

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 11/07/2014
NAME OF PROVIDER OR SUPPLIER REGENCY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 726 NORTH MARKESON CHELAN, WA 98816	
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Regency Manor on 11/07/14. A sample of 6 residents was selected from a census of 47. The sample included 6 current residents.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#3047605 #3049689 #3050462</p> <p>The survey was conducted by: Priscilla Becker, R.N.</p> <p>The survey team was from: Department of Social & Health Services Aging & Long-Term Support Administration Residential Care Services, District 1, Unit D 3611 River Road, Suite 200 Yakima, WA 98902 Telephone: (509) 225-2800 Fax: (509) 574-5597</p> <p><i>[Signature]</i> 11/24/14 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> <ol style="list-style-type: none"> How the nursing home will correct the deficiency as it relates to the resident. How the nursing home will act to protect residents in similar situations. Measures the nursing home will take or the systems it will alter to ensure that the problem does not recur How the nursing home plans to monitor its performance to make sure that solutions are sustained Dates when corrective action will be completed The title of the person responsible to ensure the correction. 	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		

Received
Yakima RCS
DEC 08 2014

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

[Signature] Administrator 12/5/14

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 225	<p>Continued From page 1</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility</p>	F 225	<p>F 225</p> <p>Cited Residents: Resident 3 and 4 incident have been reported to state as required. Investigation has been completed and residents care plans have been updated appropriate.</p> <p>All Residents: The facility has reviewed resident's charts and interviewed staff to ensure that all incidents requiring reporting per the Washington State reporting requirements have been reported and completed per the guidelines. .</p> <p>Education/System Review: Facility staff have been in-serviced in regards to the Washington State Nursing Home reporting guidelines and requirements.</p> <p>Monitoring: The facility performs routine rounds and staff/resident interviews to ensure that all potential issues are communicated and reviewed per the Washington State nursing home reporting guidelines. Any identified issues will be followed up immediately and any noted trends will be brought to the facility QA process as deemed necessary for futher follow up.</p> <p>Responsibility: The Administrator and Director of Nursing will ensure compliance.</p>	<p>12/8/14 12/15/14</p>	

LL 12/5/14

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

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F 225	<p>Continued From page 2</p> <p>failed to conduct a timely investigation, initiate timely protective interventions during the investigation, and report pertinent details to the appropriate entities, within the required timeline in accordance with 42 CFR 483.13(c)(2)-(4). Deficient practice was identified for 2 of 6 sampled residents (#3 & #4). Findings include but were not limited to:</p> <p>Resident #3: Review of the medical record revealed the resident had multiple diagnoses including depressive disorder, dementia, and chronic pain. Her plan of care identified she was dependent on staff for bed mobility and transfers. The resident was able to self-propel her wheelchair slowly but required staff assistance for longer distances/destinations. She was able to feed herself after her meal was set-up.</p> <p>According to social service entries in conjunction with quarterly comprehensive assessments, on 12/19/13, 5/28/15, and 8/14/14, Resident #3's husband lived in the facility but resided in another room. He had occasional outbursts of anger and swearing directed toward others. He had irritable periods and was easily annoyed with others. Resident #4 often shared meals with her husband. Over time, Resident #4 appeared to be declining cognitively. On occasion, she called someone into her room but then could not remember what she wanted or needed.</p> <p>Resident #4: Review of the medical record revealed the resident had multiple diagnoses including dementia with a behavioral disturbance, depressive disorder with anger, anxiety, and intermittent explosive disorder. According to his plan of care, Resident #4 was able to transfer and walk independently. His problematic behaviors</p>	F 225		

11/21/14

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F 225	<p>Continued From page 3</p> <p>included refusing care, angry outbursts, yelling, and threatening statements.</p> <p>The facility reporting log documented on 10/15/14 at 5:45 p.m. there had been a resident-to-resident altercation between Resident #3 & Resident #4.</p> <p>Review of the facility investigative document, associated with the 10/15/14 at 5:45 p.m. incident, noted a nursing assistant (NA), Staff Member B, was passing dinner trays on the hallway and heard yelling in Resident #3's room. When Staff Member B went to investigate what was going on she observed Resident #4 pushing Resident #3's wheelchair up against the overbed table. Then Resident #4 walked in front of Resident #3 and slapped her on the lower part of her face/neck. The NA got between the residents. Resident #4 then left the room.</p> <p>The investigative report also contained a note that the incident was discovered on 10/24/14, 9 days after the occurrence.</p> <p>Administrative Licensed Nurse (LN) A was interviewed on 11/07/14 at approximately 8:30 a.m. She recalled that on 10/24/14 the NA witness documentation was discovered and administrative staff followed-up with the investigation as well as protective and corrective actions at that time, 9 days after the incident. Although facility staff were aware of a past history of domestic violence between the two residents, the 10/15/14 incident was the first known physical altercation at the facility. An enhanced supervision plan of every 15 minute staff checks for Resident #3 was initiated after administrative staff became aware on the incident.</p>	F 225			

