

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

PRINTED: 05/23/2013
FORM APPROVED
OMB NO. 0938-0391

1433

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER REGENCY AT THE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTHEAST MYRA ROAD COLLEGE PLACE, WA 99324
---	---

(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 Off-Hours staggered Quality Indicator Survey conducted at Regency at the Park on 05/05/13, 05/06/13, 05/07/13, 05/08/13, 05/09/13, 05/10/13 and 05/11/13. The survey included data collection on 05/05/13 from 4:15 p.m. to 8:15 p.m. A sample of 59 residents was selected from a census of 87. The sample included 35 current residents and the records of 24 former and/or discharged residents.</p> <p>The survey was conducted by:</p> <p>██████████, RN ██████████, RN ██████████, RN</p> <p>The survey team is from:</p> <p>Department of Social & Health Services Aging and 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>[Signature]</i> 5/23/13 Residential Care Services Date</p>	F 000	<p>F000 Initial Comments</p> <p>This Plan of Correction is being submitted in compliance with specific regulatory requirements. Neither its completion nor contents should be construed as an admission by this provider of the validity of any findings or citations contained herein.</p> <p style="text-align: right;"><i>Received Yakima RCS MAY 31 2013</i></p>	
-------	--	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE interim administrator	(X6) DATE 5/23/13
---	--------------------------------	----------------------

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: 505075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/11/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTHEAST MYRA ROAD COLLEGE PLACE, WA 99324		
(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 280 SS=E	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the revision and updating of developed care plans for 4 of 22 residents (#38, 45, 102, 152) reviewed for care plan revisions. Findings include:</p> <p>Resident #10: Review of the medical record revealed the resident was admitted to the facility on [REDACTED]/13. The resident's diagnoses included a [REDACTED] ([REDACTED]) with a [REDACTED] (a [REDACTED] that was [REDACTED] through the [REDACTED] to the [REDACTED]</p>	F 280	<p>Corrective actions for resident affected</p> <p>Resident #10 is no longer within the facility</p> <p>Resident #38 urinary care plan has been reviewed and updated appropriately with the identified medication usage. Resident #45 care plan has been reviewed and updated appropriately with resident's weight bearing status.</p> <p>Resident # 102 Cardiac, skin, and nutritional care plan has been reviewed and updated appropriately with identified cardiac issues, edema management care, and fluid restriction guidance. Resident #152 is no longer residing in the facility</p> <p>Identifying other residents having the potential to be affected, and what corrective action will be taken</p> <p>The facility has reviewed the care plans in the above identified areas of all residents to ensure that they have been comprehensively completed and accurately reflect residents current status as it relates to the regulation.</p>	5/31/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REGENCY AT THE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTHEAST MYRA ROAD COLLEGE PLACE, WA 99324
--	---

(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 280	<p>Continued From page 2 [REDACTED]).</p> <p>On 05/02/13 the resident developed a [REDACTED] [REDACTED] infection ([REDACTED]).</p> <p>The care plan was not revised to identify resident risks of [REDACTED] or the actual [REDACTED] the resident had experienced.</p> <p>Resident #102: Admitted [REDACTED]/13 with a diagnosis of [REDACTED].</p> <p>On 04/04/13, the resident's hospital emergency room evaluation documented the resident "presents with worsening leg pain. Both legs are swollen... [REDACTED] to [REDACTED]" [REDACTED] was diagnosed. When her congestive [REDACTED] failure and [REDACTED] were controlled, the resident was re-admitted at the nursing home on [REDACTED]/13.</p> <p>The care plan was not revised when changes in the resident's cardiac health occurred. The alteration in health maintenance problem related to congestive heart failure did not identify the resident's atrial fibrillation.</p> <p>Interventions in place included edema checks daily but without directions as to when or who was to provide this service and when the physician and/or other health professions should be consulted. Other interventions included a generalized "medications as ordered and a dietician assessment with diet order." There were no individualized interventions regarding who, when, what or how these interventions were to be completed. A fluid restriction enacted and was added on the plan 04/22/13 but with no</p>	F 280	<p>Measures and systemic changes to prevent recurrence;</p> <p>The facility has inserviced the IDT team on the care planning process and expectations as it relates to the regulation to ensure that care plans are completed comprehensively and timely.</p> <p>Monitoring Corrective Action for sustained corrections;</p> <p>The facility will routinely review the care plans of the residents of the facility to ensure that they comprehensively and accurately reflect the resident condition. Any identified issues will be corrected immediately and any identified trends in these reviews will be brought to the facility QA process for further evaluation as deemed necessary.</p> <p>DON is responsible</p>	
-------	--	-------	---	--

