

1433

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

PRINTED: 01/13/2014
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 C 01/02/2014
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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 December 31, 2013 and January 2, 2014. A sample of 6 residents was selected from a census of 78 residents. The sample included 5 current residents and the records of 1 former and/or discharged resident.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#2912889 #2913631 #2931472</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. Colletney</i> 1/13/14 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>	
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p>	F 281	<p>Received Yakima RCS JAN 27 2014</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE administrator	(X6) DATE 1/24/14
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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 281	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and interviews the facility failed to follow professional standards of practice for 1 of 4 sampled residents (#1). Failure to follow physician's orders for medications put the resident at risk for complications. Findings include:</p> <p>A. Blood Pressure Medications</p> <p>Resident #1: Admitted from the hospital on [REDACTED]/13. Review of the hospital Discharge/Readmit Orders List form revealed physician's orders dated [REDACTED]/13 which stated [REDACTED] and [REDACTED] (medications to lower blood pressure) were to be administered daily and staff was to hold the medication if the resident's blood pressure (B/P) was below 120 systolic. The [REDACTED] was discontinued by the physician on 11/13/13. Review of the resident's November 2013 Medication Administration Record (MAR) noted both medications were scheduled to be administered at 8:00 a.m. There was no documentation at that time as to what the resident's B/P was prior to the administration of the above medications.</p> <p>Review of the resident's Vital Sign Record revealed no vital signs were documented for the dayshift on 11/12/13. The following B/Ps were recorded for the dayshifts (no designated times recorded):</p> <p>11/11/13: 118/58 11/13/13: 110/52 11/16/13: 100/40</p> <p>An interview on 1/2/14 at 12:05 p.m. with Staff A</p>	F 281	<p>F281 STANDARDS PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>Corrective actions for residents affected Resident #1 no longer resides in the facility.</p> <p>Identifying other residents having the potential to be affected, and what corrective action will be taken Facility has completed full house audit on blood pressure medications and pain medications. Any identified issues noted have had MD orders reviewed and clarified to ensure compliance.</p> <p>Measures and systemic changes to prevent recurrence; All staff have been educated on medication administration per professional standards/medication orders per regulations.</p> <p>LN management or designee to randomly audit Medication Administration Records and ensure all medications are being administered per MD orders. Any identified issues will be followed up appropriately.</p> <p>Monitoring Corrective Action for sustained corrections;</p> <p>Director of Nursing responsible.</p> <p>Date of compliance: 1/31/2014</p>

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F 281	<p>Continued From page 2</p> <p>(Resident Care Manager) revealed the vital signs obtained and documented on the above Vital Sign Record were taken by staff at various times during the morning hours.</p> <p>Despite the physician's orders to hold the two B/P medications if the resident's B/P was less than 120 systolic review of the MAR revealed [REDACTED] was administered 11/11-13/13 and [REDACTED] was administered 11/11-16/13.</p> <p>B. Pain Medications</p> <p>Review of a physician's order dated 11/13/13 stated to administer narcotic pain medication every six hours as needed for severe pain not relieved by [REDACTED] every six hours as needed for pain. Review of the resident's MAR noted when staff did not transcribe the order correctly as the [REDACTED] was not referenced in the order.</p> <p>Review of the resident's November 2013 MAR, facility Narcotic Record Book, and resident's medical record revealed the narcotic medication was administered five times between 11/14-16/13.</p> <p>Despite the above order to administer [REDACTED] prior to the narcotic medication review of the MAR noted [REDACTED] was never administered to the resident during his stay in the facility and there was no evidence he had refused it prior to the narcotic being administered.</p>	F 281		
F 309	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain</p>	F 309		

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F 309	<p>Continued From page 3</p> <p>or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews the facility failed to perform necessary assessments and facilitate timely care and treatment in response to changes in the condition of 1 of 4 sampled residents (#1) reviewed for changes in condition. This failed practice potentially resulted in a delay in medical treatment. Findings include:</p> <p>Resident #1: Admitted to the facility on [REDACTED]/13 from the hospital following surgery for a fractured [REDACTED]. Review of Progress Notes dated 11/10/13 revealed the resident was alert and oriented to time, place, and person. The resident had a [REDACTED] arm that was maintained in a sling.</p> <p>Review of the physician's Initial Visit form dated 11/13/13 revealed there was a large hematoma (collection of blood under the skin) with black and blue coloring to his right arm, which was immobilized in the sling. Documentation stated the resident complained of nausea for which the physician discontinued an antibiotic. The physician also discontinued one of the two ordered blood pressure medications due to a low blood pressure (B/P) of 100/52 and fast heart rate (HR) of 110 beats per minute.</p> <p>Review of Progress Notes dated 11/15/13 at 1:30 p.m. stated the resident complained of nausea and the physician was to write an order for</p>	F 309	<p>F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Corrective actions for residents affected Resident #1 no longer resides in the facility</p> <p>Identifying other residents having the potential to be affected, and what corrective action will be taken Facility has completed full house audit, any identified residents with acute changes of condition have been addressed to ensure that they received timely and thorough follow up per regulatory guidelines.</p> <p>Measures and systemic changes to prevent recurrence; LN staff have been educated on the facility process in regards to the identification, communication, and follow up process with any noted changes of condition</p>	