LP 12/5/14

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F 225	<p>Continued From page 4</p> <p>On 11/07/14 at approximately 10:20 a.m., Staff Member B, the NA who witnessed the 10/15/14 incident, stated she was serving trays in the hallway and saw Resident #4 being "aggravated and shoving Resident #3's wheelchair into her overbed table", swearing, and then slapping Resident #3 on the lower face area and shoulder area. Staff Member B protected Resident #3. Resident #4 became verbally aggressive toward the staff member and raised his hand toward her. Another NA, Staff Member D entered the room and assisted. Staff Member B stated she reported the details of the resident-to-resident aggression to the LN on-duty, Staff Member C directly after the incident and to Staff member D. She recalled she was advised to stay away from Resident #4.</p> <p>When interviewed on 11/07/14 at approximately 2:10 p.m., Staff Member C, the LN on-duty on 10/15/14, recalled the staff report on the incident was from Staff Member D, the second NA to enter Resident #3's room. Staff Member C heard about Resident #4's anger directed at Staff Member B. Staff Member C directed Staff Member B to stay away from Resident #4. She heard details about the incident from Staff Member B as well. When the LN went down to check Resident #3's face later there were no signs of physical injury. Both residents denied Resident #4 had struck Resident #3.</p> <p>No investigation was initiated directly following the incident. Although there was a telephone contact between Staff Member C and Administrative LN A the evening following the incident, there was no detailed report that described the incident and the witnessed resident-to-resident aggression. Necessary reporting was not initiated directly</p>	F 225		

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F 225	Continued From page 5 following the incident.	F 225	F -323		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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 sufficient supervision to prevent a resident-to-resident altercation involving 2 of 6 sampled residents (#1 & #2) who experienced resident-to-resident incidents. Findings include but were not limited to: Resident #2: Review of the medical record revealed the resident was admitted to the facility on [REDACTED] 14 with multiple medical diagnoses including dementia with behavioral disturbance, depression, abnormality of gait, and fall history. According to his plan of care, the resident was independent with bed mobility, transfers, and ambulation. Behavioral flow sheets for October 2014 and November 2014 identified problematic target behaviors: threatening statements, pacing, rummaging, crying, feeling anxious, exit seeking, angry/agitated, rejection of care, and entering other's rooms (October 2014).	F 323	Cited Resident: Resident 1 and 2 care plans have been reviewed and updated appropriately to ensure safety, adequate supervision, All Residents: The facility has reviewed all other identified similar residents to ensure that the plans of care are in place to ensure adequate supervision and assistance to prevent accidents. Education/System Review: Staff have been in-serviced on the process of assessing, implementing, care planning, and re-evaluation on plans of care to ensure plans of care are comprehensive and being followed to ensure resident safety, prevention of accidents, and resident supervision. Monitoring: The facility will routinely review daily documentation and communication to ensure that identified issues are addressed and the residents are safe and receiving adequate supervision to prevent accidents. Any identified issues will be corrected immediately and nay noted trends will be brought to the facility QA meeting as deemed necessary for further follow up. Responsibility: The Director of Nursing responsible to ensure correction.	12/8/14 12/15/14	

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F 323	Continued From page 6 Observations on 11/07/14 at approximately 2:00 p.m. revealed Resident #2 was seated in a large stuffed chair in the area north of the nurses' station. Review of the nursing entries noted on 9/07/14 at 11:00 p.m. the resident was "noticeably upset when sees another resident sitting in recliner by nurse's station." On 9/11/14 at 5:35 p.m. the entry noted, "Possessive of chair by NS (nurses' station)-Another res (resident) sitting in chair-res verbally aggressive with other res (and) took his FWW (front wheeled walker)." Another evening shift entry, on 9/12/14 at 9:00 p.m., documented Resident #2 demonstrated aggressiveness with another resident over the recliner by the nurses' station. Entries on 9/13/14 documented the resident's possessiveness of the chair. Resident #2 "Continues to attempt to move patients in their w/cs (wheelchairs)." On 9/14/14 the resident was protective of the chair and attempted to push another resident out of the way. On 9/26/14 at 10:00 p.m. Resident #2 was "yelling at another resident for sitting in the recliner near nurse's station." On 9/28/14 a nursing entry documented, "Became very combative (after) dinner, grabbing L.N. (Licensed Nurse) arms to try to get to the recliner where another pt (patient) was sitting." During early October 2014 the protectiveness of the chair and resulting aggression continued. On 10/02/14 the resident continued to be agitated and defensive about the recliner and adjacent areas. He was pushing residents away from the area around the chair. There was a similar entry on 10/03/14. On 10/04/14 the LN documented	F 323		