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

PRINTED: 05/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/11/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT THE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTHEAST MYRA ROAD COLLEGE PLACE, WA 99324		
(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 280	<p>Continued From page 3</p> <p>further instructions as to what it was and how it was to be enacted.</p> <p>Resident #152: On 05/06/13 at 9:40 a.m. the resident stated "the food is awful" and he was allergic to cane sugar. He also wanted a chicken breast every morning for protein. He also stated that he has his own seasonings that he uses on the food so he can eat it.</p> <p>On 05/10/13 at 10:50 a.m. the Director of Nursing stated the resident had an initial weight loss of fluid and since then he had been stable. She stated he was on a complicated diet due to his allergies to sugar cane and had lots of restrictions.</p> <p>Admitted [REDACTED]/13 after a hospitalization for a [REDACTED] with [REDACTED]. The admit physician orders were for a low/no purine diet with limited red meats, pork gravy, and soda related to his gout.</p> <p>The Resident Admit Assessment dated 03/12/13 indicated the resident was allergic to "many things" and was missing teeth.</p> <p>The 03/22/13 registered dietician's consult identified risk factors that included occasional nausea; mild pocketing of food in his mouth, ability to independently feed himself, and some missing teeth. A goal weight of 174-212 pounds was determined by the dietician. The registered dietician also noted he had fluctuations with weight up and down due to edema. (He weighed 222 pounds on 03/22/13, 203 pounds on 03/29/13 and 210 pounds on 04/23/13.) She recommended a management of his weight with</p>	F 280		

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

PRINTED: 05/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER REGENCY AT THE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTHEAST MYRA ROAD COLLEGE PLACE, WA 99324
--	---

(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 280	<p>Continued From page 4</p> <p>avoidance of rapid/significant/unplanned weight changes, but a gradual weight loss to lower end of his ideal body weight.</p> <p>The 03/19/13 admission comprehensive assessment documented a weight gain () of 10% or more in last six months and swallowing problems related to the recent () with recommendations by the speech therapist. The nutritional status triggered for care plan intervention.</p> <p>Although the facility had nutrition on the care plan, it related to missing teeth. The care plan was not updated to include food preferences and goal weights.</p> <p>Resident #38: Admitted with a history of chronic (). 01/2013 physician orders were for daily () to decrease his ().</p> <p>The pharmacy recommendation dated 02/2013 recommended the resident's urine, while he was on (), be checked monthly to ensure the optimum action of the ().</p> <p>The 01/31/13 care plan was not updated with the pharmacy recommendation to ensure the activity of () was not decreased related to maintaining the acidity of the urine.</p> <p>Resident #45. Admitted with a () and ().</p> <p>Review of the admission care plan documented alteration in mobility related to her "inability to ambulate." An approach identified she was</p>	F 280		
-------	--	-------	--	--

