DEPARTMENT OF HEALTH AND H\' \N SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	505379		C 04/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL PARK CARE CENTER	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 000	INITIAL COMMENTS This report is the result of an unannounced Abbreviated Survey conducted at Royal Park Care Center on 4/24-25/13. A sample of 6 residents was selected from a census of 151. The sample included 5 current residents and 1 discharged resident. The survey was conducted by: Cindy CoVille, RN, BSN The surveyor is from: Department of Social & Health Services Aging & Long-Term Support Administration Residential Care Services, District 1, Unit A 316 West Boone Avenue, Suite 170 Spokane, WA 99201-2351 Telephone: (509)323-7302 Fax: (509)329-3993 Residential Care Services	F 000	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 MAY 1 0 2013 DSHS ALSA HCS SPOKANE WA	
F 225	483.13(c)(1)(ii)-(iii), (c)(2)-(4)	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 5/15/2013

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 SS=D	Continued From page 1 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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. 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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 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.	F 225	**How the nursing home will correct the deficiency as it relates to the resident(s)** The incident was called to the hotline on 4/24/13 when it was identified to be an injury of unknown source. A full investigation was completed. **How the nursing home will act to protect residents in similar situations** Residents with recent injuries were reviewed to determine that the source was known and that the proper reporting/investigative procedures were followed at the time of injury. Counseling and education has been provided. **Measures the nursing home will take or systems it will alter to ensure that the problem does not recur** The investigative committee will review injuries of unknown sources/fractures to ensure adequate investigation and/or reporting takes place. When it is noted that a resident has increased pain and/or fracture it will be investigated. Counseling and education has been provided. **How the nursing home plans to monitor its performance to make sure that solutions are sustained** A monthly audit will be completed and reported as part of the Incident/Accident Continuous Quality Improvement report. **Title of person responsible to ensure correction** Director of Nursing, Investigative Nurse, Resident Care Managers	6/10/13

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F 225	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to investigate the cause of a new fracture for 1 of 6 sample residents (#1), or to report it to the State survey and certification agency as required. Findings include: Resident #1 had diagnoses of a hip fracture and arthritis. Per the record, she was originally admitted to the facility on [redacted] following a left hip replacement. Upon further record review, the resident was recently re-admitted to the hospital (on [redacted]) to have the hip surgery re-done after some complications. She had returned to the facility on [redacted]. Documentation from facility nursing staff and an ARNP between 4/11-4/15/13 indicated the resident was complaining of increased pain, not having her pain well controlled, and refusing some care because of pain. An x-ray of the left hip and knee were ordered on 4/15. A physician progress note on 4/16/13 documented the resident had a new left hip fracture and she was subsequently taken to the hospital. Despite the fact the resident had a new hip fracture, requiring re-hospitalization and additional surgery, there was no evidence the facility initiated an investigation to determine how the fracture may have occurred. In addition, the presence of a new fracture (considered to be a substantial injury of unknown source) was not	F 225		

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F 225	Continued From page 3 reported to the State survey and certification agency as required. On 4/25/13 at 8:15 a.m., Administrative Staff A verified that the source of the fracture should have been investigated and reported.	F 225		
F 323 SS=D	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 interview, the facility failed to ensure that 2 of 6 sample residents (#2,3), both with previous skin injuries and at continued risk, had adequate measures in place to prevent additional injuries. Findings include: 1. Resident #2 had diagnoses of [redacted] and osteoporosis (thinning of the bones causing the potential for fractures). In addition, the resident had been identified as a very high fall risk and having fragile skin. On 3/2/13, the resident received a skin tear to the left elbow. It was determined the injury occurred when the resident hit/scraped her arm against the wheelchair armrest. The care plan was modified to add "sheepskin to wheelchair arms at all times	F 323	**How the nursing home will correct the deficiency as it relates to the resident(s)** The padding was placed on resident #1's wheelchair arms and a "reacher" is accessible to the resident. Resident #3 is no longer at Royal Park. **How the nursing home will act to protect residents in similar situations** Residents with similar care plan interventions have been identified and reviewed. A central supply staff member will complete a full resident room and wheelchair audit to ensure all items for intervention are in place. Safety equipment will be available for back up. **Measures the nursing home will take or systems it will alter to ensure that the problem does not recur** Future adaptive equipment will be indicated in the resident Treatment Administration Record (TAR) for ongoing monitoring by the Licensed Nurses. Education was provided to the nursing staff **How the nursing home plans to monitor its performance to make sure that solutions are sustained** The Investigative Nurse and Resident Care Managers will be held responsible to provide a monitoring audit quarterly as the Resident assessments are completed.	6/10/13

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F 323	Continued From page 4 to prevent skin abrasions." The resident was observed periodically on 4/24-25/13, there was no padding of any kind on the arms of the resident's wheelchair, despite the fact she was identified as at risk for skin injuries and had sustained a skin injury. In addition, the resident had recently returned from the hospital on [redacted] after falling while in the facility and fracturing her hip. An assessment done on 3/28/13 documented the resident continued to be a high fall risk in part due to her poor safety awareness. Additional notes indicated the resident tended to lean to pick items off the floor. The resident fell on 3/30/13 while reaching forward to pick a menu up off the floor. The investigation indicated the care plan would be modified to include the use of a "reacher" (a long-handled device to help obtain items at a distance). A review of the most recent care plan did not include this intervention for injury prevention. The resident fell again on 4/5/13 while standing up and trying to clean off her shoe. The resident was observed periodically on 4/24-25/13, she did not have a "reacher" accessible to her. On 4/24/13 at 2:35 p.m., the resident was observed leaning forward in her wheelchair, attempting to clean water off the floor. Per interview at that time, she was not aware of any device to help her reach for things. The facility failed to put adequate preventative measures in place to prevent skin tears and additional falls. This placed the resident at risk for additional accidents with potential for injury.	F 323	Continued from page 4 **Title of person responsible to ensure correction** Director of Nursing, Investigative Nurse, Resident Care Managers	

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F 323	Continued From page 5 2. Resident #3 had diagnoses of end-stage lung disease and osteoporosis. In addition, the resident had been identified at risk for skin injuries because of her age, medications she was taking, and her poor nutritional status. The record documented on 3/5/13 the resident fell and fractured her arm. After that time she was wearing a sling, and required additional assistance with activities of daily living. On 3/10/13, the resident received a skin tear to the right shin while being transferred from her wheelchair to the toilet. The incident investigation documented the resident's leg hit the edge of the wheelchair, causing the injury. The care plan was modified to add padding to the wheelchair leg rests in an effort to prevent additional skin injuries. On 3/17/13, the resident received another skin tear and bruise to the left shin while being transferred from her bed to a wheelchair, despite the fact that the wheelchair leg rests were padded. The investigation and documentation regarding the incident did not evaluate whether/not the staff were using appropriate transfer techniques, and there was no evidence of staff training or counseling. On 3/22/13, the resident received a skin tear to right upper arm. The investigation indicated it was "scraped" on the side of wheelchair, but did not indicate how it occurred. No changes were made in the plan of care to prevent further skin injuries. The facility failed to fully evaluate how the injuries	F 323		

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F 323	Continued From page 6 occurred and to put measures in place to prevent skin injuries. As a result, the resident received skin tears and bruising on 3 separate occasions in a 2-week period.	F 323		