

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

PRINTED: 04/21/2013
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 C 04/05/2013
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NAME OF PROVIDER OR SUPPLIER REGENCY AT THE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 420 SOUTHEAST MYRA ROAD COLLEGE PLACE, WA 99324
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Regency at the Park on April 4, 2013 and April 5, 2013. A sample of 12 residents was selected from a census of 85 residents. The sample included 11 current residents and the records of 1 former/discharged resident.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#2781603 #2775829 #2782500 #2779776 #2764071 #2735691</p> <p>The survey was conducted by: ██████████, R.N.</p> <p>The survey team is from: Department of Social & Health Services Aging & Long Term Support Administration Residential Care Services, District 1, Unit C 3611 River Road, Suite 200 Yakima, Washington 98902</p> <p>Telephone (509) 225-2800 Fax: (509) 574-5597</p> <p><i>C. J. Delaney</i> 4/19/13 Residential Care Services /Date</p>	F 000	<p>Received Yakima RCS APR 29 2013</p> <p>Received Yakima RCS APR 30 2013</p> <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>	
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p>	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kate Moran</i>	TITLE interim administrator	(X6) DATE 4/26/13
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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:</p>	F 225	<p>F 225 Investigate/Report Allegations/Individuals</p> <p>Corrective actions for residents affected Resident #1 med error has been thoroughly investigated and notification of state agency has been completed.</p> <p>Identifying other residents having the potential to be affected, and what corrective action will be taken The facility has audited ther allegations of neglect and medication errors to ensure no other residents were affected.</p> <p>Measures and systemic changes to prevent recurrence; All nursing staff have been educated on reporting per the regulatory guidelines and the process of starting and conducting thorough investigations.</p> <p>Monitoring Corrective Action for sustained corrections; The DON or designee will review each investigation to ensure that notification of required agencies are complete and the investigations have been thoroughly investigated.</p> <p>Date of compliance: 4/30/13</p>	

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F 225 Continued From page 2

F 225

Based on record review and interviews the facility in accordance with 42 CFR 483.13(c)(2-4) failed to thoroughly investigate and report to the State agency an incident of neglect relative to a significant medication error for 1 of 3 sampled residents (#1) reviewed for medication errors. Findings include:

Resident #1: Review of a facility investigation report revealed on 3/16/13 a Fentanyl (redacted medication) patch was not removed by a Licensed Nurse (LN) from the resident prior to the placement of a new patch. The resident was transferred to the Emergency Room (ER) on 3/18/13. The investigation report stated there was "no impact" to the resident as a result of the medication error.

Review of the ER record dated 3/18/13 revealed the resident received [redacted] (medication used to counter the effects of [redacted]). Documentation stated she was much more awake after removing the two [redacted] patches and giving [redacted].

An interview on 4/4/13 at 2:00 p.m. with Staff Director of Nursing C revealed she was made aware by the resident's family member of two Fentanyl patches being on the resident when she was seen in the ER. The documents sent with the resident upon her return from the ER did not reference any issues relative to the Fentanyl patches. Later at 2:30 p.m. Staff C stated that when she questioned Staff Licensed Nurse (LN) B he informed her that prior to the resident returning from the ER on 3/18/13 he received report from the ER the resident had received [redacted] due to [redacted] overdose.

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F 225 Continued From page 3

Despite staff knowledge of two ██████████ being on the resident creating an overdose of the medication necessitating treatment in the ER staff did not thoroughly investigate as evidenced by lack of interviews and obtaining relative information from the ER. In addition the incident of neglect resulting in a significant medication error was not reported to the State agency as required.

Cross-refer to F333. The facility failed to ensure the resident was free from significant medication errors.

F 241 483.15(a) DIGNITY AND RESPECT OF SS=E INDIVIDUALITY

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to maintain an environment that promoted dignity for nine residents (# ' s2, 3, 4, 5, 6, 7, 8, 9, 10) who were subject to the inappropriate and demeaning actions/behaviors of Staff Nursing Assistant (NA) D. Findings include:

Interviews with staff and review of a facility investigation report dated 3/27/13 revealed the following observations involving Staff D in front of residents:

Resident #2. Review of written statement dated

F 225

F 241

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F 241 : Continued From page 4
3/27/13 stated Staff NA E witnessed Staff D laughing as he lifted his shirt to show his stomach to the resident.

Review of a written statement dated 3/27/13 stated Staff NA F observed Staff D holding the resident's hand and had his shirt up showing her his stomach.

Resident #3: Review of a written statement dated 3/27/13 stated a couple days after the above incident involving Resident #2 Staff NA E witnessed Staff D laughing as he lifted his shirt up to the resident.

An interview on 4/5/13 at 2:50 p.m. with Staff E revealed due to the position of the resident in her bed she was unsure if she was able to see Staff D's stomach.

Resident #4: Review of a witness statement dated 3/27/13 by Staff NA F noted as she was changing the resident she asked Staff D to assist her. When she turned around Staff D was lifting his shirt up and rubbing his stomach.

Resident #5: During an interview on 4/5/13 at 2:45 p.m. with Staff F she stated Staff D lifted his shirt to the resident while working the evening shift. Staff F stated she told Staff D that it was inappropriate behavior at which time he did it again. Staff F stated the resident gave her the look like she knew it was not right for him to do that.