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

PRINTED: 05/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/11/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT THE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTHEAST MYRA ROAD COLLEGE PLACE, WA 99324		
(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 280	Continued From page 5 non-weight bearing on her right leg. However, the care plan was not revised when the physician order, dated 04/22/13, updated the resident's mobility status: "Resident [REDACTED] is stable. Ok for weight bearing as tolerated."	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 the facility failed to ensure care and services were provided as ordered for 1 of 22 residents (#163) reviewed for provision of care. The lack of weekend planning placed the resident at potential risk for decline in improvement. Findings include: Resident #163. Diagnosed with [REDACTED], the physician signed orders 04/29/13 which included "wrap legs daily for [REDACTED] (localized fluid retention and tissue [REDACTED])." On Sunday, 05/05/13, at 5:00 p.m. the resident was seated on the side of the bed with her right leg ace wrap unwound and hanging on the floor. She said the wraps were for [REDACTED]. She	F 309	Corrective actions for resident affected Resident #163 is no longer residing in the facility Identifying other residents having the potential to be affected, and what corrective action will be taken The facility has reviewed all identified residents with lymphadema wraps to ensure their MD orders and plans of care reflect that services are being provided to attain or maintain the highest practicable physical, mental, and psychosocial well being. Measures and systemic changes to prevent recurrence; The facility has educated identified team members in regards to the care planning, management, and communication process of residents with lymphadema wraps. Residents with orders for lymphadema wraps will be added to the facility follow up process to ensure timely and thorough follow up.	5/31/13

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

PRINTED: 05/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/11/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT THE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTHEAST MYRA ROAD COLLEGE PLACE, WA 99324		
(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 6</p> <p>said she used the bathroom and couldn't walk very easily with her walker as the wraps could be a tripping hazard. She said she had been asking since 2:00 p.m. for them to be re-wrapped.</p> <p>On 05/06/13 at 10:00 a.m. she stated her leg was re-wrapped on Sunday at 6:00 p.m., approximately 4 hours after she had started asking for assistance. She said she did not know who had re-wrapped them.</p> <p>The Physical Therapist stated on 05/10/13 at 3:00 p.m. that if the lymphedema wraps became loose, then the therapists would re-wrap, not the nursing staff.</p> <p>On 05/06/13 at approximately 11:00 a.m. Staff Member G, licensed nurse (LN), stated that the Occupational Therapist, (OT) would be called to re-wrap the [REDACTED] leg wraps. The nursing staff is not trained to apply the edema wraps.</p> <p>When interviewed on 05/10/13 at 4:00 p.m., the facility's Regional Director stated she had spoken with the therapists and was told the re-wrapping was Monday through Friday but not on weekends. On the weekends, lymphedema wraps would be observed by nursing staff. If they were loose, the nurse could not replace them as they would not know how to apply proper tension. If the wrapping remained mostly intact, tape could be applied. If the wrapping was falling off and becoming a tripping hazard, they should be removed and the therapists called.</p> <p>The undated admission care plan identified the problem of alteration in skin related to [REDACTED]. One of the interventions was " lymphedema</p>	F 309	<p>Monitoring Corrective Action for sustained corrections;</p> <p>The facility will review residents with lymphedema wraps routinely and PRN to ensure that the plan of care is accurate and being followed as appropriate. Any identified issues will be corrected immediately and any identified trends will be brought to the QA process as necessary for further evaluation. DON is responsible.</p>	

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

PRINTED: 05/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER REGENCY AT THE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTHEAST MYRA ROAD COLLEGE PLACE, WA 99324
---	---

(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 7 wraps OT (occupational therapy) daily." The facility failed to ensure the resident need for skilled service, the precise wrapping of the compression wraps, was timely and/or identify interventions related to foreseeable complications such as whom and how the wrapping would be cared for if it became loose when the therapists were unavailable	F 309		
F 329 SS=D	483.25(I) 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.	F 329	<p>Corrective actions for resident affected Resident #106 TSH level has been obtained and plan of care has been reviewed as appropriate.</p> <p>Identifying other residents having the potential to be affected, and what corrective action will be taken</p> <p>Any identified residents have had their orders reviewed and plans of care updated appropriately in regards to the use of thyroid medication and TSH levels.</p> <p>Measures and systemic changes to prevent recurrence;</p> <p>LN management has been educated on the need of monitoring of TSH levels with residents on thyroid medication and the follow up necessary to ensure that medications are given necessarily as it relates to the federal regulation</p>	5/31/13

