:</b> At the time of inspection only closed records were reviewed and Resident #1 had already been detained by Mental Health. Resident #2-6 remain at the facility and have not had any documented aggressive incidents with other resident's.  <b>All Residents:</b> All residents will have an environment that remains as free of accident hazards as is possible; and that each resident receives adequate supervision and assistance devices to prevent accidents. Of note the facility had called the mental health crisis hotline more than 10 times in a 30 day period seeking assistance with resident #1. Resident #1 had a diagnosis of [REDACTED] 3 and unfortunately several of the recommendations that were made by mental health were not feasible or were contra- indicated for this diagnosis.  <b>Education/System Review:</b> Facility staff have been trained in behavior intervention techniques and the facility utilized the CMS Hand in Hand training manual.		

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F 323	<p>Continued From page 2</p> <p>Resident #2 was offered an opportunity to change tables but he declined.</p> <p>Resident #2: Review of a 3/26/14 comprehensive assessment revealed the resident scored 14 out of 15 on a cognitive assessment, indicating he was cognitively alert.</p> <p>When interviewed, on 4/24/14 at approximately 10:45 a.m., Resident #2 stated he was one of four residents assigned to a table in the dining room. Resident #1 sat next to Resident #2. They were both in wheelchairs, but Resident #1 was always angled toward Resident #2's place at the table. Resident #2 had difficulty accessing his spot at the table. He stated, he "didn't know how to get in right." Resident #2 "accidentally" bumped Resident #1. Reportedly, the facility had moved Resident #3 away from the table because Resident #3 and Resident #1 "didn't get along." Resident #3 was "in no condition" to say much to Resident #1. Staff had offered Resident #2 a table change but he stated, "I wasn't going to give him (Resident #1) the pleasure of making me move. I'm just that hard-headed."</p> <p>At the time of the interview with Resident #2, an intact pink area was observed on the back of his left hand at the base of his fingers. The resident stated he had been struck by Resident #1 but the area had healed without any problems. Resident #2 recalled on that occasion, Resident #1 was back 3-4 feet from their table in the dining room and "people couldn't get by." Resident #2 told Resident #1 to move and then Resident #1 struck resident #2's hand causing the injury. When asked if staff were present at the time, Resident #2 stated he couldn't recall but stated if they were, they were all afraid of Resident #1.</p>	F 323	<p><b>Monitoring:</b></p> <p>Daily review of 24 hour report, "Stop and Watch" forms, incident reports and alert charting is reviewed at Stand up meeting to ensure behaviors are identified and are addressed on the comprehensive care plan.</p> <p>Behavior interventions on care plans are reviewed as needed, quarterly, with change in condition and annually. In addition to the Daily Stand up meeting, the facility IDT (interdisciplinary team) holds monthly behavior management meetings to address resident's behaviors. The facility will continue to use mental health resources as they are available.</p> <p><b>Responsibility:</b> The Director of Nursing to ensure ongoing compliance.</p>	