Resident #6: An interview with Staff NA H on 4/5/13 at 2:40 p.m. revealed Staff D stated when he observed the soles of the resident's shoes,

F 241

F 241 Dignity and Respect of Individuality

Corrective actions for residents affected

Resident's 2, 3,4,5,6,7,8,9,10 plans of care have been reviewed and are receiving care that maintains or enhances each residents dignity and respect in full recognition of their individuality. Nursing Assistant 'D' is no longer employed for the facility.

Identifying other residents having the potential to be affected, and what corrective action will be taken

Resident interviews have been conducted to ensure no other resident has been affected to maintain their individual dignity and respect.

Measures and systemic changes to prevent recurrence;

All staff have been educated on conducting themselves in a manner to promote dignity and respect to all residents.

Monitoring Corrective Action for sustained corrections;

Social Services or designee will meet with random residents to ensure that their dignity and respect is maintained. Any identified issues will be brought to the DON and Administrator for thorough investigation and follow up as needed. Any identified trends will be brought to QA as deemed necessary for further evaluation.
Social Services responsible.

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F 241	Continued From page 5 "wow, looks like a bunch of (profane word used) on his shoes". Resident #7: Review of a written statement dated 3/27/13 revealed on the first day Staff D worked Staff NA I was trying to fix the leg rests on the resident's wheelchair. As Staff I was bending down Staff D stated to her in front of the resident that she "looked like a monkey (profane word used) a football". Resident #'s 8, 9, 10, 2: During a telephone interview on 4/10/13 at 2:50 p.m. with Staff I she stated on 3/17/13, while bringing residents into the dining room, a statement was made to her by Staff D. He stated that because she was not wearing green he would just bend her over his knee and give her a "wedgy" and see if she had green underwear on - if not she could bend over to see if she had a green bra on. She stated the residents looked "kinda shocked" but did not say anything. The four residents would have been able to understand what had been said by Staff D.	F 241		
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to ensure 1 of 5 sampled residents (#1) were free from significant medication errors. This failed practice resulted in harm to Resident #1 as she was transferred to the Emergency	F 333		

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F 333	<p>Continued From page 6</p> <p>Room (ER) to treat symptoms of lethargy secondary to an overdose of [REDACTED] ([REDACTED] medication). Findings include:</p> <p>Resident #1: Review of physician's orders noted [REDACTED] patches were to be applied to the resident's skin every three days for chronic pain. Standards of nursing practice require that the old patch be removed prior to a new patch being applied to ensure the correct dosage of medication ordered by the physician.</p> <p>Review of Progress Notes dated 3/18/13 at 6:30 p.m. noted the resident had a decline in her level of consciousness during the shift and had intermittent "blowing respirations". She was responsive but sluggish and her eyes were "glazed over." She exhibited a poor appetite at supper. The physician was notified and orders were received to transfer her to the ER.</p> <p>Review of hospital records dated 3/18/13 revealed the resident received [REDACTED] (medication used to counter the effects of narcotic overdose). Documentation stated she was much more awake after removing the two Fentanyl patches and administering [REDACTED].</p> <p>Review of the facility investigation report revealed on 3/16/13 Staff Licensed Nurse (LN) A placed a new Fentanyl patch on the resident; however, the old patch was not removed. The investigation stated no "impact noted."</p> <p>A telephone interview on 4/4/13 at 4:00 p.m. with Staff LN B revealed when the ER called the facility on 3/18/13 with an update on the resident's condition prior to sending her back to the facility</p>	F 333	<p>F 333 Residents Free of Significant Med Errors</p> <p>Corrective actions for residents affected Resident #1 meds have been reviewed and placement of fentanyl patch established.</p> <p>Identifying other residents having the potential to be affected, and what corrective action will be taken Facility has reviewed all other potential resident medications and established procedure for placement and checking of patches.</p> <p>Measures and systemic changes to prevent recurrence</p> <p>All nursing staff inserviced on the process of passing medications in accordance with acceptable standards and process of removing and placement of patches.</p> <p>Monitoring Corrective Action for sustained corrections; LN management will conduct random ed pass audits to ensure compliance. Any identified issues will be followed up with med error report process to ensure timely follow up. Any trends will be followed up on and brought to QA for further evaluation if needed. DON responsible.</p> <p>Date of completion: 4/30/13</p>	

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F 333 Continued From page 7

they stated she had two [redacted] on at the same time. They administered [redacted] (medication used to counter the effects of a narcotic overdose) to the resident.

An interview on 4/4/13 at 3:00 p.m. with Staff A revealed she placed a new [redacted] on the resident on 3/16/13. She stated she did not remove the old patch as she was unable to find it. The resident was very difficult to turn due to her size thus she only looked at her upper back area in an attempt to locate the old patch.

During a telephone interview on 4/4/13 at 3:25 p.m. with the resident's family member she stated she was with the resident in the ER on 3/18/13. She stated when she arrived to the ER the resident was not moving or talking, her face was swollen and she was drooling. Staff was reversing the effects of the [redacted] by administering a medication intravenously. After the medication was completed the resident started to talk and seemed "more like normal".

Despite standards of practice to remove the old [redacted] prior to placing a new one staff did not thoroughly visualize the resident's body thus the resident received an overdose of the [redacted] medication necessitating a transfer to the ER for treatment.

F 333