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

PRINTED: 05/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER REGENCY AT THE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTHEAST MYRA ROAD COLLEGE PLACE, WA 99324
---	---

(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 329	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to ensure that each resident's drug regimen was free from unnecessary drugs. For 1 of 10 residents (#106) sampled the facility failed to monitor for efficacy and adverse consequences of administered medications. This failure placed the residents at risk of not receiving needed treatment or of receiving unnecessary medication. Findings include:</p> <p>Resident #106: Resident was admitted on [REDACTED] 13 with multiple diagnoses that included [REDACTED] (a [REDACTED]) produced by the [REDACTED] with an order for [REDACTED] (a [REDACTED]) to be taken daily. The resident continued on this medication during her stay in the facility.</p> <p>On 05/10/13 at 10:00 a.m. Staff Member S (LN) stated that she could not find documentation in Resident #106's medical record that a [REDACTED] [REDACTED] ([REDACTED]) level had been done.</p> <p>By failing to test the TSH level, the facility did not assure that the [REDACTED] was needed or, if it was needed, that it was being given at the proper dose for Resident #106. This denied the resident of the opportunity to maintain her health at the highest practicable level.</p>	F 329	<p>Monitoring Corrective Action for Sustained corrections</p> <p>Facility will review all new residents upon admit and all existing residents routinely and PRN to ensure that they are receiving medications appropriately and necessarily. The facility will use the contracted pharmacy reviews to ensure compliance. Any identified residents will be corrected immediately and any identified trends will be brought to the QA process as necessary for further evaluation. DON is responsible.</p>	
F 364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper</p>	F 364	<p>Corrective actions for resident affected</p> <p>Residents #45, 32, 167, 29, 96, 48, 73 are now receiving foods at appropriate temperature. Residents # 163 and 152 are no longer in the facility.</p>	5/31/13

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

PRINTED: 05/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/11/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT THE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTHEAST MYRA ROAD COLLEGE PLACE, WA 99324		
(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 364	<p>Continued From page 9 temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure food served to residents was palatable. The food temperatures were not consistent and some received cold food that was difficult to eat as observed on four of seven days of the survey. Failure to serve hot food caused the taste and/or flavor of the food to be less than satisfactory for the residents' enjoyment of their meals. Findings included:</p> <p>1) On Sunday 05/05/13 the menu consisting of a hamburger with bun, lettuce and tomato, tater tots and a canned fruit mixture was served.</p> <p>At 5:00 p.m. meal trays for room service were served from the steam table in the kitchen prior to dining room service. They were placed in unheated wheeled carts on warmed plates with covers. The following interviews took place during the dinner meal on 05/05/13.</p> <p>Resident #45: Eating in her room, she stated the food was "cold, it's always cold." She said they maybe needed to keep the plate lids on tighter.</p> <p>Resident #32: Eating in his room, he stated the food was cold and it usually was when he was served. He stated there were to be three nurse aides on his hall but two had called in and they had borrowed a nurse aide from another unit. He stated this was usual for the facility staffing, and it impacted how food was served.</p>	F 364	<p>Identifying other residents having the potential to be affected, and what corrective action will be taken</p> <p>This has the potential to affect all residents in the facility.</p> <p>Measures and systemic changes to prevent recurrence;</p> <p>A review was conducted to evaluate the process followed for meal delivery. Adjustments were made to ensure timely delivery of trays to maintain adequate food temperatures</p> <p>Dietary staff have been educated on food preparation and following recipes to ensure food palatability.</p> <p>Staff have been educated regarding serving hot food in the proper temperature range.</p> <p>Monitoring Corrective Action for sustained corrections;</p> <p>Random sample trays will be audited for meal appearance, palatability and temperature.</p> <p>Random resident interviews will be conducted weekly to audit meal appearance, palatability and temperature</p>	