*JH*  
04/24/14

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F 323	<p>Continued From page 3</p> <p>According to a 1/31/14 facility investigation, Resident #5 (a cognitively impaired resident) was in the dining room on 1/31/14 at 1:50 p.m. (after the lunch meal) seated in her wheelchair close to Resident #1. Therapy Staff Member A responded when he heard yelling. Therapy Staff Member A observed Resident #1 telling Resident #5 to move then he hit her right arm. There was no injury to Resident #5. Following the incident, Resident #1 was transported to the hospital and then later was sent to a gero-psychiatric unit for medication review and a psychiatric assessment.</p> <p>Resident #1: Review of the medical record revealed the resident was admitted to the facility on 1/12 with multiple diagnoses including Alzheimer's disease, dementia with behaviors, anxiety, and edema. He re-admitted to the facility on 1/14 following his stabilization stay at the gero-psychiatric unit.</p> <p>The cognitively impaired resident's Behavior Interventions document, updated on 1/28/14, directed staff to: 8. "Remind (Resident #1) to disengage from the focus of his upset to avoid confrontation. Assist to another area or activity. (Resident #1 does have awareness of his irritability) 9. If (Resident #1) becomes verbally disruptive/aggressive in d/r (dining room) during meals-escort him to his own room to complete his meal."</p> <p>The Resident Care Guide, dated 2/07/14, documented the resident required assistance with bed mobility and transfers. He was able to self-propel his wheelchair but might require assistance to destinations and/or activities. The resident ate in the main dining room. Identified</p>	F 323		
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F 323	<p>Continued From page 4</p> <p>behaviors included: "grabbing, yelling, cursing at others, resistance to care, confrontational(.) *Caution, res (resident) doesn't like to be touched. Protect (Resident #1) and other residents." Staff were referred to the behavior interventions list (referenced above).</p> <p>According to a 3/01/14 facility investigative document, on 3/01/14 at 12:00 noon, Resident #2 accidentally bumped into Resident #1's foot at the dining room table. Resident #1 became aggressive. When staff informed him he would be escorted to his room if he didn't calm down, Resident #1 began to move toward another resident to "fight him" because he had looked at him (Resident #3). Resident #1 resisted removal from the dining room. The police were called and stood in the hallway supervising while Resident #1 ate in the dining room.</p> <p>Resident #3: Review of the 3/01/14 nursing entry noted "no emotional discomfort noted (with) disagreement (with) another resident (Resident #1) in the dining room during lunch." A 3/05/14 late entry for a 3/03/14 follow-up documented Resident #3 stated he would not mind trying a different table during meal times. "Another resident had yelled and it had appeared to upset (Resident #3)."</p> <p>Review of a 3/29/14 facility investigative document revealed at 5:00 p.m., Resident #1 was in the dining room in his wheelchair and was blocking the pathway for people coming in. A tablemate (Resident #2) asked him to move his wheelchair closer to the table and Resident #1 started yelling and threw a few punches. Resident #2 sustained several abrasions on his left knuckles. Also noted, on 4/01/14 with the</p>	F 323		

*JL*  
5/11/14

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F 323	<p>Continued From page 5</p> <p>investigative conclusion, were three less than 1/2 inch skin tears on the back of Resident #2's right hand.</p> <p>According to another facility investigative document, on 3/30/14 at 5:00 p.m., Resident #1 was observed sideways at his table in the dining room. When the church services ended, Resident #4 was rolling past Resident #1 and accidentally bumped him. Resident #1 struck out and hit Resident #4 on his left upper arm. No injury was noted. The facility contacted the mental health crisis line to request a mental health evaluation. A facility inservice focused on "monitoring and reporting Resident #1 for any behaviors, when they are within his vicinity, to protect all other residents.</p> <p>Resident #4: Review of the medical record revealed the cogntively impaired resident had multiple diagnoses including dementia without behavioral disturbances and a mental health diagnosis. No injuries or psychosocial distress was identified following the 3/30/14 incident.</p> <p>Further review of Resident #1's medical record revealed the resident's plan of care was amended on 4/01/14 to include visual checks every 15 minutes to assure the safety of other residents. A nursing entry on 4/02/14 at 6:00 p.m. documented the resident was in the dining room sitting at the table. When a tablemate asked a question about the name of another resident, Resident #1 replied, "What the f--- is it to you(?)" Resident #1 began to move toward the other resident with his arm in the air as if he was going to hit him. A Nursing Assistant (NA), Staff Member C, remained with the resident until he showed no signs of aggression toward the other</p>	F 323		

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F 323	<p>Continued From page 6 residents.</p> <p>On 4/04/14 a Mental Health Professional (MHP) evaluated the resident and documented the resident was to receive a one-on-one monitor (staff member) in the dining room.</p> <p>Review of Resident #1's plan of care did not include the intervention of a one-on-one caregiver supervising the resident in the dining room.</p> <p>A 4/06/14 nursing entry documented Resident #1 became very angry when exiting the dining room and someone was blocking his pathway. Resident #1 used a long, angry tone. He was removed from the area.</p> <p>A 4/08/14 nursing entry documented Resident #1 "verbally attacked another resident across the table." he stopped when warned that if he continued he would eat in his room.</p> <p>A 4/13/14 8:00 a.m. nursing entry recorded Resident #1 raised his voice to Resident #6 and mocked him and "the way he speaks." He was redirected by staff.</p> <p>Documentation of a 4/13/14 MHP evaluation of Resident #1 contained a recommendation for continuing every 15 minute checks in the resident's room and the use of a one-on-one individual for redirection when Resident #1 was eating with peers or in public. However, the plan of care was not changed to reflect the MHP's recommendation.</p> <p>A 4/16/14 facility investigative document noted on 4/16/14 at 11:40 a.m. a staff member (Staff Member B) heard shouting in the main dining</p>	F 323			

