

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

PRINTED: 08/25/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2014
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NAME OF PROVIDER OR SUPPLIER ROYAL PARK CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7411 NORTH NEVADA SPOKANE, WA 99208
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(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
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INITIAL COMMENTS

This report is the result of an unannounced Quality Indicator Survey conducted at Royal Park Care Center on 8/5/14, 8/6/14, 8/7/14, 8/8/14, 8/11/14 and 8/12/14. A sample of 42 residents was selected from a census of 158. The sample included 25 current residents, the records of 17 former and/or discharged residents.

The survey was conducted by:

- Jessica Dingwall, M.S.W.
- Lisa Harting, R.N.
- Colleen Daniels, R.N.
- Linda Loffredo, R.N.
- Tamara Smith, M.S.W.
- Kathleen Robl, R.N.

The survey team is from:

Department of Social and Health Services
Aging and Long-Term Support Administration
Residential Care Services, District 1, Unit A
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Telephone: (509) 323-7302
Fax: (509) 329-3993

Cindy Colwell FSA 8/25/14
Residential Care Services Date

F 280

483.20(d)(3), 483.10(k)(2) RIGHT TO

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Royal Park Care Center provides the Plan of Correction according to State and Federal Law. Royal Park Care Center neither admits nor denies but provides this Plan of Correction so it may continue to be in compliance with State and Federal Law.

RECEIVED

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DSHS ADSA RCS
SPOKANE WA

F 280

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jessie Seller</i>	TITLE <i>Administrator</i>	(X6) DATE <i>9-3-14</i>
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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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SS=D Continued From page 1
PARTICIPATE PLANNING CARE-REVISE CP

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.

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.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined the facility failed to review and revise a care plan for 1 of 7 residents (#26) related to mouth pain and oral care in a sample of 42.

Findings include:

Resident #26 had diagnoses of [REDACTED] and dementia with a history of dental issues, weight loss, and muscle spasms.

Per the functional assessment, the resident needed total assistance (one to two person total

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How the nursing home will correct the deficiency as it relates to the resident(s)
Resident #26 careplan was reviewed and updated to address resident's oral pain and refusals.

How the nursing home will act to protect residents in similar situations
Oral exams were completed on all residents to identify residents at risk for oral and related issues. Careplans were reviewed and revised to include increased offerings of oral care and alternate interventions.

Measures the nursing home will take or systems it will alter to ensure that the problem does not recur
Staff education will be completed on oral care expectations and interventions and the need to report changes to LN's. Resident Care Managers will complete a thorough oral cavity exam on each resident with the scheduled minimum data set (MDS).

How the nursing home plans to monitor its performance to make sure that solutions are sustained
Staff development and infection control nurse will complete quarterly audits of high risk residents for 3 quarters.

Title of person responsible to ensure correction
Director of Nursing Services, RCM's

9/13/14

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F 280	<p>Continued From page 2</p> <p>physical assist) for most of her daily care except eating for which the resident needed extensive assistance.</p> <p>The most current care plan for Resident #26 had interventions to direct staff to provide oral care 2 times per shift and as needed - the resident required total assistance for oral care. In addition, the care plan noted the resident's teeth were in poor condition and she denied oral pain.</p> <p>In an interview on 8/11/14 at 8:30 p.m., Staff #D stated the resident refused her oral care because the resident was in "so much pain" and she rarely would let the staff do oral care.</p> <p>On 8/11/14 at 8:40 a.m., Resident Care Manager (RCM) Staff #G stated Resident #26 refused her oral care often because of pain in her mouth. Staff #G stated the resident did not like to brush her teeth and she confirmed the nursing assistants were not documenting the frequency of the resident's refused oral care and source of pain.</p> <p>The facility failed to review and revise the current care plan to address the resident's oral pain and frequent refusals for oral care. This placed the resident at risk for pain, poor oral hygiene, tooth loss, poor nutrition and weight loss.</p>	F 280		
F 309 SS=E	<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 or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p>	F 309	<p>How the nursing home will correct the deficiency as it relates to the resident(s)</p> <p>Pain: A complete pain assessment was completed on Resident #26 including the oral cavity. Careplan interventions were implemented to include alternate oral care, and reporting non-compliance and/or pain.</p> <p>Dialysis: Resident #277 was discharged home [REDACTED] 14.</p> <p>Bowel Management: A complete assessment of residents #26, #202, #277 and #170 was completed and interventions were initiated as appropriate.</p>	9/13/14

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Continued From page 3

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review it was determined the facility failed to provide care and services for 1 of 4 residents (#26) related to pain, 5 of 9 residents for bowel management (#26, 170, 202, 277, 324) and 1 resident for dialysis monitoring in a sample of 42.