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

PRINTED: 05/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/11/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTHEAST MYRA ROAD COLLEGE PLACE, WA 99324		
(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 364	<p>Continued From page 10</p> <p>Resident #167: Eating in her room, she stated the food was cold and the hamburger dry.</p> <p>Resident #163: Eating in her room, she stated the food was cold.</p> <p>Resident #152: Eating in his room, he stated the food "is awful; I put BBQ sauce on it." He said this morning the chicken breast tasted bad and was "raw" in the middle. " They do not cook the chicken breast too well--it's like saw dust. I am allergic to cane sugar and they send me canned fruit with fructose. It causes me to breakout and makes me very tired."</p> <p>In the small dining room, the dinner meal was served at 6:10 p.m. The steam table was brought into the small dining room after serving residents in another unit's larger dining room.</p> <p>Resident #29: At 6:10 p.m. resident was served and said her hamburger was " lukewarm " - she would like it warmer but it was "too late to worry about it." The tater tots were "cold " and falling apart into crumbles.</p> <p>Resident #96: Sitting at a table with a chicken puree mixture on her hamburger bun, she stated the food was cold and needed mayonnaise.</p> <p>Resident #48, Resident #29, and one other resident were served at 6:15 p.m. and staff assisted with condiments at 6:20 p.m. The residents all indicated the hamburgers were dry without the mayonnaise and the food cold.</p> <p>2) On Monday 05/06/13 the steam table arrived in small dining room at approximately 12:25 p.m.</p>	F 364	<p>Audit results related to palatability and food temperatures to be reviewed monthly at QA for the next quarter then quarterly</p> <p>Administrator responsible for the maintainance and monitoring of this correction</p>		

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

PRINTED: 05/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/11/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTHEAST MYRA ROAD COLLEGE PLACE, WA 99324		
(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 364	<p>Continued From page 11</p> <p>for the noon meal. Food temperatures taken in the kitchen prior to food services were in the 170-180 degrees fahrenheit (F) range on the steam table. Prior to serving in the small dining room from the kitchen, the temperatures on the steam table were significantly lower between 121 degrees F to 150 degrees F. The chicken breasts were 121 degrees F.</p> <p>05/06/13 at 12:35 p.m., Resident #29 stated the food was not warm.</p> <p>3) On Wednesday 05/08/13 at 3:46 p.m. Resident #163, who ate in her room, stated her macaroni and cheese at lunch was served cold.</p> <p>4) On Thursday 05/09/13 at 12:20 p.m. Resident #32, eating in his room, stated the meat was tough and not able to be chewed. He showed his plate contained rice with sauce and meat dish. There were two pieces of chewed meat on the plate. In an attempt to cut the meat with a utensil, it was found to be tough and unable to be cut through without pressure on a knife.</p> <p>On 05/09/13 at 12:30 p.m. the small dining room had already been served (meal time was set at 12:25 p.m.) and many residents had left the dining room. There were approximately eight resident meals of rice with sauce and meat cubes left uneaten on their tables.</p> <p>Three residents sat at one table (#11,48,73). Resident #73 stated none of them could eat the food because the meat was "so tough." She stated a fourth resident at the table had already left because she couldn't chew the food. Resident #73 asked for a sandwich from a</p>	F 364			

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

PRINTED: 05/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/11/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTHEAST MYRA ROAD COLLEGE PLACE, WA 99324		
(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 364	Continued From page 12 passing staff member who was cutting through the dining room to the hall beyond. Resident #11 was sitting back from the table. When asked if her meat was tough, she stated she was "not going to eat that meat!" Using her fork, she demonstrated how the meat was unable to be cut without force. (Chewed meat was observed on her plate.) When Resident #73 was brought her sandwich, Resident #11 looked at it and asked the unidentified staff member, "Oh, can I have one too?" The staff member obtained one for her, also. One nursing assistant in the dining room on 05/09/13 was assisting another table with their noon meal. She attempted to cut the meat of one resident requiring physical assistance. She said it was hard to cut through. Resident #96 entered the dining room for lunch on 05/09/13 at 12:30 p.m. and found her pureed food plate on the table. She started eating and said the food was cold but she would eat it anyway. No staff were available to request warming of the plate and she ate it cold.	F 364			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	Corrective actions for resident affected Soiled cloth has removed. Pancake and flour dry good bins and wheel stands have been cleaned. Three tiered carts have been cleaned.	5/21/13	