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F 323	<p>Continued From page 7</p> <p>Resident #2 was "often pushing those in w/c despite their objections." On 10/07/14 Resident #2 attempted to strike another resident. Two nursing entries on 10/10/14 documented the resident was trying to move other residents in their wheelchairs down the hall against their wishes. There was a similar observation of the resident's behavior on 10/11/14.</p> <p>Despite the multiple incidents related to the recliner, no specific interventions or supervision plan was documented to help guide staff in preventing recurrence.</p> <p>According to a 10/13/14 nursing entry, Resident #2 was trying to move Resident #1's wheelchair by pushing him. Resident #1 put his feet down to prevent the movement. Resident #2 became "upset and grabbed (Resident #1's) arm and hit his right shoulder." No injuries were identified.</p> <p>On 11/07/14 at approximately 11:20 a.m. the resident's family member was interviewed. She stated Resident #2 loved the larger recliner. It was comfortable for his size. The resident appeared to have an increase in his frustration level at night. They called it "sundowners."</p> <p>On 11/07/14 at approximately 3:30 p.m., Staff Member E, the LN on-duty on 10/13/14 at the time of the resident-to-resident altercation, was interviewed. Staff Member E stated Resident #1 was in the hallway in his wheelchair moving up the hallway toward the area of the nurses' station (and recliner). It appeared Resident #2 was attempting to move Resident #1 to prevent him from coming near the area of the recliner. When Resident #1 put his feet down to prevent movement of the wheelchair, Resident #2</p>	F 323			

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F 323	<p>Continued From page 8</p> <p>grabbed his arm. No bruises or injuries were found. Resident #2 appeared to have an increase in his behaviors around dinner time or later.</p> <p>Further review of the nursing entries on 10/16/14 and 10/17/14 noted additional incidents of agitation related to other residents near "his recliner."</p> <p>Resident #1: Review of the medical record revealed the resident had multiple diagnoses including dementia with delusions and hallucinations. His target behaviors for 9/2014 included threatening statements and anxious/agitated behaviors. Resident #1's care plan included keeping him in high traffic areas when he was up in his wheelchair. He required assistance with transferring. The resident was documented as confused.</p> <p>Review of the facility investigation for the 10/13/14 incident documented Resident #1 did not have recall of the incident.</p> <p>Observations on 11/07/14 at approximately 9:25 a.m. revealed Resident #1 was in his wheelchair west of the nurses' station. When staff approached him about his need for assistance (in response to his verbalization) he stated, "I don't know." Directly thereafter, he did not answer when spoken to by the Investigator.</p> <p>Facility staff were aware of Resident #2's territoriality related to the recliner near the nurses' station and the area in proximity to the chair. Many of the documented behaviors were during the evening timeframe. However, despite staff knowledge of Resident #2's behavioral pattern,</p>	F 323		

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F 323 F 329 SS=D	Continued From page 9 there was insufficient supervision to prevent recurrence of the behaviors that eventually resulted in Resident #2 striking Resident #1. 483.25(l) DRUG REGIMEN IS FREE FROM 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 reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure psychoactive medications for 1 of 5 sampled residents (#2) were administered with an appropriate dose, with adequate indication for	F 323 F 329	F 329 Cited Resident: Resident #2 is no longer receiving Haldol. All Residents: All residents psych medications have been reviewed to ensure that psychiatric medications are appropriate, with appropriate diagnosis/indication, and appropriate monitoring. Education/System Review: Licensed Nurses have been in-serviced on reviewing new medications routinely and the appropriate required assessments, care planning, monitoring, communication, and follow up per regulatory guidelines. Also licensed nurse have been in-serviced on appropriate documentation prior to the administration of psychiatric medication. Monitoring: Facility will review medication orders and documentation daily to ensure that medications and noted behaviors and moods are followed up appropriately per regulatory guidelines. Any identified issues will be corrected immediately and any identified trends will be brought to the facility QA process as deemed necessary for further follow up. Responsibility: The Director of Nursing and Social Service to ensure ongoing compliance.	12/15/14 12/21/14	