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F 309	<p>Continued From page 4</p> <p>medication to relieve it. There was no evidence the physician was ever notified that day regarding the resident's complaint of nausea , thus no medication for nausea was ever administered. In addition, there was no further nursing assessment of the resident until the following day on [REDACTED]/13 at 2:00 p.m. (approximately 24 hours later). Documentation at that time by Staff Member B (Licensed Nurse - LN) stated the resident refused to eat much, had a BP of 100/40 with a respiratory rate (RR) of 24 breaths per minute, and was working with therapy.</p> <p>Later that day at 3:30 p.m. documentation stated the resident started to complain of shortness of breath, was diaphoretic, B/P- 80/60, HR- 109, and RR-26. The physician was notified and the resident was transferred to the Emergency Room (ER).</p> <p>Review of hospital ER records noted that upon arrival of the ambulance to the facility the resident's oxygen saturation level was low at 80% and his B/P was 60/30. The resident was noted in the ER to be in "severe distess, ill-appearing...bruising and swelling" to [REDACTED] arm. The resident expired approximately 10 minutes after he was seen in the ER.</p> <p>Despite the assessment by LN B on 11/16/13 at 2:00 p.m. stating the resident worked with therapy review of the Physical Therapy (PT) notes on 11/16/13 stated the resident complained of not feeling well and shortness of breath. The PT documented she attempted to see the resident twice that day and coordinated with the LN on duty relative to the resident's condition.</p> <p>Review of a written statement by the above PT.</p>	F 309	<p>Monitoring Corrective Action for sustained corrections;</p> <p>The facility will routinely audit residents charts to ensure that the identification, communication, and follow up of identified changes of condition are completed per regulatory guidelines and facility process. Any identified issues will be corrected immediately and any identified trends will be brought to the facilities QA process as necessary for further evaluations and follow up.</p> <p>Director of Nursing responsible.</p> <p>Date of compliance: 1/31/2014</p>	
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F 309	<p>Continued From page 5</p> <p>dated 1/6/14 revealed her first attempt to see the resident on 11/16/13 was close to lunch time. The resident refused therapy due to fatigue and shortness of breath. The PT documented she talked to Staff Member B immediately regarding his condition. Staff Member B reported to the PT that the resident's vital signs were within normal limits (however, review of the Vital Sign Record revealed vital signs were not within normal limits: B/P-100/40, HR-118, and RR-24). The PT's second attempt was after 2:00 p.m. and the resident continued to complain of shortness of breath and fatigue, thus therapy was again deferred.</p> <p>A telephone interview on 1/2/14 at 12:20 p.m. with Staff Member B revealed the recorded B/P of 100/40 taken on 11/16/13 was at approximately 10:30 a.m. and no further B/Ps were taken on that shift. He stated the resident's respirations were "alittle fast" and he was having "alot of diarrhea." He stated the resident complained of nausea that day and ate very little at breakfast and lunch.</p> <p>Despite the physician's recent order to discontinue one of the B/P medications on 11/13/13, recent [redacted] surgery and admission to facility, poor appetite, swelling/bruising to right arm, diagnosis of high [redacted] and [redacted] there was no evidence of any vital signs taken between dayshift of 11/15/13 through dayshift of 11/16/13.</p> <p>A telephone interview with the resident's family member on 12/31/13 at 12:40 p.m. noted the resident had a poor appetite and complained of nausea during his stay in the facility and the staff only provided him with crackers. The family</p>	F 309		

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F 309	Continued From page 6 member stated s/he had expressed concern to staff regarding this. Review of a written statement by Staff Member C dated 11/25/13 acknowledged the resident's family member had expressed concerns to her relative to the resident's nausea. Despite significant changes in the resident's condition (complaints of nausea and shortness of breath, low B/P, high HR and RR) and need to monitor the resident closely due to his condition upon admission, staff failed to perform timely and/or accurate assessments.	F 309		
F 323 SS=G	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 interviews the facility failed to provide adequate supervision and assistive devices to prevent accidents for 1 of 3 sampled residents (#2) reviewed for accidents. In addition, staff failed to ensure preventative measures were followed to prevent further injuries. Resident #2 sustained second degree burns to her chest from hot coffee. Findings include:	F 323		

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F 323 Continued From page 7
Resident #2: Admitted to the facility on [REDACTED]/11 with diagnoses which included a [REDACTED] disorder that affected her [REDACTED] coordination, [REDACTED] decline, and [REDACTED] problems. In addition, the resident suffered a [REDACTED] in September 2013.