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4/16/14

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F 323	<p>Continued From page 7</p> <p>room. Resident #6 said, "Please calm down." Resident #1's teeth were exposed, he was glaring, and had fists in the air. The residents were originally across from each other but Resident #1 moved toward Resident #6 and "hammer-fisted" Resident #6's right hand. According to the facility investigation, Resident #1 had been telling a joke about women that Resident #6 found inappropriate. Resident #6 stated the joke was not a good joke. Resident #1 yelled back and Resident #6 then told him to calm down. Resident #1 escalated at that point and struck Resident #6 in the hand. On 4/17/14 the resident was transferred from the facility at the directive of the mental health professional.</p> <p>Resident #6: Review of the medical record revealed the resident was confused but was able to walk independently. Later when interviewed by facility staff, Resident #6 stated Resident #1 was a "bad man" but he was not afraid of him and did not wish to change to a new table. Following the incident there was a plan to have staff present in the dining room to monitor resident interactions and assure the safety of all residents in the dining room.</p> <p>Observations of the dining room and the residents' table location were conducted on 4/23/14 at approximately 4:25 p.m. Staff Member B, a Licensed Nurse (LN), was present and stated he had witnessed three recent resident-to-resident incidents involving Resident #1. One time Resident #1 challenged another resident to a fight and the LN called the police when the resident refused to exit the dining room (3/01/14). There was another incident after the church service (3/30/14). Finally, (on 4/16/14) Staff Member B recalled he was outside the</p>	F 323			

*Handwritten signature and date: 4/24/14*

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F 323	<p>Continued From page 8</p> <p>dining room across the hallway reviewing his medication book (approximately 35 feet away). The LN overheard Resident #6's statement and then witnessed Resident #1 strike Resident #6 on the hand with his fist. The LN was unable to reach the residents to prevent the incident from his position in the hallway (approximately 35 feet away).</p> <p>Staff Member B further stated staff typically were in and out of the dining room transporting residents, no one was assigned to directly supervise the residents in the dining room until closer to dinner service (approximately 6:00 p.m.). The LN stated that on 3/30/14 and 4/16/14, during the incidents, he did not recall any staff members being present in the dining room. The LN attempted to assist staff with supervision from the hallway when other staff were in and out of the dining room.</p> <p>During the dining room observation on 4/23/14, Resident #6 entered the dining room. The cognitively impaired resident had no evidence of bruising on his hand and stated he had not been hit by anyone at the facility.</p> <p>On 4/24/14 at approximately 11:20 a.m., Staff Member E, a NA, stated Resident #1 would enter the dining room on his own by self-propelling his wheelchair. He knew where he sat. Staff were involved in transporting residents prior to the meal. If someone was too close to Resident #1's feet that would set him off. If Resident #1 was calm they could continue to transport residents but if he was "in a mood," staff could stay in the dining room. Staff were unable to remove him," he would stay."</p>	F 323		

*Handwritten initials and date:*  
4/26/14

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F 323	<p>Continued From page 9</p> <p>When interviewed on 4/24/14 at approximately 12:45 p.m., Staff Member D, a NA, stated Resident #1 was cautious about his wheelchair and feet. He could be "gruff" and was "easily agitated." There were frequently residents in the dining room prior to meals. Staff members were in and out. No one was assigned to stay in the dining room before meals. The assigned one-on-one monitor did not start until after the incident with Resident #6 (on 4/16/14). The assigned monitor (NA) was to make sure no one got close to Resident #1.</p> <p>Although the facility was aware of Resident #1's pattern of resident-to-resident aggression in the dining room, and had implemented some interventions to address Resident #1's problematic behaviors, they continued to allow Resident #1 to remain in close proximity to other residents in the dining room without direct staff supervision. Staff were left to create their own supervision plans, such as positioning the medication cart in the hallway across from the dining room or interpreting the resident's mood to see if a staff member should remain in the dining room once residents were present. Additionally, The plan of care was not changed timely to incorporate the MHP suggestions for one-on-one monitoring in the dining room and public setting.</p>	F 323		

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6/24/14*