Findings include:

Pain:

Resident #26 had a diagnoses of [REDACTED] and dementia. Per the record, she also had a history of dental issues, weight loss, and muscle spasms.

The resident required total assistance with most activities of daily living, and required extensive assistance with eating.

The record indicated on 4/18/14 the resident had swelling and tenderness of her upper lip. Recommended treatment for the resident was to have warm moist packs applied to the upper lip 3 times a day, and to treat pain. The resident continued to have a swollen lip, with related pain and refusals of meals. An antibiotic was started on 4/28/14.

Per April 2014 dietary records, the resident refused 8 out of 21 meals in 7 days. Weight records from 3/23/14 to 5/25/14 showed the resident lost 18 pounds as a result of her lip condition, dental issues, and pain. She was also identified on a 5/16/14 dietary note as having a broken tooth, which caused further pain and decreased food intake.

An assessment on 7/22/14 documented the resident had obvious or likely cavities and/or broken natural teeth. There was no identification

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How the nursing home will act to protect residents in similar situations

Pain: All residents were assessed; those with poor oral hygiene, refusals and/or pain have a plan of care to reduce the risk of pain, poor oral hygiene, poor food intake and potential for weight loss.

Dialysis: During the admission process an assessment of all fistulas will be completed. Daily checks of fistulas will be completed and documented. Abnormal assessments will be reported to the dialysis center and the physician.

Bowel Management: All residents bowel records were assessed. Interventions were initiated as appropriate.

Measures the nursing home will take or systems it will alter to ensure that the problem does not recur

Pain: Nursing staff were counseled and re-educated on thorough assessment and documentation of pain.

Dialysis: LN's were educated on the assessment and documentation of fistula sites. A guest speaker also presented to the LN's on the continuum of care for the dialysis patient.

Bowel Management: Counseling and re-education was given to the LN's responsible for the delay in interventions. All LN's received education of bowel intervention protocol and timely implementation of bowel management.

How the nursing home plans to monitor its performance to make sure that solutions are sustained

Pain: Care plans will be audited to ensure appropriate pain interventions for 3 months.

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F 309

Continued From page 4 of the resident's mouth pain, or difficulty chewing, despite the fact these had been problems over several months.

The assessment further indicated the resident had frequent pain, which affected her sleep, and limited her day to day activities. The source of the pain was not identified, and her care plan was not modified related to the mouth pain (see F280 for additional information). The most recent care plan identified the resident as having no oral pain.

Additional pain assessments from April and July 2014 identified left arm and leg pain - no mouth or facial pain was identified or assessed.

In reviewing the July and August 2014 medication administration documentation, the resident had received scheduled and as needed pain medication. Most of the time the source of pain was identified as "general." Mouth pain was never specifically identified.

In addition, the August 201 meal monitor documentation was reviewed - the resident had refused 14 of 33 meals. The reason was not identified.

On 8/7/14 at 1:33 p.m., the resident's spouse stated Resident #26 had a history of dental issues and her gums were sore at times. He indicated she had to eat soft foods due to her mouth pain.

Several staff were interviewed related to the resident's history of mouth pain and poor oral intake. On 8/8/14 at 9:00 a.m., Licensed Nurse #A reported the resident does not have any mouth/oral pain. In an interview with Staff #C on 8/8/14 at 10:25 a.m., she stated the resident refused oral care and her breakfast that day. The resident told Staff #C she was not feeling well. At 1:20 p.m. the same day, Staff #B reported the resident's teeth hurt her and are sensitive which made the resident refuse oral care. On 8/11/14 at

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Dialysis: Random monthly audits will be done on residents receiving dialysis.

Bowel Management: Weekly audits of bowel records will be done for 6 weeks to ensure interventions are implemented timely. Then, RCM's will conduct monthly reviews. The DNS will complete random audits in addition to the consulting pharmacists' monthly review.

Title of person responsible to ensure correction
Director of Nursing Services, RCM's