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F 329	<p>Continued From page 10</p> <p>their use, and without evidence of adverse consequences according to 42 CFR 483.25(l)(i)(iv)(v). Without an appropriate indication and dose the resident was unnecessarily subjected to the potential medication side effects/risks. Findings include:</p> <p>Resident #2: Review of the medical record revealed the resident was admitted to the facility on [REDACTED] 14 with multiple medical diagnoses including dementia with behavioral disturbance, depression, abnormality of gait, and fall history. Review of the 3/21/14 Level 1 Pre-Admission Screening and Resident Review noted the resident did not have any psychotic or delusional disorders/diagnoses prior to admission to the facility.</p> <p>According to his plan of care, the resident was independent with bed mobility, transfers, and ambulation.</p> <p>Behavioral flow sheets for October 2014 and November 2014 identified problematic target behaviors: threatening statements, pacing, rummaging, crying, feeling anxious, exit seeking, angry/agitated, rejection of care, and entering rooms (October 2014). No psychotic symptoms such as delusions or hallucinations were identified as target behaviors.</p> <p>On [REDACTED] 14, the day of admission, the psychotropic medication log noted the resident was to receive Risperdal, an anti-psychotic medication, 0.5 milligrams (mg) twice daily for dementia with a behavioral disturbance. An evaluation/assessment for the presence of abnormal involuntary movements (a potential side effect of anti-psychotic medications) was</p>	F 329		

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F 329	<p>Continued From page 11</p> <p>performed on the day of admission. No abnormal symptoms were identified.</p> <p>On 9/02/14 the Risperdal was increased to 0.5 mg in the morning and 1 mg at bedtime. In addition, the resident's antidepressant was increased and a twice daily anti-anxiety medication was added that month (and later discontinued on 9/17/14). Another anti-anxiety medication, Buspar 15 mg twice daily was added for anxiety on 9/27/14.</p> <p>A 10/06/14 nursing entry documented the resident had a weak/unsteady gait that had been progressively increasing (worsening) since 9/16/14. The resident had lost his balance in his room and landed on the arm rest of the couch. He was placed in a wheelchair. The mood stabilizer was discontinued the next day, on 10/07/14.</p> <p>On 10/10/14 the Risperdal was discontinued. An order for Haldol 2 mg twice daily, another ant-psychotic was written with Benadryl 25 mg twice daily, an antihistamine with sedating properties, both to address the resident's dementia with behavioral disturbances.</p> <p>An interdisciplinary team meeting was held on 10/15/14. There was a documented concern from the pharmacist about the resident's medication regimen with Haldol 2 mg, Buspar 15 mg, and Benadryl 25 mg, all twice daily. The resident had experienced multiple side effects from some of the medications in the past. On 10/15/14 doses were lowered by the physician for the antidepressant and Benadryl.</p> <p>A 10/16/14 nursing entry noted the resident had</p>	F 329			

PP.10/14/14

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 11/07/2014
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F 329	<p>Continued From page 12</p> <p>tremors in his upper extremities and a shuffling gait (a potential side effect from the anti-psychotic medication, Haldol). A specific evaluation for abnormal movements was performed on 10/16/14. Abnormal movements were identified in the resident's face, lips/mouth area, upper extremities, and lower extremities. There was a new order to discontinue the resident's antidepressant on 10/15/14. No changes were made to the anti-psychotic at that time. The 10/17/14 nursing entry documented the resident had an increase in upper extremity shakiness. On 10/18/14 the resident had difficulty rising out of the recliner. A nursing entry on 10/20/14 documented the resident had increased shakiness in his hands and he had difficulty when standing from a sitting position. The 10/21/14 entry revealed an unsteady gait.</p> <p>There was a 10/21/14 physician's order to reduce the Haldol to 1 mg daily. However, review of the October 2014 medication administration record revealed a transcription error. Instead of Haldol 1 mg daily it was written as 1 mg twice daily through 10/31/14, a 10 day interval. Eight of the 10 days he received twice the ordered dose.</p> <p>Nursing entries on 10/22/14 continued to document the resident was having difficulty with walking and required assistance at the time due to the upper extremity tremors. He also had diaphoretic episodes (cold clammy skin). Entries 10/24/14 through 10/26/14 continued to document symptoms such as continued shakiness, shuffling gait, mild full body tremors, and needing mobility assistance. The Benadryl was discontinued on 10/27/14.</p> <p>A reassessment was completed for abnormal</p>	F 329			

LL 11/14

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

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F 329	Continued From page 13 movement on 10/27/14 and it showed only abnormal movements in the upper extremities at that time, the other previously abnormal symptoms appeared normal. The Haldol transcription order was identified and corrected effective 11/01/14 but a new order was written on 11/03/14 to increase the Haldol to 1 mg twice daily. On 11/07/14 at approximately 2:45 p.m an interview was conducted with Administrative Licensed Nurse A. She reported the resident was receiving an anti-psychotic medication for managing his dementia with behavioral manifestations rather than to manage psychotic symptoms.	F 329			

Ed. 2/5/14