

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

PRINTED: 12/16/2014
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 11/18/2014
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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 amended report is the result of an unannounced Abbreviated Survey conducted at Regency at the Park on November 6, 2014 November 14, 2014 and November 18, 2014. A sample of 11 residents was selected from a census of 82 residents. The sample included 10 current residents and the record of 1 former and/or discharged resident.</p> <p>The following were complaints investigated as part of this survey:</p> <p>#3049784 #3047128 #3049836 #3047118 #3046708</p> <p>The survey was conducted by: Patti Zimmer, 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>Patti Zimmer</i> Residential Care Services Date <i>12/14/14</i></p> <p>F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4) SS=G INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</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 12 DEC 20 2014</i></p>	12/16/14
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>administrator</i>	(X6) DATE 12/09/2014
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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: Based on interviews and record reviews the</p>	F 225	<p>F225 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>Corrective actions for residents affected</p> <p>Resident #5 has been reviewed and updated appropriately with the residents identified behaviors and interventions for staff utilization. Resident # 2,3, and 4 have been monitored for any psychological harm and any necessary follow up has been completed.</p> <p>Identifying other residents having the potential to be affected, and what corrective action will be taken</p> <p>Facility has reviewed all resident to resident altercations in the past six months to ensure other residents are safe and appropriate interventions and plans of care have been implemented.</p> <p>Measures and systemic changes to prevent recurrence;</p> <p>Facility staff have been in-serviced on reporting, investigating, and appropriate immediate interventions for resident to resident altercations per Washington state reporting guidelines.</p>		

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F 225	<p>Continued From page 2</p> <p>facility failed to thoroughly investigate incidents of sexual abuse, protect residents, prevent further incidents, and report to appropriate agencies in accordance with 42 CFR 483.13(c)(3)(4) for three of six female residents (#s 2,3,4) involving one male resident (#5). This failure placed residents at risk for abuse due to lack of thorough investigations and prevention. This resulted in actual harm to Resident #4. Findings include:</p> <p>Resident #5: Admitted to the facility on [REDACTED] 13 with diagnoses which include dementia and [REDACTED]. Review of the resident's plan of care revealed he was able to propel his wheelchair, had a language barrier, and transferred with staff assistance.</p> <p>Review of a facility investigation report revealed on 9/28/14 at 1:58 p.m. the resident reached over to Resident #2, removed her blanket from her chest, and repeatedly squeezed her breast. The incident occurred at the nursing station. The resident was immediately removed from the area. Resident #2 had stated to the resident during the incident, "Stop that, don't do that." Following the incident Resident #2 had no recollection of what had occurred and stated no one had been bothering her. Medication changes were made and a urinalysis was done, which was negative. Despite the resident's ability to self propel the prevention plan established following the incident was to keep the resident at least an arm's length from female residents and frequent visual checks. An interview on 11/14/14 at 4:15 p.m. with Staff B (Director of Nursing) revealed frequent visual checks were every hour as standard checks were every two hours.</p> <p>On 10/23/14 at 7:50 a.m. the resident was</p>	F 225	<p>Monitoring Corrective Action for sustained corrections;</p> <p>Facility will ensure that any further resident to resident altercations will be discussed with the facility IDT team and reviewed with regional corporate staff to ensure compliance is maintained and resident safety is provided at the highest level. All resident to resident altercations will be brought to the facility QA process to ensure compliance with reporting and appropriate interventions for the next six months.</p> <p>Director of nursing is responsible</p> <p>Date of compliance: 12/16/14</p>		

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F 225	<p>Continued From page 3</p> <p>observed grasping Resident #3's breast with his left hand and was squeezing aggressively. The resident was immediately removed from the area. The investigation noted the resident was initially placed in the dining room by staff, however he propelled himself out of the dining room and approached Resident #3, who was seated right outside the dining room and squeezed her breast. In addition to medication changes and discharge planning, the preventative plan following the incident was to keep the resident in line of sight at all times when he was out of his room and every 15 minute checks. The investigation did not determine the pace at which the resident was able to self propel prior to the development of a preventative plan. Following the incident Resident #3 displayed no changes in behavior.</p> <p>Review of a facility investigation report revealed on 10/26/14 at 12:50 p.m. Resident #4 was screaming at the nursing station area and pointing to her right breast. The investigation revealed the resident's caregiver had placed him to the right of the couch at the nursing station (his usual place). She then informed the LN that she had to go into another resident's room to perform care. The LN had her back turned to Resident #1 when he propelled his wheelchair over to Resident #4 and grabbed her breast.</p> <p>Review of Resident #4's medical record and facility investigation report revealed she was aphasic but could communicate her needs, alert and oriented, and aware of her surroundings. Following the incident she was upset from being grabbed inappropriately.</p> <p>An interview on 11/14/14 at 1:50 p.m. with Staff C (LN) noted the resident propelled himself using</p>	F 225		