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

PRINTED: 05/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/11/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT THE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTHEAST MYRA ROAD COLLEGE PLACE, WA 99324		
(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 371	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was stored and served under sanitary conditons to a highly susceptible population of vulnerable adults. The kitchen had noticeable soiling on two dry food storage bins and on clean carts for serving food. Further, a soiled cloth on the clean side of the dishwashing counter was contaminating clean dishes. Findings include:</p> <p>On 05/11/13 at approximately 10:30 a.m. the following was observed in the kitchen setting:</p> <p>The dishwashing counter had a soiled cloth not in sanitizing solution that was sitting next to and touching a clean glass and small bowls. These clean dishes were in the area awaiting storage after going through the dishwasher.</p> <p>There were large dry goods bins storing flour and pancake mix that were soiled on the outside with dark matter and drips. The wheeled stands were visibly soiled with a build-up of particles.</p> <p>A three tiered plastic service cart sat in the food preparation/storage area (clean area). It had one large circular handle with mulitple small grooves. Each of the grooves had dark soiling imbedded in them. Crumbs and particles were scattered on each shelf. The sides and ends of the cart had a build-up of soiling visible.</p> <p>On 05/11/13 at approximately 10:45 a.m., the dietary manager, Staff Member P, stated the cart</p>	F 371	<p>Identifying other residents having the potential to be affected, and what corrective action will be taken</p> <p>All residents have potential to be affected.</p> <p>Measures and systemic changes to prevent recurrence;</p> <p>A review of the cleaning procedures followed in the kitchen was completed and adjustments made as necessary to ensure timely and thorough cleaning of kitchen areas and equipment</p> <p>Dietary staff have been inserviced on sanitary procedures. Staff inserviced on revised cleaning procedures for carts and wheel stands.</p> <p>Monitoring Corrective Action for sustained corrections;</p> <p>Random kitchen sanitation audits will be conducted. Any issues identified will be corrected immediately and trends will be taken to the facility's QA process for further evaluation as deemed necessary</p> <p>DM to monitor for compliance.</p>	