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F 309	<p>Continued From page 5</p> <p>8:30 a.m. Staff #D said the resident refused her oral care because the resident was in "so much pain" and rarely let the staff do oral care. On 8/12/14 at 10:30 a.m., Nurse #E stated the resident had some teeth pulled in the past and had no current mouth pain. Nurse #E said the nursing aides are supposed to let the nursing staff know if the resident had any pain and the source of pain.</p> <p>The facility failed to communicate, identify and thoroughly evaluate the resident's long-standing mouth pain. This placed the resident at risk for continued pain, poor oral hygiene, poor food intake, and additional weight loss.</p> <p>Dialysis: Resident #277 had diagnoses that included kidney disease. Per record review, the resident went to dialysis (a process to filter blood to maintain kidney function) three days a week at an outside facility.</p> <p>Per review of the resident's most recent plan of care, the resident's fistula (connection of an artery to a vein for access during dialysis) was to be assessed and staff were to notify the dialysis center if there were abnormalities.</p> <p>Per record review, there was no documentation found that the resident's fistula was being assessed by staff which would include assessing the bruit or thrill (ways to check blood flow thru the fistula site) or to assess the fistula for any signs of infection.</p> <p>Per interview on 8/11/14 at 2:20 p.m., Licensed Nurse (LN) #F stated when a resident returned from dialysis he would take off the dressing that was over the fistula and would make sure there weren't any problems with the site. He stated he was not aware there were any</p>	F 309		

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F 309	<p>Continued From page 6</p> <p>places to document the monitoring of the site.</p> <p>On 8/11/14 at 3:10 p.m., LN #F stated when residents returned from dialysis the pressure dressing on the fistula was either taken off by her or the resident would remove it. She stated the cite would be monitored at that time. Staff #E stated there was no documentation showing the monitoring of the site.</p> <p>During an interview on 8/12/14 at 10:22 a.m., Resident Care Manger (RCM) #H stated the licensed staff should assess the resident's fistula daily. She confirmed there was no documentation of the assessment/evaluation of the fistula.</p> <p>The lack of inconsistent monitoring of the resident's fistula site by the facility placed the resident at risk for complications which could include infection, bleeding, and clotting of the fistula site.</p> <p>Bowel Management: The facility's bowel protocol included the following treatments:</p> <ul style="list-style-type: none"> * At the beginning of the shift each Licensed Nurse (LN) will chart bowel movements (BM) on the Medication Administration Record (MAR), the nurse will evaluate/assess the need for intervention. The assessment was to include assessing for distention (swelling of abdomen), tympany (hollow drum like sound) and bowel sounds. * If no BM for 5 shifts an oral laxative may be administered. If no BM for 7 shifts and the oral laxative was ineffective, a suppository may be administered. If the suppository was not effective, a follow up suppository, an enema, or manual removal of feces would be done. * If an individual pattern has been established in the Plan of Care or MAR, a laxative will be administered on shift following the last day of the 	F 309		
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F 309	<p>Continued From page 7</p> <p>normal pattern and suppository will be administered on 3rd shift following the last day of the normal pattern</p> <p>1. Resident #26 had diagnoses that included [REDACTED] and dementia. The resident received narcotic pain medications, which can cause constipation. Per record review, the resident was routinely taking 2 types of medications to prevent constipation.</p> <p>The resident's normal bowel pattern was assessed as every 1-2 days. It was documented that from 7/19/14-7/23/14 the resident went over 4 days without a BM. On 7/31/14-8/4/14 the resident again went over 4 days without a BM.</p> <p>Per record review, there was no documentation that the facility initiated the bowel protocol nor had the resident been assessed for the need for intervention.</p> <p>During an interview on 8/12/14 at 10:07 a.m., Residential Care Manager (RCM) #G stated the licensed nurses (LN) were to monitor the bowel records of each resident. If the resident did not have a BM, then the nurses would do an abdominal assessment and initiate the bowel protocol.</p> <p>2. Resident #202 had diagnoses that included diabetes. The resident received narcotic pain medications, which can cause constipation.</p> <p>Per record review, the resident's normal bowel pattern was assessed as every 1-2 days. It was documented that the resident did not have a BM in June 2014 for over 3 days on 3 different occasions. In July 2014, the resident went 4 days without a BM, and in August 2014, 5 days.</p> <p>Per record review, there was no documentation that the facility initiated the bowel protocol, nor had the resident been assessed for</p>	F 309		
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F 309	<p>Continued From page 8 the need for intervention.</p> <p>During an interview on 8/12/14 at 10:22 a.m., RCM #H reviewed the resident's record and confirmed the bowel protocol had not been initiated.</p> <p>3. Resident #277 had diagnoses that included kidney failure. The resident received narcotic pain medications, which can cause constipation. He was on a routine medication that was given twice daily to prevent constipation.</p> <p>The resident's normal bowel pattern was not identified. In July 2014, the resident went 8 shifts on 2 different occasions without a BM. In August 2014, the resident went 12 shifts and 7 shifts without a BM.</p> <p>Per record review, there was no documentation that the facility initiated the bowel protocol nor had the resident been assessed for the need for intervention.</p> <p>When interviewed on 8/12/14 at 10:22 a.m., RCM #H reviewed the resident's record and confirmed the bowel protocol had not been initiated.</p> <p>4. Resident #170 had diagnoses that included history of a stroke and dementia. The resident was taking 2 types of medications to prevent constipation.</p> <p>Per review of the resident's plan of care, it was documented the resident had constipation due to decreased movement. The resident was assessed to have a normal bowel pattern of every 2-3 days and licensed staff were to monitor for constipation.</p> <p>In July 2014, the resident went over 4 days without a BM on 2 separate occasions during the month.</p> <p>There was no documentation to indicate the</p>	F 309			