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F 225	Continued From page 4 his left leg. The LN stated the resident was "quicker than you think...if resident was in need of something he can propel himself."	F 225			
F 309 SS=G	The above sexual abuse incidents on 9/28/14 and 10/23/14 were not reported to local law enforcement or the State agency as required. 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 record review and interviews the facility failed to perform the necessary assessments, care, and treatment in response to changes in the condition of 1 of 3 residents (#1) reviewed for changes in condition. This failure to timely and accurately assess the resident's change of condition and administer pain medication caused harm to Resident #1 and placed all residents at risk for inadequate care and treatment. Findings include: Resident #1: Admitted to the facility on [REDACTED] 13 with diagnoses which included dementia, adult failure to thrive, and osteoporosis. Review of the resident's plan of care revealed she had impaired cognition with memory impairments, and required staff assistance with transfers.	F 309	F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Corrective actions for residents affected Resident #1 has had comprehensive pain assessment completed and plan of care updated as appropriate. Identifying other residents having the potential to be affected, and what corrective action will be taken Facility has reviewed all similar residents to ensure that proper assessments and timely follow up of identified resident resident conditions. Measures and systemic changes to prevent recurrence; Licensed staff have been educated on the expectations of thorough assessments and timely follow up of identified resident conditions per the regulation.	12/16/14	

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	<p>Continued From page 5</p> <p>Review of the resident's medical record noted on 10/11/14 at 3:45 p.m. and on 10/13/14 at 2:30 p.m. the resident was found on her back on the floor of the bathroom. The resident stated she did not know how it happened. Documentation stated there were no obvious injuries with either fall. at the time they occurred.</p> <p>On 10/14/14 at 1:53 p.m. documentation stated the resident complained of some left hip pain that morning. The resident was able to stand and when she was assisted in the bathroom at lunch she did not appear in pain as she had that morning. The alert status was updated at that time to monitor the resident for left hip pain. That evening (10/14/14) at 7:25 p.m. documentation by Staff A (Licensed Nurse - LN) stated the resident "grimmacing and sucking air through her teeth" when transferring to the toilet. The resident was unable to tell the LN where the pain was located or how severe it was. Later at 9:48 p.m. the resident grimaced when assisted to stand to use the bathroom and sucked air through her teeth. She denied pain when asked if she was hurting. Despite the resident's expression of pain with transfers, and knowledge of two recent falls, there was no evidence a thorough assessment of the resident was performed to determine if any injuries existed</p> <p>Despite changes in the resident's condition and need for monitoring (recent fall and onset of grimmacing with transfers) there was no further assessment of the resident until 10/15/14 at 9:05 a.m. (11 hours and 17 minutes later). Documentation at that time stated the resident continued to grimace and groan with transfers with pain to left hip. The physician was faxed at</p>		<p>Monitoring Corrective Action for sustained corrections;</p> <p>Nursing supervisors will do routine assessment reviews to ensure regulatory compliance. Any noted issues will be corrected immediately and any noted trends will be brought to facility QA process as appropriate.</p> <p>Director of Nurses responsible</p> <p>Date of compliance: 12/16/14</p>		

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F 309	<p>Continued From page 6</p> <p>that time and caregivers were made aware of the resident's pain.</p> <p>Upon consultation on 10/15/14 at 10:30 a.m. with the resident's guardian relative to the left hip pain following the fall on 10/13/14, she agreed to have x-rays performed on the resident if the physician felt it was appropriate. The physician was faxed at that time for x-ray orders. On 10/16/14 at 12:32 a.m. documentation stated a narcotic medication was administered to the resident for "severe pain on the left side" with noted effectiveness documented at 6:38 a.m. Review of the resident's Medication Administration Record revealed this was the first dose of pain medication administered since her fall on 10/13/14, despite her expressions of pain upon transfers and known diagnosis of dementia.</p> <p>X-rays of the left hip were obtained on 10/17/14 and results obtained on 10/20/14 revealed a left hip fracture.</p> <p>A telephone interview with Staff A on 11/18/14 at 1:35 p.m. noted that when she transferred the resident to the toilet and later to bed on 10/14/14 she grimaced like she was in pain, however the resident denied it.</p> <p>Despite the resident's falls and expressions of pain during transfers in conjunction with her dementia, staff failed to thoroughly assess the resident for possible injuries and provide pain management in a timely manner.</p>	F 309			