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

PRINTED: 05/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/11/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTHEAST MYRA ROAD COLLEGE PLACE, WA 99324		
(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 371	Continued From page 14 was used for soiled and clean things such as soiled dishes and delivery of clean food items. When the soiled areas were pointed out, she stated it had not been "taken outside and sprayed down in a while." The individual shelves were reported to be wiped down with a sanitizer before use, but not the rest of the cart. Staff Member P also stated the dry good bins were to be cleaned on the outside at the end of each shift and were cleaned inside and out when there was more dry goods added to the bins. She stated they did not need to change the dry goods very often, though. Although a cleaning schedule was in place, these kitchen areas were not exhibiting cleanliness in order to prevent food-borne illness.	F 371			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and record review, for 2 of 10 residents (#38 and #106) sampled for unnecessary medication use, the facility failed to	F 428	Corrective actions for resident affected Resident #106 pharmacy recommendations have been followed up on appropriately and any necessary changes have been made per MD orders Resident #38 pharmacy recommendation has been followed up on appropriately and any necessary changes have been made per MD orders Identifying other residents having the potential to be affected, and what corrective action will be taken The facility has ensured that all recent pharmacy recommendations are being followed up on timely, thoroughly, and all necessary changes have been made per MD orders.	5/31/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/11/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT THE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTHEAST MYRA ROAD COLLEGE PLACE, WA 99324		
(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 428	<p>Continued From page 15</p> <p>act on a report by the pharmacist of potential adverse consequences of the resident's drug regime according to §483.60(c)(2). Findings include:</p> <p>Resident #106: Resident was admitted on [REDACTED]/13 with multiple diagnoses that included [REDACTED] (a condition where [REDACTED]) and [REDACTED] (a condition in which the [REDACTED]) and [REDACTED]. She was receiving [REDACTED] (a procedure that [REDACTED]) to treat the [REDACTED].</p> <p>Per review of physician orders, on 03/04/13 [REDACTED] (a [REDACTED] to treat [REDACTED] and decrease the risk of [REDACTED]) was ordered in a dose of 60 milligrams (mg), to be taken daily. [REDACTED] (a medication to treat [REDACTED]) was also ordered in a dose of 70 mg weekly.</p> <p>Per record review, on 03/13/13 the pharmacist recommended to discontinue the [REDACTED] as it was a potential duplication of therapy and because it had the potential to increase the risk for blood clots. He also recommended decreasing the [REDACTED] dose from 70 mg weekly to 35 mg weekly because of Resident #106's [REDACTED]. It was noted on these written recommendations that they were faxed to the physician on 03/26/13.</p> <p>On 05/09/13 at 8:30 a.m. Staff Member D, Director of Nursing Services (DNS) stated that the recommendation to discontinue the [REDACTED]</p>	F 428	<p>Measures and systemic changes to prevent recurrence; The LN management team has been educated on the pharmacy recommendation process to ensure timely and thorough follow up is completed. All necessary changes are done per MD orders and are accurately reflected in the resident medical record.</p> <p>Monitoring Corrective Action for sustained corrections; The DON will review the pharmacy recommendations process routinely to ensure that all pharmacy recommendations are completed timely and thoroughly per MD orders. Any identified issues will be corrected immediately and any identified trends will be brought to the QA process for further evaluation as necessary. DON is responsible.</p>	

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

PRINTED: 05/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/11/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT THE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTHEAST MYRA ROAD COLLEGE PLACE, WA 99324		
(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 428	<p>Continued From page 16</p> <p>was not followed up and Resident #106 was still receiving the medication. She also stated after the recommendations were received, Resident #106 had other medical issues and was sent to the hospital on 04/04/13. When she returned from the hospital on [REDACTED]/13, the [REDACTED] was not ordered for her. The DNS stated they have recently changed pharmacies and the new pharmacist sends them more recommendations. She stated that "It is kind of overwhelming" to deal with the increased volume of recommendations.</p> <p>Per review of the medical record on 05/11/13 Resident #106 was still receiving the [REDACTED]. Also noted during the record review, on 05/10/13 [REDACTED] was restarted in a dose of 70 mg by mouth weekly. No documentation was found in the medical record that addressed the pharmacist's recommendations for these medications.</p> <p>Resident #38. Admitted with a history of [REDACTED] requiring antibiotics, physician orders included a daily medication of [REDACTED] (a [REDACTED]) to decrease his [REDACTED].</p> <p>The pharmacy recommendation dated 02/2013 recommended the acidity (pH) of the resident's urine be checked monthly while he was on [REDACTED]. Acidity of the urine was needed for [REDACTED] to be effective in the kidneys for its action. A higher reading than 5.5 (alkaline) would decrease the activity of medication's conversion.</p> <p>A fax to the physician dated 02/22/13 documented the acidity of the resident's urine was between 5-6.</p>	F 428			

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

PRINTED: 05/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505075	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/11/2013
NAME OF PROVIDER OR SUPPLIER REGENCY AT THE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTHEAST MYRA ROAD COLLEGE PLACE, WA 99324		
(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 428	Continued From page 17 However, besides the 02/22/13 urine acidity check, there were no others done monthly and documentation did not reflect further review or orders from the physician regarding the recommendation.	F 428		