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F 309	<p>Continued From page 9</p> <p>facility initiated the bowel protocol, nor had the resident been assessed for the need for intervention.</p> <p>When interviewed on 8/12/14 at 10:07 a.m., RCM #G said the licensed nurses (LN) monitored the bowel records of each resident. If the resident did not have a BM, the nurses were responsible to do an abdominal assessment and initiate the bowel protocol. She confirmed the bowel protocol had not been initiated for this resident.</p> <p>5. Resident #324 had diagnoses that included heart failure.</p> <p>Record review indicated the resident's normal bowel pattern was every 1-2 days and that he had a history of constipation.</p> <p>The care plan goal was for the resident to have a bowel movement every other day. Interventions to accomplish this goal included: monitoring the resident for constipation, administering medications per doctor's orders, and monitoring the effectiveness of the medications.</p> <p>Review of Resident #324's bowel records for July-August 2014 showed that he went 5 days (a total of 14 shifts) without a BM on one occasion, and 3 days (9 shifts) on another occasion.</p> <p>There was no documentation to indicate the facility initiated the bowel protocol, nor had the resident been assessed for the need for intervention.</p> <p>During an interview on 8/12/14 at 10:07 a.m., Staff #C stated the licensed nurses (LN) were to monitor the bowel records of each resident. If the resident did not have a BM, then the nurses would do an abdominal assessment and initiate the bowel protocol.</p> <p>The facility failed to adequately monitor 5</p>	F 309		

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F 309	Continued From page 10 residents to ensure they were having bowel movements as per their normal routine, and to utilize the physician ordered interventions when they were not. In addition, licensed nursing staff did not complete abdominal assessments as directed. This placed residents at risk for constipation, abdominal discomfort, decreased appetite and additional complications.	F 309			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to monitor and reassess the effectiveness of planned interventions in place to prevent the development of pressure ulcers for 1 of 4 residents (#179) in a sample of 42. Findings include: Resident #179 had diagnoses that included a left hip replacement. The resident required extensive assist with bed mobility and transfers, and wore a left knee brace. A skin assessment of 5/28/14 identified the	F 314	How the nursing home will correct the deficiency as it relates to the resident(s) Resident #179 was discharged [REDACTED] 14 How the nursing home will act to protect residents in similar situations All residents were assessed for skin issues. All skin interventions were re-evaluated for effectiveness. Measures the nursing home will take or systems it will alter to ensure that the problem does not recur Re-education to all LN's will be completed to ensure knowledge of skin at risk protocols and interventions. A weekly audit of skin interventions and documentation will be completed for 3 months. How the nursing home plans to monitor its performance to make sure that solutions are sustained A weekly audit of skin interventions and documentation will be completed for 3 months. Ongoing education on re-evaluating and implementing effective skin interventions will be completed. Title of person responsible to ensure correction Director of Nursing	9/13/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/12/2014
NAME OF PROVIDER OR SUPPLIER ROYAL PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7411 NORTH NEVADA SPOKANE, WA 99208		
(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 314	<p>Continued From page 11</p> <p>resident was at risk for the development of a pressure ulcer. Preventative interventions included: weekly skin checks, a pressure reducing wheelchair cushion and bed surface, and floating his heels in bed as the resident allowed.</p> <p>Per review of progress notes, there was no documentation in regards to whether the resident was compliant or non-compliant with floating his heels.</p> <p>On 6/8/14, it was documented the resident had developed a left heel blister. On that same day, the area was described by a different staff member as an unstageable (when the base of the wound is covered by slough or black tissue) heel ulcer measuring 2.5 centimeters (cm) x 1.7 cm with 100% eschar (black, dead tissue).</p> <p>When interviewed on 8/12/14 at 11:20 a.m., Licensed Nurse (LN) #K said the resident wasn't able to float his heels prior to developing the pressure ulcer because of the knee brace. She indicated the knee brace placed the leg at an angle, which pushed his heel down onto the mattress. While wearing the brace the heels couldn't be floated. She indicated that after the pressure ulcer was identified, the resident was given a soft boot to wear so that it didn't worsen.</p> <p>Failure of the facility to reassess the interventions that were in place to prevent the development of a pressure ulcer resulted in the resident developing a left heel unstageable pressure ulcer.</p>	F 314			