Review of the resident's plan of care revealed she had impaired memory and decision making ability, was short tempered with aggressive/disruptive behaviors. Review of the Resident Status Sheet dated 12/17/13 noted the resident fed herself in her room following set-up, and had abnormal movements to all extremities,

Review of an Occupational Therapy (OT) Evaluation form dated 12/18/13 noted the resident had impaired gross and fine motor skills relative to coordination and manipulation with poor sitting balance and safety awareness. The evaluation also stated the resident's mood fluctuated between calm to rage.

Review of Progress Notes dated 12/5/13 noted the resident threw her entire 240 milliliters of tea on a staff member's shirt.

Review of a facility investigation report revealed on 12/22/13 at 7:00 p.m. the resident had spilled coffee onto her chest. Staff Member D (Nursing Assistant - NA) had given her thickened coffee like she did every night. The resident sustained a large red area on her [REDACTED] upper chest, a smaller red area just above it, and redness to the [REDACTED] knuckle and first [REDACTED] fingers of her [REDACTED] hand. By 8:45 p.m. that evening the areas to her chest were noted to be fluid filled blisters (second degree burns). The facility investigation concluded the resident had "abnormal involuntary

F 323

F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

Corrective actions for residents affected
Plan of Correction for resident #2 has been reviewed and revised for appropriate preventative devices and is effectively protecting resident at this time.

Identifying other residents having the potential to be affected, and what corrective action will be taken
Facility has reviewed all other at risk residents to ensure that care plans are appropriate, in place, and being followed to protect them from preventable accidents and are safe within the facility.

Measures and systemic changes to prevent recurrence;
Licensed staff have been educated on following the resident's plan of cares to ensure that all interventions are in place to prevent accidents. Licensed nurses have been educated on assessment of risks to accidents to ensure that all risks are identified accurately and appropriate follow up is documented accordingly per regulatory

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F 323 Continued From page 8

movements to all extremities." Staff Member D had obtained hot water from the staff breakroom coffee maker and used a nectar thick coffee packet to make the resident's coffee which she gave to her. The resident jerked and spilled coffee causing the burn. The water temperature from the coffee maker in the staff break room was eight degrees higher at 173 degrees than it should have been (no more than 165 degrees).

Preventative measures established following the above incident included placing lids on all coffee drinks, clothing protector on resident when given coffee, and staff obtaining hot water from the coffee maker in the activities room rather than the staff break room.

A telephone interview on 1/2/14 at 2:40 p.m. with Staff Member D revealed hot water for the resident's coffee in the evening was obtained from the staff break room as the kitchen was closed. She stated that five minutes after she had given the resident her coffee she had spilled it onto herself causing the burns. There was no clothing protector on the resident, nor were any lids used on the coffee cup. Staff Member D stated the resident displayed jerking movements of her arms and head. She "spills her tea alot," but had never seen her spill coffee before.

Staff Member E (NA) stated on 1/2/14 at 11:20 a.m. resident would get upset and start flailing her arms if her schedule was not the same. She stated since the burn incident on [REDACTED]/13 the resident had thrown her entire meal tray onto the floor. Paper plates were utilized during meals due to her behaviors of throwing plates.

An interview on 12/31/13 at 3:20 p.m. with Staff

F 323

Monitoring Corrective Action for sustained corrections;
Director of Nurses or designee will review all incidents and plans of care to ensure that all appropriate interventions are in place and plans of care are being followed to ensure that preventable accidents do not occur in the facility. Any identified issues will be corrected immediately and any noted trends will be brought to the QA process as deemed necessary.

Director of Nursing responsible.

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F 323	<p>Continued From page 9</p> <p>Member F (OT) revealed the resident "spills all the time, often see signs of spillage on clothes, she grabs drinks no matter how far away they are placed." She stated the coffee drink was new for the resident as usually she only drank cold tea. Since her hip fracture in [REDACTED] her trunk control had worsened and had more delay in her response time.</p> <p>Despite the resident's involuntary, jerking type movements; poor decision making, safety awareness, and sitting balance; impaired cognition with behavioral problems; and recent decline secondary to a hip fracture; the facility failed to adequately supervise staff to ensure the safety of the resident while taking hot beverages relative to assistive devices and hot water temperatures.</p> <p>On 12/31/13 at 12:00 noon a meal tray was served by a NA to the resident in bed. A cup containing thickened coffee was on the tray without a lid. The pureed food was served on paper plates. The NA then exited the room without recognizing the need for a coffee lid. The resident's head was in constant motion with jerking type movements during the observation. She kept her head down while eating. The state investigator made staff aware of the situation prior to the resident drinking from the cup.</p> <p>Despite preventative measures to place lids on all coffee drinks staff did not supervise to ensure measures were implemented.</p>	F 323		
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